



Royal College of  
General Practitioners

# **THE RCGP GUIDANCE FOR CLINICAL SUPERVISORS (WHEN NOT IN PRIMARY CARE) ON COMPLETING WORKPLACE BASED ASSESSMENT (WPBA)**

A GUIDE FOR SUPERVISORS

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## **Guidance for Clinical Supervisors (when not in Primary Care) on completing Workplace Based Assessment (WPBA)**

### **Introduction**

This document outlines the GP Trainee Workplace Based Assessment (WPBA) requirements whilst not in Primary Care and provides a basic understanding of what is required from each WPBA. This guide has been created after receiving feedback that supervisors would welcome more easy access to user-friendly resources. It is hoped that this guide will aid consistency and trainee/supervisor satisfaction. The RCGP are keen to enable the use of WPBA tools to support formative learning whilst also recording the learning and performance at the time that they are carried out.

WPBA comprises one third of the MRCGP qualification. WPBA provides a framework for evaluating a GP trainee's progress in those areas of professional practice best tested in the workplace, complementing the other components of the MRCGP licencing examination. Throughout GP specialty training, trainees collect evidence relating to 13 areas of professional capabilities and record it in their trainee Portfolio. This evidence is used to inform six-monthly reviews and - at the end of training - to make a judgement about their readiness for independent practice.

WPBA tools when not in Primary Care are:

- Case Based Discussion (CbD)
- Mini Clinical Evaluation Exercise (MiniCEX)
- Multi-Source Feedback (MSF)
- Clinical Examination and Procedural Skills (CEPS)
- Clinical Supervisors Report (CSR)
- Learning Log – via Portfolio
- Personal Development Plan (PDP) – via Portfolio

Additional WPBA tools used in Primary Care:

- Patient Satisfaction Questionnaire (PSQ)
- Consultation Observation Tool (COT) and Audio-COT– replaces MiniCEX
- Care Assessment Tool which includes Case Based Discussions

Appendix 1 WPBA minimum evidence requirements (full time training).

For further information and more detailed resources throughout this guide, please see the RCGP WPBA website: <http://www.rcgp.org.uk/training-exams/training/mrcgp-workplace-based-assessment-wpba.aspx>

## **WPBA capabilities**

The WPBA component of the MRCGP exam is designed to test a GP trainees' competence in 13 key areas derived from the core RCGP curriculum statement 'Being a GP'.

Competence means having the abilities, knowledge and skills necessary for professional practice. The framework for WPBA is made up of 13 capabilities:

1. Fitness to practise – your awareness of when your performance, conduct or health, or that of others, might put patients at risk, and taking action to protect patients.
2. Maintaining an ethical approach – practising ethically, with integrity and a respect for diversity.
3. Communication and consultation skills – communication with patients, and the use of recognised consultation techniques.
4. Data gathering and interpretation – the gathering, interpretation, and use of data for clinical judgement, including information gathered from the history, clinical records, examination and investigations.
5. Clinical examination and procedural skills – competent physical examination of the patient with accurate interpretation of physical signs and the safe practice of procedural skills.
6. Making a diagnosis / decision – a conscious, structured approach to making a diagnosis and decisions.
7. Clinical management – recognition and management of common medical conditions in primary care.
8. Managing medical complexity – aspects of care beyond managing straightforward problems, including management of co-morbidity, uncertainty, risk, and focusing on health rather than just illness.
9. Working with colleagues and in teams – working effectively with other professionals to ensure good patient care, including sharing information with colleagues.
10. Maintaining performance, learning and teaching – maintaining performance and effective CPD for oneself and others.
11. Organisation, management and leadership - understanding how primary care is organised within the NHS, how teams are managed and the development of clinical leadership skills.

12. Practising holistically promoting health and safeguarding – operating in physical, psychological, socioeconomic and cultural dimensions, considering feelings as well as thoughts.
13. Community orientation – management of the health and social care of the practice population and local community.

## **GP Curriculum**

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

For the purpose of WPBA, the topic guides have been grouped into a shorter list of Clinical Experience Groups and these are linked to the assessments the supervisor completes with their trainee.

## **Clinical Experience Groups**

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

## **Assessments**

### **Who can complete the assessment in non-primary care placements**

- The Clinical Supervisors Report (CSR), should be completed by the trainees named Clinical Supervisor, who needs to have met the educator requirements of the GMC.
- It is to be expected that at least one assessment and ideally one CbD and one MiniCEX for each trainee will be completed by the Clinical Supervisor before the CSR. This allows the CS to have evidence of the trainees' performance before completing the CSR.

- Other assessments can be completed by a doctor who is at a level of ST4 or above, or SAS equivalent.
- Assessors should not be completed by one of the trainees' peers, or anyone who is at the same or a lower level of training.

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

### **Calibrating the standard required in assessments**

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

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

All assessors are asked to define the level of complexity of the case as low, medium, or high and to link the case to the relevant Clinical Experience Groups.

Below, are the grades for the assessments and descriptors for the 'assessment of performance levels'. In addition, as part of the CSR, the Clinical Supervisor is also be asked an entrustable question relating to the level of supervision the trainee has needed during that post.

Word pictures for the grades within each Capability have been written to support both the trainee and the supervisors. These should be used alongside the assessment until you become familiar with their content.

Guidance on the standards expected for GP trainees in the CSR (Clinical Supervisor's Report) are available [here](#)

### **Non-primary care assessment grades for the capability area being assessed:**

- Significantly below expectations
- Below expectation
- Meets expectations
- Above expectations

MiniCEX also has a grade of 'not applicable'.

