NHS West Midlands

*General Practice Specialist Training*

**ST1**

---Survival guide---

*Electronic starter pack*

Sandwell VTS

Website: [www.scvts.co.uk](http://www.scvts.co.uk)

NB: This document is best used as an electronic copy so that the hyperlinks can be accessed. Printing it will just waste trees.

Updated by Dr. Sarbjit Saini
Sandwell VTS

“Helping to develop the future independent practitioners of tomorrow.”

Sandwell comprises of six towns of Oldbury, Rowley Regis, Smethwick, Tipton, Wednesbury, and West Bromwich. It is a vibrant, diverse area with the challenges and joys that come from working in the inner city. Located centrally within the West Midlands there is easy access to the great shopping and city life experience of Birmingham as well as the peaceful tranquillity of the Shropshire and Malvern Hills.

We offer a wide variety of teaching methods; combining half day release with some modular courses throughout the three years as well as termly symposiums – for large group interactions.

Hospital posts are split across two sites: City hospital and Sandwell hospital. There are a wide variety of hospital jobs offered, including specialties such as ENT, dermatology and ophthalmology, as well as medicine, obstetrics and gynaecology, paediatrics, psychiatry, accident and emergency and geriatrics. Our teaching sessions take place at Sandwell hospital.

Sandwell encourages self directed learning for the development of our future independent general practitioners. This is facilitated by clusters sessions throughout the year. Clusters sessions allow small group interactions and better TPD to trainee ratio's to get the best out of your three years.

We have an active junior doctor forum, so enthusiastic young doctors can get involved in the teaching as well as have their say on teaching and training matters and ensuring that social events are organised throughout the year. The emphasis is on learning through enjoyment and active participation. There are three TPDs who facilitate the half day release scheme and offer support throughout your training and they are: Dr Charanpal Sikka, Dr Rod Macrorie and Dr Sarbjit Saini. Each trainee has their own TPD mentor for the three year.

"Sandwell VTS offered an enriching chance to experience patients of various ethnicities and cultures with varied health seeking behaviour. The wide variety of teaching programme offered on the VTS helped me to evolve as a GP appreciating the diversity of healthcare. I would recommend it to trainees who value diversity in General practice.” - Dr Dilsher Singh (ST3, 2013).

"Sandwell VTS encompasses exposure to a diverse ethnic population with many varied health seeking behaviours. It is a dynamic scheme led by enthusiastic TPDs adapting working to meet and adapt to trainees learning needs, has helped me and others to evolve into holistic GPs.” – Dr Suneil Bath (ST2 -2013).
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Appendix:

Useful form/books and websites.
Meet the team

VTS Committee (Junior Doctors Forum –JDF):

AIT Rep (ST3) Dr. Rupert Millard

Charanpal’s cluster reps:
(ST3) Dr. Rebecca Hartwell
(ST3) Dr. Emma Radford
(ST2) Dr. Anurada Arambepola
(ST1) Dr. Serena Deller

Rod’s cluster reps:
(ST3) Dr. Deborah Endersby
(ST3) Dr. Nisha Ahuwalia
(ST2) Dr. Alyvn Wongso
(ST2) Dr. Anusha Philips

Sarbjit’s cluster reps:
(ST3) Dr Zainab Naqvi
(ST2) Dr. Samuel Tilley
(ST2) Dr. Serena Rakha
(ST1) Dr. Azhar Hawa

*** We’re looking for budding new ST1’s to join the JDF ***
If interested please email Rupert Millard.

Sandwell VTS website: www.scvts.co.uk

Training Programme Directors (TPD’s)

The VTS is split up into three clusters, each with a lead TPD:

Dr. Charanpal Sikka
Dr. Rod Macrorie
Dr. Sarbjit Saini

Course Secretary

Administration is provided by Anita Powell (Anita.Powell@wm.hee.nhs.uk), who is based at St Chads Court, West Midlands Deanery, Hagley Road, Birmingham.

Area Director for the Black Country:

Dr. Amjad Khan also based at St Chad’s Court.