### **Assessment of performance levels for the Cbd and MiniCEX**

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

- Below the level expected prior to starting on a GP Training programme
- Below the level expected of a GP trainee working in the current clinical post
- At the level expected of a GP trainee working in the current clinical post
- Above the level expected of a GP trainee working in the current clinical post

## Assessment of Performance for Clinical Examination and Procedural Skills

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

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

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

Level	Supervision definition
<b>1*</b>	Cannot be left without direct supervision Limited to observing care and/or Seeing patients alone but not allowed to let patients leave the building or complete an episode of care before review by the supervisor.
<b>2*</b>	Requires more supervision than expected in their clinical role Requires direct supervision by named supervisor: The trainee may provide clinical care, but the supervisor (or in their absence a delegated supervisor) is physically within the building and is immediately available if required to provide direct supervision on specific cases and non-immediate review of all cases.
<b>3</b>	Requires expected levels of supervision in their clinical role Requires indirect supervision by the named supervisor: The trainee may provide clinical care when the supervisor is at a distance (urgent /unscheduled care, home visits) but is available by means of telephone to provide advice, and available to attend jointly if required to provide direct supervision. The trainee does not need to have every case reviewed but a regular review of random or selected cases takes place at routine intervals.
<b>4 (ST3 only)</b>	Requires no supervision in their clinical role <i>It is proposed that GP trainees will only reach Level 4 at the end of their training.</i>

\*If levels 1 or 2 are selected the Clinical Supervisor will be required to clarify their reasons for this choice and it is expected that they would then also contact their local GP Associate Dean/Training Programme Director and/or Educational Supervisor to inform them of their concerns.

## **Indicators of Potential Underperformance**

The competency framework, developed for the MRCGP from the GP curriculum, is a series of word descriptors that describe 'positive' behaviours that doctors display in practice. This framework has been augmented by selectively adding a number of 'negative' behaviours and placing them alongside the themes in the framework to which they are particularly (but not exclusively) related. These behavioural descriptors are intended as an additional interpretative tool to make it easier to recognise underperformance, to do so early in training and this material may be used to give constructive feedback to the trainee. Further information on these indicators can be found on the WBPA section on the RCGP website.

## **The roles of the Clinical Supervisor and Educational supervisors**

### **Clinical supervisor**

The Clinical Supervisor (CS) should (normally) be a consultant to whom a GP ST1/2 trainee should remain attached throughout the post. Though in some areas the hospital CS has access to the Portfolio, in many areas the hospital CS does not. For those clinical supervisors who do not have access to the trainees Portfolio, the trainee will send you a 'ticket code' with a link to the assessment form via an email in advance of your planned meeting or agreed assessment, to enable formative discussion and joint completion of the assessment forms.

All doctors who are named GP Clinical Supervisor, must have attended appropriate clinical supervisor training. The Clinical Supervisor is required to :

- Be the named supervisor for the duration of the post
- Undertake an initial induction meeting reviewing the learning needs of the GP trainee and agreeing an educational plan for the post. The trainee needs to complete a mandatory placement planning meeting learning log entry in their Portfolio after the meeting -see below
- Complete at least one WPBA for the trainee and ideally one Cbd and 1 miniCEX.
- Complete a Clinical Supervisors Report (CSR) on the Portfolio at the end of the post (access to the assessment and report forms are sent via a 'ticket code' as described above when the supervisor doesn't have access to the trainees Portfolio).

### **Placement planning meeting**

Within the first few weeks of each new placement you need to meet with your trainee for a placement planning meeting. This is an opportunity to ensure that the trainee has appropriate learning objectives for the placement. At the Placement planning meeting it is recommended that dates are agreed for a mid-post review and for a final review to complete and discuss the CS report.

### **Educational Supervisor**

The trainee's Educational Supervisor (ES) will always be a GP. Normally this GP will provide continuity and support and at least six-monthly reviews which are summarised in the



Educational Supervisor Reports (ESRs) throughout the GP trainee's training. The ES will always have access to the Portfolio and is normally the first person that the CS should contact if there are issues with progression or illness etc. Alternatively, the GP Training Programme Director can be contacted with any issues.

## Completing WPBA

### 1) How to complete a Case Based Discussion (CbD)

#### Who can complete a CbD?

CbDs can be carried out in hospital by clinical supervisors (which is best practice), or by doctors who are ST4 or above, or doctors with equivalent experience if SAS (Specialist and Associate Specialist) and have met the GMC assessor requirements. Trainees choose who undertakes their CbDs. Trainees are encouraged to complete assessments with a breadth of assessors, ideally with several completed by consultants and senior specialist registrars. Trainees are encouraged to have at least one CbD completed by their named clinical supervisor during each rotation.

#### How to manage and assess a trainee in a Case Based Discussion

A CbD is a structured interview between educator and trainee; the assessor is required to stick to the 'here and now' (the 'there and then') rather than asking 'what if...' questions. The cases should be ones that the trainee managed independently (it is NOT appropriate to have got advice from another doctor for the consultation and then to be assessed on actions which were not independent).

Assessor instructions: BEFORE YOU START

- **Protected time** is needed for CbDs.
- The **trainee is responsible** for selecting the case, organising a time for the assessment with the identified, approved assessor and completing any preparatory work.
- For each CbD interview, the trainee should select a case and share details of the clinical entry and a medical summary with the supervisor at least three days before the discussion.
- The trainee needs to have prepared the case against the capabilities they believe the case covered or capabilities they wish to discuss. It is expected the trainee will have covered 3 to 4 capability areas.
- When a case is presented to you for a CbD, it is helpful if you are familiar with it **beforehand**.
- **Case selection is very important:** encourage your trainee to present cases that focus on the capabilities they have not covered in previous CbDs or those that have previously been flagged as needing development during this post. Cases where there was an

element of uncertainty or where a conflict in decision-making are particularly good ones to choose.

- Use the 'CbD question maker' See [Appendix 2](#) to help **work out questions you would want to use on each** capability domain you are assessing (some assessors may want to use the word descriptors to generate their own questions).
- It is important for the progress of the trainee that the discussion is used to guide further development by offering structured feedback. The CbD discussion should normally take no longer than 30 minutes in total which allows about 20 minutes for feedback together with any recommendations for change (10 minutes feedback).

### **The CbD process**

- Ask the trainee to **introduce the case briefly**– try not to interrupt (2-3 mins). Another useful starting point is to ask them 3 things:
  - i. *what issues did you feel the case raised?*
  - ii. *what issues did you feel needed resolving?*
  - iii. *what bits did you find challenging/difficult?*
- **Clarify matters of fact** e.g. *'what did you mean when you told her....?'*
- **Take notes** as they talk: especially of some of the things they say that relate to the capability domains you want to assess; explore those later.
- **Set the agenda:** review the capability domains selected by the trainee It may be appropriate to select different capability domains that you planned to look at having considered the presentation that the trainee has made.  
*'Today, were going to use this case to explore three capability domains. The first is.... and the second.... and finally.....'*
- Before asking the set of questions relating to a specific capability, **signpost the capability** being assessed.  
*'Okay, let's move on. The next set of questions I am going to ask you relate to the capability ....'*
- **Do not ask hypothetical questions** like 'What if' scenarios. CbDs are testing what they actually did and why AND NOT what they would do in an ideal world. You can ask *"What is your next step?"*
- It is good practice to **ask for evidence of what they did**  
*'So, how did you actually phrase that? What did you actually say? What was the response to that?'*
- And / Or **ask for justification** of what they did  
*'So, what made you do that?'*  
*'Why did you choose that option above all the others?'*  
*'Did you use any guidance, protocols or evidence to guide you?', 'Where did you look for that?', 'What did it say?'*
- **Once you've got enough evidence** to rate the trainee on that capability, move onto the next one. To make the assessment decision for each capability, you need to push the

trainee to his/her limit (the point at which they despite encouragement appear to have nothing further to add).

- If a particular capability is causing concern, stay with it and give it the time it deserves to enable you to tease out what the trainee needs to do in order to improve.
- **Don't teach during the assessment phase of the process.** Some supervisors assess and teach at the same time. This disrupts the process, shifts the balance in terms of the time devoted to assessment and to teaching, and can result in cases taking an awfully long time to complete. You can have a deeper discussion when the assessment bit is over; it is appropriate to flag that you intend to return to teach on this areas later during the discussion.
- Continuously monitor **trainee's verbal and non-verbal cues**. If they look threatened or anxious, pause until it is appropriate to restart. CbDs are an opportunity to tease out a true picture of what they did and why. That's unlikely to happen if the discussion is adversarial.

### **When you are giving feedback**

- At the end of **each case**, ask the trainee how they felt they performed.
- A judgement of the level of performance demonstrated by the trainee should be recorded on the marking grid along with recommendations for further development. Remember, your feedback should be specific and descriptive. *'Let's look at each capability area we covered... practising holistically – how did you feel that went for you?'*
- For each capability state what they did well and what they could improve. The RCGP capability descriptors will help you to do this.
- You might wish to ask the trainee:  
*'What's the most important things you're going to take away from today's session?'*  
*'What do you need to follow up?'*
- Now record it in their Portfolio using the ticket code provided in advance by the trainee if the CS does not have personal access to Portfolio. It is best to do this jointly so that what is written is shared and therefore owned, though the final responsibility for what is written lies with the assessor. The formative written feedback is reviewed by the trainee and their educational supervisor when completing their sixmonthly educational supervisor review. Please capture your discussions within the assessment tool to help facilitate the trainee's reviews.

## **2) How to complete a miniCEX (Clinical Evaluation Exercise)**

The Clinical Evaluation Exercise (miniCEX) assesses clinical skills, attitudes and behaviours in a non-primary care setting. The miniCEX should provide a 15-minute snapshot of how the trainee interacts with patients in a non-primary care setting.

Each miniCEX should represent a different clinical problem. It is helpful to vary the types of cases that are assessed using miniCEX so that the trainees' competence is reviewed on different challenges. One miniCEX should be assessed by the clinical supervisor. Other assessments can be completed by a doctor who is at a level of ST4 or above, or SAS equivalent. The observer should not be a GP trainee or specialty trainee at a similar stage in training.

The assessor should give the trainee immediate feedback and then provide a contemporaneous report, rating the trainee and capturing the feedback within the MiniCEX form in the Portfolio. Some assessors will have full access to Portfolio but in non GP settings many will have to be sent a ticket code by the trainee to enable the report to be completed. When assessors have provided more detailed written feedback on the MiniCEX this has been very helpful evidence for the ESR

When in a hospital setting trainees are rated in comparison to other trainees at the same stage.

### **3) How to complete a Clinical Examination and Procedural Skills (CEPS)**

The development and assessment of Clinical Examination and Procedural Skills (CEPS) is an extremely important part of GP training. Competence in these skills is integral to good clinical practice. CEPS has replaced 'DOPS' Directly Observed Procedural Skills, which is currently used in other hospital specialties. Trainees need to gather evidence of their clinical skills through several different assessments and reflective log entries.

Trainees are required by the GMC to demonstrate competence in five intimate examinations. These are breast, rectal, prostate, female genital, (which includes a bimanual and speculum examination) and male genital examinations. A suitably trained professional must observe the trainee performing these examinations. The assessor should record their observation on the CEPS evidence form on the trainee's ePortfolio. (The trainee can provide a 'ticket code' via an email if the assessor does not have personal access.) If this is another doctor they must be at ST4 level or above. If the colleague is another health professional - such as a specialist nurse - they must confirm their role and the training which ensures they have skills in this assessment so that the trainee's Educational Supervisor can be satisfied that they have been appropriately trained. It is the individual patient who determines what is intimate or invasive for them and this will be determined by a number of possible factors including their prior experiences, their religion and their cultural background.

The five mandatory examinations are not a 'minimum requirement' and cannot by themselves demonstrate overall competence in CEPS. A range of CEPS which are relevant to GP are also required. This again is not an exhaustive list, nor is there a set minimum number as everyone has different needs. The trainee is expected to document their performance in CEPS in their learning log and /or discuss their learning needs during placement planning meetings with their Clinical Supervisor and at their 6 monthly reviews with their Educational Supervisor. The range

of examinations, procedures and the number of observations will depend on the trainee's particular requirements and the professional judgement of the trainee's clinical and educational supervisors. For example, the trainee may recognise that their learning needs are joint examinations, the examination of the eye or doing newborn baby checks.