Your Educational Supervisor  - This is the GP that you are allocated to as a trainee for the next 3 years and you will be joining them in their surgery in your final year. There name can be found on your e-portfolio (if not on the portfolio – please email Anita and it will be added). Your educational supervisor will be viewing your progress via regularly reviewing your e-portfolio and also by 6 monthly meetings.
**Escalating concerns**

It is important for you to ensure that if you have any concerns about your training or issues with regards to patient safety, that these are brought to our attention.

The first step would be to speak to your JDF if you feel that you cannot go to your Clinical/Educational supervisor. If this is not helpful, then you should speak to your Clinical/Educational supervisor. If this has not helped then please come and speak to your TPD.
**Acronyms**

When starting the GP speciality training there may be a lot of acronyms that you come across, to help you on your journey here are just a few explained:

- **CCT** – Certificate of Completion of training.
- **WPBA** – Work Place Base Assessment
- **HDR** – Half Day Release.
- **ARCP** – Annual Review of Competency Progress
- **E-portfolio**
- **TPD’s** – Training Programme Directors.
- **CBD’s** – Case Based Discussion.
- **JEST** – Job Evaluation Survey Tool.
- **RCGP** – Royal College of General Practitioners.
- **LTFT** – Less Than Full Time Training.
- **AKT** – Applied Knowledge Test.
- **AD** – Associate Dean.
- **COT’s** – Consultation Observation tool.
- **JEST** – Job Evaluation Survey Tool.
- **COT’s** – Consultation Observation tool.
- **CSA** – Clinical Skills Assessment.
- **ESR**
- **DOPS**
- **CSR**

These are just a few to help you along your journey. See if you can figure out the rest as you come across them.
Teaching

Induction days:
Thursday 14th August 2014, Half day session at the WBA. ST1’s only.
Thursday 11th September 2014 – All day, All years at The MAC –Birmingham.

Term time:
Dates are on the website.
Autumn Term   = September - November
Spring Term    = January/February - April
Summer Term   = May – July
-Each term is approximately 8-9 weeks long and teaching will alternate between VTS and clusters.

VTS term-time teaching is from 14.00 -17.00pm at the Sandwell Postgraduate Centre, Sandwell Hospital.

Cluster sessions are based at the individual TPD venues (see below).

- Trainees are expected to lead in the cluster sessions.

Cluster learning:
Cluster sessions will be taking place outside of term time. Exceptions will be four weeks over summer, Easter and Christmas.

Attendance is compulsory, unless on annual leave, study leave sick leave or due to department service requirements.

➔If you cannot attend teaching you MUST email your to let us [TPDs] know why.

Venues for cluster teaching:

<table>
<thead>
<tr>
<th>Dr. Sikka’s Cluster</th>
<th>Dr. Macrorie’s Cluster</th>
<th>Dr. Saini’s Cluster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oakeswell Health Centre, Brunswick Park Road, Wednesbury, WS10 9HP</td>
<td>Cape Hill Medical Centre, Raglan Road, Smethwick, B66 3NR</td>
<td>Sandwell Postgraduate Centre, Sandwell Hospital, Lyndon, West Bromwich, West Midlands 0121 553 1831</td>
</tr>
</tbody>
</table>
GP Curriculum

The RCGP came up with a document that tries to identify the knowledge and skills that are needed to be a GP. This is known as the RCGP curriculum and is composed of a number of curriculum statements relating to general practice, clinical areas and also special groups.

Click here for the RCGP Curriculum Map

► Or you can click on the hyperlinks below to access the individual curriculum headings. **Core Curriculum:**

- Being a General Practitioner

  - The GP consultation in practice
  - Patient safety and quality of care
  - The GP in the wider professional environment

- Enhancing professional knowledge

  - Promoting health and preventing disease
  - Genetics in primary care
  - Care of acutely ill people
  - Care of children and young people
  - Care of older adults
  - Women’s health
  - Men’s health
  - Sexual health
  - End of life care
  - Care of people with mental health problems
  - Care of people with intellectual disability
  - Cardiovascular health
  - Digestive health
  - Care of people who misuse drugs and alcohol
  - Care of people with ENT oral and facial problems
  - Care of people with eye problems
  - Care of people with metabolic problems
  - Care of people with neurological problems
  - Respiratory health
  - Care of people with musculoskeletal problems
  - Care of people with skin problems
There are also 12 Key Competencies
These will be assessed via WBPA tools.