If the trainee is performing below the level expected in this domain it is important for the assessor to be specific about why this conclusion has been reached and what steps the trainee can take to rectify the situation.

**Unlike other hospital assessments the standard that the assessor is assessing against is that of an independent fully qualified GP.** As well as the technical aspects of examination and the ability to recognise abnormal physical signs, it includes the choice of examination best suited to the clinical context. For example, a competent GP very rarely performs an extensive neurological examination but will perform a limited neurological examination as determined by the history taken from the patient.

#### **4) How to complete a Clinical Supervisor Report (CSR)**

The CSR is a short, structured report completed by the Clinical Supervisor and completed towards the end of the trainees' placement. It is an opportunity for the CS to give the trainee feedback on their performance. A well completed CSR is also a valuable source of evidence for each capability in the Educational Supervisor Review and for ARCP panels.

The CSR makes a clear link between each section and the relevant GP capabilities and includes an overall assessment by the Clinical Supervisor (CS) of the level of supervision that the trainee has required.

#### **Who carries out the CSR?**

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

#### **What does the form review?**

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

Word descriptors have been written to support the grading and feedback for each question which are available [as an appendix here](#)

The CS is also asked to make an assessment of the level of supervision required compared to the expected level of performance for a GP trainee at this stage. There are 4 levels of supervision and if more supervision than would be expected is required, or the trainee cannot be left without supervision, then an additional comment box will appear asking for further details.

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

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

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

### **Understanding the Multi-Source Feedback process when not in primary care**

Trainees, are required to complete one cycles of MSF during their ST1 and ST2 years. The trainee must get responses from at least ten clinicians who know the trainee' work well; they should come from a range of roles and include people with a range of seniority. The trainee's educational supervisor reviews the responses and releases the information to the trainee, in

### **Trainee Time out of Training**

Trainees can become unwell and need to be signed off from work. General Practice is the only specialty training programme which has a specified minimum duration of training. This is set in statute. Trainees must complete this minimum time in order to get their Confirmation of Completion of Training. Trainees can only be absent from training for a period of 2 weeks cumulatively in any training year, over and above their allowed annual leave.

It is therefore essential that Clinical Supervisors advise the GP School or Deanery of:

- any sickness absence.
- any adjustment to working hours e.g. not doing nights, reduced hours. (Any such amendment to participation in a rota will be reviewed at their next ARCP panel and a decision about additional training time made.)
- Details of referrals to Occupational Health, or any reasonable adjustments made, should also be shared with the GP school/ Deanery to ensure access to support services available in the area.

### **RCGP Portfolio queries**

If you have any queries about using the Portfolio, please contact the RCGP Helpdesk.

### **Queries regarding trainees**

If you have a query about the trainee then it is appropriate to contact either the trainee's Educational Supervisor or the local GP Training Programme Director/Associate Dean to discuss these further.

## Appendix 1: WPBA minimum evidence requirements (full time training) in ST1/2

	ST1		ST2	
	Old *	Post Aug 2020	Old*	Post August 2020
MiniCEX	6	4	6	4
Cbd	6	4	6	4
MSF	0	1 cycle of 10 respondents	0	1 cycle of 10 respondents
CEPS	Across all years of training need to complete 5 mandatory CEPS and range of others			
Placement planning meeting	Suggested	1 per post	Suggested	1 per post
CSR	1 per post	1 per post	1 per post	1 per post
Learning logs	Trainee's responsibility to complete up to 3 case reviews per month FTE			
Significant event	Trainee's responsibility to document if reaches GMC threshold of potential or actual serious harm to patients			
Learning event	1 required per year of training – trainee's responsibility to document			
ESR	Trainees responsibility to arrange and meet ES every 6 months			

\*Trainees who have not completed their current training year in August 2020 and have less than 6 months FTE to go before they do change training years remain on the old assessment numbers.

## **Appendix 2: Case Based Discussion (CbD) Question Generator for Clinical Supervisors when not in General Practice**

The trainee should have shared information in advance of the CbD meeting including details of the cases to enable you to prepare well. You should not aim to cover every capability area, concentrating instead on those most relevant to the case you choose. It should be unusual to cover more than four capability areas during a CbD. You should bear in mind the trainee's request to have evidence for certain competences to help them show evidence in all areas from a range of sources for each capability in this review period. The prompts below should generate information related to each capability you choose to address. You don't have to ask every question in each category, but keep exploring until you feel you have enough info to make a decision in relation to the description of the capability in the hyperlink.

Case based discussions should be about what was actually done rather than what the trainee might have done. The cases should be ones which they managed independently. (It is NOT appropriate to have got advice from another colleague for the consultation and then to be assessed on actions which were not independent.)

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

**Fitness to practise** - *awareness own performance, conduct or health, or of others; action taken to protect patients*

- Was there any point in the consultation where you felt out of your depth? How did you define your limits? What did you then do?
- It sounds like this was quite an emotionally charged case. It may have caused some internal feelings. How did you manage or neutralise those to ensure they did not impact on the next patient you had to see?
- Our home or family life can change our behaviour and performance at work. Can you tell me about how your non work life might have affected you, when you were caring for this patient?
- Safety Netting: did you advise on when to come back? Why did you choose this time/ approach? (How did you ensure patient safety?)
- Chaperones: Did you use a chaperone? Tell me more about your decision on this. Was it for your benefit or theirs? (protecting patients, protecting doctors)
- How did you feel after you looked after this patient? How did you care for yourself?
- After the consultation, did you have any thoughts on your performance (include knowledge, skills and your approach to the patient)? Did you have any thoughts on how your performance could have been improved? What were these? Have you made any plans to tackle them? (PUNs and DENs)
- Were there any significant learning issues raised by this consultation (including complaints)? What were they? How did you proceed?



- Did you have any concerns over what any of the previous health care professionals had done? What did you do about it?
- Have you considered ringing your defence organisation for advice? (If relevant to the case) Why did you call them? What did you ask? What did they say?

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

- Given there is an ethical dimension to all cases (e.g. did you overload or starve the patient of information, involve them too much/little, spend too much time with them (to the loss of other patients) or spend too little):
- Tell me about the ethical aspects of his case? What were they? How did you manage them?
- Did any of your own values attitudes or ethics influence your behaviour this case?
- What particular professional codes of practice did you have to make sure you adhered to in this case? (e.g.in relation to Equality and Diversity issues or those who might perceive themselves as marginalised.)
- Do you think you might have directly/indirectly discriminated and therefore judged this patient because of their x? If not – how did you anticipate it – making sure the patient didn't feel discriminated against??
- What ethical principles did you use to inform your choice of treatment? How did you ensure the patient had an informed choice in terms of management?
- Was there a need to address confidentiality issues with the patient (e.g. in cases where the patient is a teenager )

**Communication and consultation skills- *communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consultations and the use of interpreters.***

- What questions did you ask to establish what the patient expected to achieve when coming to the hospital. How did you separate these from what the patient thought about his or her health problems?
- Describe what you did or asked to balance the need to be focussed and see enough patients in the department with the need to allow patients to explain things in their way and feel heard.
- How did you adapt your language or communication to suit this patient? [for example the patient might have communication difficulties, have learning difficulties, be working in a second language, or be a child] Please give me examples of things that you said.
- Describe how you used the patient's health understanding to adapt your language and explanations.
- Describe how you adjusted your medically safe plans to suit the patient's agenda and desire for inclusion in decision making.
- How did you adjust your consultation to suit this patient given their background and beliefs?

- Describe how you used communication techniques or materials to improve patient understanding.

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

- Tell me about the key findings in this case including duration of symptoms, pattern etc.
- How did you focus on getting this information in the limited time available to you?
- How did you make sure that you gathered enough information to make sure the patient was safe?
- Describe how you kept a balance between keeping focussed and excluding worrying things? (for you and for the patient?)
- How did you use pre-existing information (consultations, summary, letters, investigations) to help formulate your diagnosis/decision?
- Had you gathered any further information about this case from others?
- What bits of information from the history, examination and investigations) did you find helpful in this case? Why? How did you elicit those?
- What examinations and/or investigations did you do? Explain why you did all of these? Were there any abnormalities?
- How did you interpret your findings from your examinations and/or investigations? How did you act on any abnormal or unexpected findings/results?
- I see from the notes that there is no reference to examining... their “chest” for example. Why is it not there?
- What prior knowledge of the patient did you have which affected the outcome of your consultation(s)?
- Tell me about the abnormalities that you have found examining this person and that you found on investigation. Tell me about which bit of the examination were most useful. Can you explain why this was?
- You have described how you gathered your data, how was this adapted for this particular patient?

**CEPS** - *clinical examination and procedural skills*

- Which examinations did you do in this case and why each one carried out?
- When you examined this patient, how did you assess his or her x e.g. knee/ abdomen etc. What were you intending to gain from assessing x in this level of detail?
- Do you think that your assessment (examination) allowed you to make a definitive assessment; what further assessment might you have done?
- You have explained that you found x when you examined the (part of body). Tell me what this implies to you. What further examination did you do? What was the order of your examination (and your reason for this)?
- You have described doing x examination and then going on to do y. Was it your preference or the patient's?

- How did you manage the medico-legal aspects of your examination here? (considering informed consent, mental capacity, best interests etc.)
- You have described doing an intimate examination. Tell me how you managed the patient's needs and care whilst also gaining the clinical information you needed.
- Patients do not always want to have the examinations that a doctor might want to carry out. (How did you manage this difference?)
- Describe how you managed any cultural and ethical issues that arose

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

- Tell me about the commonest causes locally of these symptoms? How does knowing this help you to care for this patient?
- What is the natural history/pattern of this condition? How does that fit with your findings and your plans for the next steps?
- What differential diagnoses did you consider? What features made each one more or less likely?
- You have suggested that the diagnosis might be x. Which bits of the history and examination made or make you wonder about other diagnoses?
- How did you come to your final working diagnosis? Remind me which bits of the history and examination were instrumental in this?
- When you got the result of the (*names particular test*) can you explain how it changed the diagnoses that you were considering?
- Did you use any tools, guidelines or frameworks to help you with making the diagnosis? (Which ones?)
- Tell me about how you used time to help you when making decisions here.
- Hospitals have clear guidelines which are easily applied in clear situations. How did you use these when approaching this rather more confusing situation?
- What were your treatment options? Which did you choose? Why this one? Convince me that you made the right choice.
- Did you consider any evidence in your final choice? Tell me about it.
- Did you use any tools, guidelines or frameworks to help you with treatment decisions?

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

- You have described a patient with several different problems. How did you choose which of these to prioritise?
- In what ways could this patient have been followed up. What were the advantages of using the way you have suggested? (What form of follow up did the patient suggest/want, how did you incorporate this and keep the follow up plan safe?)
- What management options did you consider at the time? Tell me about some of the pros and cons of these options. Did the patient's preferences or situation affect the management plan? How?

- What made you prescribe x? How did you come to choosing that? What does the evidence say about it? Do you know how much that costs? Why not y which is cheaper and effective? What else is the patient on: did you check for interactions?
- You have described various medications that you have used. What non-drug interventions did you suggest to manage this patient?
- Did you involve, or make a referral to, anyone else? What was the added value of involving this other team or person? (Considerations here might include use of resources, (including time) but also patient safety, and/or recognition of limits to personal recognition of medical conditions)
- Describe how you monitored the patient's progress. How did you ensure continuity of care?
- Did you put in place any follow up/review? If so, why do you want to see them again?