**Key competences**

| 1 | Communication and consultation skills |
| 2 | Practising holistically               |
| 3 | Data gathering and interpretation     |
| 4 | Making a diagnosis/decisions         |
| 5 | Clinical management                  |
| 6 | Managing medical complexity          |
| 7 | Primary care admin and IMT           |
| 8 | Working with colleagues and in teams |
| 9 | Community orientation                |
| 10| Maintaining performance, learning and teaching |
| 11| Maintaining an ethical approach      |
| 12| Fitness to practise                  |

More information can be found in your e-portfolios about each of the twelve competencies. Ask your Educational Supervisors about this when you meet them.
Assessments:

The New MRCGP consists of three components:

1) WPBA (Work Place Based Assessment) – ePortfolio
2) AKT (Acquired Knowledge Test) – MCQ
3) CSA (Clinical Scenario Assessment) – Clinical

WPBA (aka e-Portfolio):

Please do the following as soon as possible:

- Register as an Associate in Training (AiT) with the RCGP in order to get access to the e-Portfolio, which is essential. (www.rcgp.org.uk)
- The E-portfolio forms a significant part of your training log (WPBA). If it is not completed regularly and properly you will not be able to progress with your training and be eligible for your Certificate of Completion of Training (CCT) at the end of your training scheme.

The e-portfolio serves two main purposes

1. Primarily HELPING YOU to identify what you're doing well at and what needs further development
2. Providing evidence for others that you are progressing well enough to move onto the next ST stage or certification (ARCP panels, trainers, educational supervisors)

WPBA consists of learning log entries and assessment tools (logged in the e-portfolio):

Assessments that need to be completed during the year:

CSR – Clinical supervisor report (Supervisor from clinical post)
ESR – Educational supervisor report (Normally a GP Tutor)
MSF – Multi-source feedback
PSQ – Patient satisfaction questionnaire (Only in when in GP placements)
DOPS – Two types:
   1) Mandatory,  2) Others
      - Try and get mandatory ones signed off in hospital, it gets difficult in GP placements.
CBD – Case based discussion
COT – Consultation observation tool
Mini-Cex – Clinical examination
### Number of assessments required:

<table>
<thead>
<tr>
<th>Assessment</th>
<th>6 months (ST1)</th>
<th>12 months (ST1)</th>
<th>18 months (ST2)</th>
<th>24 months (ST2)</th>
<th>30 months (ST3)</th>
<th>36 months (ST3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBD</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>COT/Mini-cex</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>DOPS</td>
<td>No minimum number</td>
<td>No minimum number</td>
<td>No minimum number</td>
<td>No minimum number</td>
<td>No minimum number</td>
<td>All mandatory DOP’s</td>
</tr>
<tr>
<td>CSR</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ESR</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>PSQ</td>
<td>n/a</td>
<td>n/a</td>
<td>1 (if in GP only)</td>
<td>1 (if in GP only)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>MSF</td>
<td>1</td>
<td>n/a</td>
<td>1</td>
<td>n/a</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**NOTE**

The above are minimum requirements; you should try and do more than this.

- OOH (Out Of Hours – GP work)
  - This forms part of your WPBA
  - Need to do 108 hours of Out-Of-Hours training (Spread out over ST2-ST3)
    - Sometimes also referred to as one session of OOH for each month in GP.
  - Can do up to 25% of hours in ST2 and remaining in ST3 (Get in early!)
  - You are not currently permitted to do OOH in ST1
  - OOH can ONLY be done during your GP placement
    - This is to comply with EWTD as well as Defence union cover.
  - The centre you work at depends on where you are working:
Calendars

These calendars are designed to help you plan each year, as there are many milestones to reach and hurdles along the way.

**ST1 Calendar.**

<table>
<thead>
<tr>
<th>POST</th>
<th>Month</th>
<th>On-going</th>
<th>Jobs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital–POST 1</td>
<td>August</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Register with RCGP – get E-portfolio</td>
</tr>
<tr>
<td>Hospital–POST 1</td>
<td>September</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Attend VTS inductions. Start making log entries</td>
</tr>
<tr>
<td>Hospital–POST 1</td>
<td>October</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Meet ES – arrange December meeting date.</td>
</tr>
<tr>
<td>Hospital–POST 1</td>
<td>November</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
</tr>
<tr>
<td>Hospital–POST 1</td>
<td>December</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs, CSR from current post</td>
<td>Complete self rating for 6 month review with ES.</td>
</tr>
<tr>
<td>Hospital–POST 1</td>
<td>January</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Complete 6 month ESR with ES.</td>
</tr>
<tr>
<td>Hospital–POST 2</td>
<td>February</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>ARCP</td>
</tr>
<tr>
<td>Hospital–POST 2</td>
<td>March</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>ARCP</td>
</tr>
<tr>
<td>Hospital–POST 2</td>
<td>April</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>ARCP</td>
</tr>
<tr>
<td>Hospital–POST 2</td>
<td>May</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs, CSR from current post</td>
<td>Apply for performers list.</td>
</tr>
<tr>
<td>Hospital–POST 2</td>
<td>June</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Complete form R7 for GP placement</td>
</tr>
<tr>
<td>Hospital–POST 2</td>
<td>July</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>ARCP</td>
</tr>
</tbody>
</table>

Calendars for ST2/ST3 are on the VTS website.

**Posts**

**ST1** = 2 x 6 month, hospital posts.

**ST2** = 1x 6 month hospital post + 1x 6 month GP placement

**ST3** = GP registrar year. One full year in a GP Placement.
**IMPORTANT**

**Annual Review of Competency Progress (ARCP)**

Although the academic year finishes in August, the ARCP Panel meet normally in mid May. This means that all your e-portfolio assessments for that year must be completed by **MAY**. This means all your CBD’s, Mini-cex’s, COT’s, DOP’s, CSR and ESR.

**Educational Supervisor Review (ESR)**

It is your responsibility to contact your educational supervisor to arrange the meeting, contact them early!

**Job Evaluation Survey Tool (JEST)**

This is a very important survey that needs to be completed by all trainees in all years. You will receive an email in Jan-April each year with a password to complete this survey. It is important that you complete this and then attached the certificate of completion to your e-portfolio. **No certificate can mean that you get a negative outcome at your ARCP.**

**Placement Planning Meeting (PPM)**

*This area is new to the e-portfolio.* All trainees are expected to complete a PPM learning log entry at the start of each hospital or GP post.

It is important for you all to be able to generate a learning plan for each of your placements - for this reason you are asked to meet with your hospital clinical supervisors at the start of each rotation to generate a 'Placement Planning Meeting’ [one of the drop down menu options for learning log headings]. It is your responsibility to organise this and complete a log entry at the start of every post.

A guide is available as to what GP trainees are expected to gain from their hospital placements, see link: [https://gpst.mvm.ed.ac.uk/page:1647](https://gpst.mvm.ed.ac.uk/page:1647) - the combination of the two will allow you all to gain the maximum amount of benefit.

**Secondary Care 4 Primary Care**

In order to help you with what you need to know/learn for each hospital rotation that you complete please use the following link and then select the speciality:

[https://gpst.mvm.ed.ac.uk/page:1647](https://gpst.mvm.ed.ac.uk/page:1647)
E-portfolio entries

- Learning Log entries:
  o Reflective entries are needed in your e-portfolio on a regular bases
  o A minimum of 1 x clinical case entry and x1 other entry (e.g. reading, courses, etc)
  o The quality of the entries is really important.

  o Handy Hint:
    ▪ A very useful guide can be found as a link on the GPVTS Website, or
    ▪ If you go to the following link:
      • [http://www.bradfordvts.co.uk/MRCGP/eportfolio.htm](http://www.bradfordvts.co.uk/MRCGP/eportfolio.htm)
        o Select E-portfolio Pearls – making the e-portfolio work for you.

Use the following link for the RCGP guide to the e-portfolio:


Levels of Reflection and the Learning Log Entry
From the Bradford VTS website: Dr. Ramesh Mehay, Programme Director (Bradford), 2010

To be able to judge whether a log entry shows good reflection, you need to have an understanding of what reflection is and the different levels describing the depth of reflection. It is a skill which we all do to varying depths and the role of the ES and CS is to help the trainee develop or enhance what they already have.