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

- What made this case medically complex? How did you resolve that?
- Were there any areas of uncertainty? What strategies did you use to manage that uncertainty? (e.g. using time)
- There was a lot to coordinate in this consultation – from the acute to the chronic comorbidities. What strategies did you use to coordinate it all?
- The advantages and disadvantages of different options were complex here. How did you explain these to the patient? How do you know that this worked for them?
- In the course of your work with this family (carer or patient network) can you describe the areas where your “medical” training found it hard to adjust to their “patient” perceptions of what should be done. How did you manage these differences? What did you do to address this area?
- Was there a difference of agendas? How did you tackle this? Tell me exactly how you managed to merge agendas.
- Tell me about how you managed the ongoing problems that added to the complexity of this case whilst also dealing with the immediate acute problems?
- How did you explain ‘risk’ to the patient? Did you involve them in the risk management? To what extent and how? How did that risk affect your management plan?
- Did you use any health promotion strategies? How did you encourage the patient to e.g. stop smoking/lose weight/go back to work/other rehabilitation and recovery? Can you describe how this fitted into the rest of the discussions you had with this patient?

**Working with colleagues and in teams** - *working effectively for good patient care; sharing information with colleagues*

- Did you involve anyone else in this case? Who? Why? How did they help? What skills did they bring that you don't have? (This may be especially relevant when involving Allied Health Professionals.)
- Did you involve any other organisations/agencies in this case? For what purpose?

- Some of the teams that you worked with have been working with this patient before your involvement. How did this affect your role in the wider team caring for this patient?
- What information did you provide with your referral? How did you make sure that this was as useful as possible to the team you referred to?
- How did you ensure you had effective communication with others involved in this particular case?
- *If many people/organisations are involved in the case, what do you see as your role considering so many others are already involved in this case? Do so many people need to be involved? Did you do anything to ensure coordination of the overall care to promote more effective team working?*
- What steps did you take to ensure continuity of care?

**Organisation Management and Leadership** - *This is about understanding primary care's role in the NHS; how teams are managed and the development of clinical leadership skills.*

- Can you explain why you have included (or excluded) all the information that you have about the patient in their computer (or paper) records so that it meets governance standards? How have you balanced being concise and being thorough? Has the record captured the patient's narrative?
- Did you use appropriate coding for diagnosis and treatment in line with local expectations or guidance?
- How effective and helpful is the future management plan they have written for their colleagues? What is the trainee's suggestion on how to improve this?
- Did you use any online information or resources to help you? What? Why? How did this help?
- Describe the ways in which delegation and good time management improved your care of this patient.
- Do you have any suggestions about how your management of this case would have been better if the guidance or organisation in the hospital was different? What suggestions for change can you make based on this experience?
- How did the overall workload of the department affect how you managed this patient?

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

- What was the patient's agenda (ideas, concerns and expectations)? How did you elicit their agenda? Why did they present now? What feelings did you explore?
- Did you identify any ongoing problems which might have affected this particular complaint?
- What effect did the symptoms have on the patient's work, family or carers and other parts of their life? (i.e. consider the difference between illness and disease)
- How did the symptoms affect him/her psychosocially? What phrases did you use to elicit these?

- What did you discover about the patient's culture and background? How did you use this to help advise the patient and their family about the next steps in their care?
- Did you explore the impact it had on other family members, carers or close friends? What did you find? How did you support them?
- What other teams or organisations have become involved in this person's care? How does this involvement link to the patient's needs?
- How have you involved the patient (and their carers or family?) in planning their own care?
- How did the patient feel about your choice of treatment? Did this influence your final decision?

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

- You have described the care you and this hospital have given this patient; how would it be different at x Hospital (either more specialist or less specialist than current setting) Can you explain this difference by thinking of the two local populations and the roles of the hospitals?
- Can you tell me about the cost of investigation, treatment and/or referral/care here? How did you consider these when making your decisions?
- How have you have adjusted the care to fit the resources we have here?
- Can you tell me now about the implications of your treatment/investigations/referral on the individual patient and on society? Tell me more about these conflicting pressures.
- How did you balance the needs of this patient against the needs of the whole local population?
- What characteristics of the local community impact on this patient's care (epidemiological/social/economic/ethnic)?
- What local health resources are available that you encouraged the patient to access? (e.g. particular clinics that the hospital offers or weight loss/exercise classes)
- You have prescribed a range of different medications. Please tell me more about them concentrating on their costs and the evidence base for their use in this setting?
- Are there any limitations of local healthcare resources that impact on this patient's care?
- Did this case make you think of any greater social/health care changes/provision we need to consider for our local population? What would we need to do to make this happen?

Developed in Dec 2006 by Dr. Ramesh Mehay, Programme Director Bradford VTS (updated April 2010) for the Bradford VTS website [www.bradfordvts.co.uk](http://www.bradfordvts.co.uk) an independent GP site. Further adapted and updated with permission by RCGP WPBA group October 2018)

## Trainee assessment grade word descriptors for CSR when not in Primary Care

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

When considering the grading each of the areas the following gives a suggestion for the level observed:

Significantly below	Below level expected at completion of Foundation Programme
Below expectations	At the level expected at completion of Foundation Programme/ early GP Training
Meets expectations	At the level expected of a GP trainee completing the current clinical post
Above expectations	Above the at the level expected of a GP trainee completing the current clinical post

<b>Trainee performance descriptor</b> Professionalism			
Includes being respectful, diligent and self-directed in their approach to patients and others and to their own learning needs, developing resilience, making appropriate ethical decisions. <i>Capabilities: Maintaining Performance Learning and Teaching, Ethics, Fitness to practice</i>			
<b>Significantly Below expectations</b>	<b>Below expectations</b>	<b>Meets expectations</b>	<b>Above expectations</b>