Why do we go on and on about reflection?
- Because effective learning won’t happen unless you reflect.
- Reflecting on or during some experience in light of known theoretical concepts or previous learning should lead to new insights into different aspects of that situation.
- So we see that the outcome of reflection is learning (Meziros, 1981).

The proper definition

Kemmis (1985) the process of reflection is more than a process that focuses ‘on the head’. It is a positive active process that reviews, analyses and evaluates experiences, draws on theoretical concepts or previous learning and so provides an action plan for future experiences.

Johns (1995) adds that reflection is a personal process enables the practitioner to assess understand and learn through their experiences. This results in some change for the individual in their perspective of a
situation or creates new learning for the individual.

**Types of reflection**

Do not confuse this with levels of reflection. Levels of reflection refers to how deeply one reflects. Types of reflection is different.

Schön (1987) in his work identifies two types of reflection; these are reflection-in-action (thinking on your feet) and reflection-on-action (retrospective thinking). He suggests that reflection is used by practitioners when they encounter situations that are unique, and when individuals may not be able to apply known theories or techniques previously learnt through formal education.

Encourage a trainee to use both TYPES of reflection. Most trainees write reflection-on-action. In other words, they write about situations which went either particularly well or badly to see what they might continue to do and what they might change. Encourage them to write about reflection in action – writing about the reflective process happening in their heads DURING the situation (like one which they have never encountered before and had to therefore think on their feet).

**The key qualities and skills and individual needs to do proper reflection**

Gillings (2000) states that commitment to self-enquiry and readiness to change practice are important if the individual is to get the most out of the process.

**Qualities needed** (Richardson & Maltby 1995, Gillings 2000)

These are the sorts of attitudes you want to instil in your trainee:

- Open mindedness
- Commitment to self-enquiry
- Motivation and
- Readiness to change practice

**Skills needed** (Richardson & Maltby 1995)

You need to analyse the trainee’s log entry in these terms. I call them the ISCE criteria.

- Information – describing what happened or what was observed in enough detail.
- Self Awareness - being open and honest about performance but also writing about own feelings and/or that of others
- Critical Thinking – analysing the bigger and smaller pictures, problem solving, describing own thought processes
- Evaluation – pooling the above three things together (synthesis) and describing what needs to be learned, why and how.

**Levels or depths of reflection – ISCE levels**

That brings us nicely onto the different depths of reflection. Take a look at this table for a minutes. Hit the pause button below now.
So, when trying to figure out how reflective a log entry is, think of four things – the **ISCE levels**.

1. Information provided
2. Critical Analysis
3. Self Awareness
4. Evidence of Learning

Have you read a trainee’s log entry and thought it was a bit dire? And that’s putting it nicely? Did you struggle in terms of trying to identify why it was dire? Well, usually it’s because the trainee has written endless descriptive notes on what happened without any further analysis or evaluation. By applying the ISCE criteria, you should now be able to see that they fit into the first column.

I won't detail what makes a really good deeply reflective log entry because the descriptors under the ‘excellent’ column in the table above say it all.

**How do I get my trainee to reflect more deeply?**

A handy tip for you might be to print this little table and keep it with you when reading log entries. Share it with the trainee and get them to assess their own level of reflection on a few of their own log entries. They’re more likely to learn in this way.

Another thing you might do is to pick a log entry that you think could have been more reflective and get them to apply Kolb’s experiential learning cycle (1984) in a clockwise direction. Why not print a copy of Kolb’s cycle for them so they get used to this method of thinking. Hopefully, that should result in new things that they could have done which they will now consider in the future. Get them to see the value of doing this methodically.