<p>Is not aware of the limitations of their knowledge or skills and practices outside their ability, level of experience or confidence without seeking necessary support.</p> <p>Does not identify, address or attend to own learning needs. Does not participate in the education of others.</p> <p>Approach to other people's beliefs, dignity, preferences and rights adversely affects patient care and / or team work.</p> <p>Fails to show willingness to reflect on own attitudes or behaviours and does not demonstrate an ethical dimension in their work.</p>	<p>Is inconsistent in their awareness often not aware of their own knowledge and skills s and/or does not always seek help appropriately.</p> <p>Struggles to identify and /or consistently address own learning needs in a timely way. Peripherally involved in the education of others.</p> <p>May make comments that are inappropriate or seem to be discriminatory but this does not appear to effect the team or patients.</p> <p>Demonstration of an ethical dimension to their work is inconsistent with limited willingness or demonstration of reflection on own attitudes and behaviours.</p> <p>Needs support to manage the</p>	<p>Demonstrates the same level of knowledge and skills as other trainees at this stage of training.</p> <p>Keeps up to date with immediate clinical learning needs. Contributes to the education of others.</p> <p>Understands the need to treat everyone with respect for their differences, beliefs, dignity preferences, and rights and does not discriminate.</p> <p>Demonstrates an understanding of ethical principles and reflects on own attitudes and behaviours.</p> <p>Aware that personal physical or mental illness, or habits may</p>	<p>Demonstrates a level of knowledge above other trainees at this stage of training.</p> <p>Shows a commitment to professional development through reflection on performance and identification of personal immediate and long term learning needs. Actively seeks out training experiences and opportunities and regularly uses opportunities to teach others.</p> <p>Demonstrates equality, fairness and respect in their day to day practice. Values and appreciates different cultures and personal attributes in patients and colleagues.</p> <p>Reflects on and discusses moral dilemmas encountered in the course of their work.</p> <p>Addresses personal health issues</p>
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<p>Does not appropriately balance personal and professional demands resulting e.g. in failure to achieve deadlines, or observe contractual obligations. This may include unplanned absences from professional commitments.</p> <p>Involved in more than one complaint and either fails to respond appropriately or to learn from the experience. Is resistant to feedback that is perceived as critical.</p> <p>Unaware and unresponsive to the need to respond to local or national governance changes or new guidelines</p>	<p>balance between personal, physical or mental illness demands and patient or team work especially when under pressure. Attendance at meetings and achievement of deadlines is largely achieved.</p> <p>Provides a limited response to complaints though able to improve this with help.</p> <p>Demonstrates a limited response to local or national governance or new guidelines</p>	<p>interfere with the competent delivery of patient care even when under pressure. Manages to attend meetings and deadlines consistently.</p> <p>Responds to complaints or performance issue appropriately.</p> <p>Changes behaviour in response to the organisation's clinical governance activities but may have limited involvement</p>	<p>or habits that impact on their performance as a doctor even when under significant pressure.</p> <p>Reflects and learns from complaints to improve patient care.</p> <p>Personally, participates in quality improvement activities or audits and suggests appropriate responses</p>
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<p><b>Trainee performance descriptor</b> Communication and consulting skills</p>
<p>Includes communication with patients, establishing patient rapport, managing challenging consultations, third-party consulting, the use of interpreters</p> <p><i>Capability: Communication and consultation skills</i></p>

<b>Significantly Below expectations</b>	<b>Below expectations</b>	<b>Meets expectations</b>	<b>Above expectations</b>
<p>Does not establish rapport with patients.</p> <p>Consultations are disorganised/long &amp; lack structure.</p> <p>Explanations are confusing or unclear and / or medically inaccurate.</p> <p>Consultations may be chaotic or very formulaic</p> <p>Does not treat patients with adequate attention, sensitivity or respect for their contribution.</p>	<p>Rapport is only intermittently established.</p> <p>Consultations take longer than peers and may lack focus.</p> <p>Explanations are inappropriately doctor-centred and generally medically correct.</p> <p>Consultations are commonly rigid or formulaic.</p> <p>Treats patients with some sensitivity and respect but the trainee regularly does not sufficiently facilitate or respond to the patients' contribution.</p>	<p>Rapport is established with almost all patients.</p> <p>Consults in an organised and structured way.</p> <p>Provides explanations that are always medically correct but may be doctor-centred.</p> <p>Consultations are rarely rigid or formulaic.</p> <p>Shows sensitivity and tries to involve the patient.</p>	<p>Achieves excellent rapport with patients.</p> <p>Responds to the preferences of the patient achieving an effective consultation.</p> <p>Offers patient centred explanations.</p> <p>Language and consultation are fluent, adapted to the needs and characteristics of the patient.</p> <p>Shows sensitivity, actively shares ideas and may empower the patient.</p>

<p><b>Trainee performance descriptor</b> Working with colleagues and in teams</p>
<p>Includes working effectively with others, sharing information with colleagues, leadership, management and team-working skills <i>Capabilities: Working with colleagues and in teams, Organisation Management and Leadership</i></p>

<b>Significantly Below expectations</b>	<b>Below expectations</b>	<b>Meets expectations</b>	<b>Above expectations</b>
<p>Routinely works in isolation giving little support to team members. Doesn't appreciate the value of the team. Inappropriately leaves their work for others to pick up</p> <p>Communication with others in the team is incomplete or late (or haphazard) impacting on patients and colleagues.</p> <p>Organisation of self and others, time-management and hand over skills have clear effects and / or create problems for colleagues or patients. e.g. regularly or consistently being late for shifts, not advising of lateness or sickness, failing to complete tasks required or failing to respond to emails</p>	<p>May intermittently work on own without involving the team. Respects other team members and their contribution but has yet to grasp the advantages of harnessing the potential within the team. Completes own work normally.</p> <p>May fail to communicate constructively or in a timely fashion with others in the team though generally this does not affect patient care.</p> <p>Organisation of self and others, time-management and hand over skills may be limited and impact on colleagues and patients.</p>	<p>Works effectively in a team rather than in isolation. Respects and understands other team members, their roles and contributions.</p> <p>Responds to communications from other team members in a timely and constructive manner.</p> <p>Organisation of self and others, time-management and hand over skills are sufficient that patients and colleagues are not unreasonably inconvenienced or come to any harm.</p>	<p>Is an effective team member, working flexibly with the various teams and supporting others. Enables collaborative working.</p> <p>Communicates proactively with the team members so that patient care is enhanced.</p> <p>Is consistently well organised with due consideration for colleagues as well as patients. Demonstrates effective:</p> <ul style="list-style-type: none"> <li>● Time-management</li> <li>● Hand-over skills</li> <li>● Prioritisation</li> <li style="padding-left: 20px;">Delegation.</li> </ul>

**Trainee performance descriptor**

Clinical assessment

Includes patient history, Clinical Examination and Procedural Skills (CEPS), choosing investigations, and making an appropriate diagnosis or decision. Please also comment on clinical skills that have been observed.

*Capabilities: Data Gathering, CEPS, Making a diagnosis / decisions*

**Significantly Below  
expectations**

**Below expectations**

**Meets expectations**

**Above expectations**

<p>Has an approach which is disorganised, chaotic, inflexible or inefficient.</p> <p>Examination and/ or investigation is not planned with a clear relevance to the history or situation.</p> <p>Fails to identify or examine for significant physical or psychological signs and examination technique is technically incompetent.</p> <p>Fails to obtain informed consent for examinations or procedures.</p> <p>Struggles to provide an appropriate differential diagnosis and fails to consider the serious possibilities and fails to review in the light of new information</p> <p>Is indecisive, illogical, incorrect or inappropriately independent in decision-making.</p>	<p>Accumulates a mixture of relevant and irrelevant information from the patient.</p> <p>Examines and/ or investigates patient but with inconsistent relevance to the patient's problem.</p> <p>Misses some abnormal signs or fails to recognise the significance of signs they identify. Examination technique is some of the time technically proficient.</p> <p>May fail to explain the need or process of the examination.</p> <p>Generates a limited differential diagnosis or one that is poorly focused around the problem (but covers serious possibilities).</p> <p>At times may not ask for help when should or asks for help too often. May struggle to work independently.</p>	<p>Accumulates information from the patient that is mainly relevant to their problem.</p> <p>Chooses examinations and investigations broadly appropriate for the patient's problem.</p> <p>Identifies common abnormal and recognises their significance and examination technique may not be fluent but is technically proficient.</p> <p>Performs procedures and examinations with the patient's consent.</p> <p>Generates and tests out an adequate differential diagnosis.</p> <p>Asks for help appropriately but may not progress to making independent decisions.</p>	<p>Systematically gathers information, using questions appropriately targeted to the problem.</p> <p>Chooses examinations and investigations targeted to the patient's problem.</p> <p>Has a flexible &amp; organised approach to examination and interprets physical signs accurately.</p> <p>Fluently incorporates consent for examination, assessment of mental capacity and other medico-legal issues into consultations.</p> <p>Generates a differential diagnosis clearly and flexibly, integrating available information.</p> <p>Owens their decisions whilst being aware of their limitations.</p>
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<b>Trainee performance descriptor</b>			
Management of Patients			
Includes recognition and appropriate management of medical conditions encountered in the role, prescribing safely, and taking account of co-morbidity, poly-pharmacy. Managing uncertainty & risk <i>Capabilities: Clinical management , Medical complexity</i>			
<b>Significantly Below expectations</b>	<b>Below expectations</b>	<b>Meets expectations</b>	<b>Above expectations</b>
<p>Struggles to think of management options.</p> <p>Prescribing decisions are commonly not safe; or not based on guidelines. Side effects and interactions are commonly neglected</p> <p>Ignores or are unaware of appropriate referral pathways.</p> <p>Fails to identify or respond to emergencies safely or may fail to work collaboratively in this setting</p>	<p>Uses appropriate but limited management options.</p> <p>Makes suggestions for prescribing but without considering interactions or side effects. May make some prescribing errors.</p> <p>Referral pathways are followed inconsistently.</p> <p>Tentatively or hesitantly identifies or responds to medical emergencies and may struggle to engage the rest of the team.</p> <p>Manages problems in isolation</p>	<p>Uses appropriate management options but may not include all options.</p> <p>Makes safe prescribing decisions, routinely checking on drug interactions and side effects.</p> <p>Refers safely, acting within the limits of their competence.</p> <p>Recognises medical emergencies and responds to them safely but may struggle to coordinate with other services.</p>	<p>Varies a good range of management options responsively.</p> <p>Prescribes safely including applying local and national guidelines and uses drug and non-drug therapies appropriately.</p> <p>Refers appropriately considering all available resources.</p> <p>Responds rapidly and skilfully to emergencies with appropriate follow up. Ensures care is coordinated with other services.</p> <p>Simultaneously manages the</p>

<p>Unable to contribute in complex or uncertain situations. Finds it difficult to suggest a way forward in unfamiliar circumstances.</p> <p>Does not consider the impact of the patient's lifestyle on their health or the problem.</p> <p>Does not prioritise management options based on patient risk, and or inappropriately burdens the patient with uncertainty.</p> <p>Does not safety net appropriately</p>	<p>struggling to take into account the impact or effect of other conditions.</p> <p>Limited consideration on the impact of patient's lifestyle on their health or the problem.</p> <p>Restricted prioritisation of management options based on the doctor's assessment of patient risk.</p> <p>Uses safety netting intermittently.</p>	<p>Manages health problems separately without necessarily considering the implications of co-morbidity.</p> <p>Considers the impact of patient's lifestyle on their health.</p> <p>Attempts to prioritise management options based on the doctor's assessment of patient risk.</p> <p>Safety nets appropriately.</p>	<p>patient's health problems, both acute and chronic.</p> <p>Integrates patient's lifestyle into suggested approaches.</p> <p>Communicates risk effectively to patients and involves them appropriately in its management.</p> <p>Excellent use of safety netting</p>
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<p><b>Trainee performance descriptor</b> Clinical record-keeping</p>
<p>Includes showing an appropriate use of administration systems, effective and appropriate record-keeping and use of IT for the benefit of patient care</p> <p><i>Capability: Organisation Management and Leadership</i></p>

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

<b>Trainee performance descriptor</b> Context of care			
Includes seeking to understand and support patients through an appreciation of the interplay between their disease and their lives and considering local pathways, formularies and resources. <i>Capabilities: Holistic care (HC), Community orientation (CO)</i>			
<b>Significantly Below expectations</b>	<b>Below expectations</b>	<b>Meets expectations</b>	<b>Above expectations</b>



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