<table>
<thead>
<tr>
<th>LEVELS OF REFLECTION</th>
<th>Not acceptable</th>
<th>Acceptable</th>
<th>Excellent (in addition to the acceptable column)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Information Provided</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entirely descriptive e.g. lists of learning events/certificates of attendance with no evidence of reflection.</td>
<td></td>
<td></td>
<td>Uses range of sources to clarify thoughts and feelings.</td>
</tr>
<tr>
<td><strong>Critical Analysis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No evidence of analysis (i.e. an attempt to make sense of thoughts, perceptions and emotions).</td>
<td></td>
<td></td>
<td>Demonstrates well-developed analysis and critical thinking e.g. using the evidence base to justify or change behaviour.</td>
</tr>
<tr>
<td><strong>Self Awareness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No self-awareness.</td>
<td></td>
<td></td>
<td>Shows insight, seeing performance in relation to what might be expected of doctors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consideration of the thoughts and feelings of others as well as him/herself.</td>
</tr>
<tr>
<td><strong>Evidence of Learning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No evidence of learning (i.e. clarification of what needs to be learned and why).</td>
<td></td>
<td></td>
<td>Good evidence of learning, with critical assessment, prioritisation and planning of learning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some evidence of learning, appropriately describing what needs to be learned, why and how.</td>
<td>Shows insight, seeing performance in relation to what might be expected of doctors.</td>
<td></td>
</tr>
</tbody>
</table>
- **Concrete Experience** is about something that has happened to you or that you have done.
- **Reflection** is concerned with reviewing the event or experience and exploring what you did and how you and others felt about it.
- **Abstract Conceptualisation** is all about developing an understanding of what happened by seeking more information or bringing in theoretical concepts or previous learning to form new ideas about ways of doing things in the future.
- **Active Experimentation** is about trying these newly formed ideas.

When reflecting-on-action, the first step in the process is the description of the incident. Therefore, you might want to encourage your trainee to keep a reflective diary in which they record details of incidents that either troubled or pleased them (as memory cannot be relied upon for the detail of events). Encourage them to record details as soon after the event as possible.

Why not encourage the unreflective trainee to sum up each day with a reflective comment in his/her diary, spending only a few minutes doing it. You may also set them an example by keeping a reflective diary of your own professional practice or indeed your experiences as a Educational or Clinical Supervisor, thus demonstrating that learning is always ongoing! And remember, the more you can coach your trainee to do reflection properly, the more you move them from ignorance to understanding. And that means that they soon continue at a much swifter pace, requiring less input from you, and as a result, your work as ES/CS becomes easier. Bliss!

**My trainee doesn't like writing it all down. He says he does it all in his head anyway!**

Loads of trainees say that they do it in their head, but remember, reflection is an **active process** rather than about passive thinking. The problem with thinking 'in your head' is that people often rush through the reflective process. Writing it down encourages them to slow their pace. Slowing down promotes a better description, better critical analysis, better self awareness and therefore better evaluation (or learning) – Richardson & Maltby 1995, Zubbrizarreta 1999 and Tryssenaar 1995 (is that enough evidence for you?)

**Time for reflection**

As and ES or CS, don't forget that you're a role model (whether you like it or not). McClure (2005) says how important the time for reflection is – and that applies to you too; you need to make time during training and day to day practice to encourage the trainee (and yourself) to reflect. In that way, reflection becomes a part of your and the trainee's way of working. It’s an integral part of practice and trainees need time to develop the skill. You can't rush it and must be a dynamic part of working life (i.e. avoid saying 'let’s reflect on that later' – do it when it’s hot!).
References

Learning Log entries

How to Produce Good Learning Log Entries.

RCGP Workplace Based Assessment (WPBA) Standards Group.

June 2010.

How to Produce Good Learning Log Entries.

Role of the Learning Log

Your learning log is your personal learning record. Log entries that you choose to ‘share’ can be read and commented on by your clinical or educational supervisor. These entries will contribute to the evidence that your educational supervisor will consider at your 6 monthly educational supervision meetings.

*Maintaining your log is therefore just as important as completing your formal assessments.*

Log entries can contribute to your evidence in two ways. They determine your curriculum coverage and contribute to the evidence in the 12 competency areas if they are ‘validated’.

Curriculum coverage

When you make a new entry to your log you have the opportunity to select the most appropriate curriculum headings from the pick list and thereby indicate which parts of the curriculum you think you are addressing.

When linking to curriculum headings take care to look at the learning objectives in the relevant curriculum statement and ask yourself:

*does my log entry provide evidence that relates to the specific learning objectives in this statement?*

Although in many cases an individual entry may merit more than one curriculum heading, try to ensure that you don’t choose inappropriate ones.
Evidence in the 12 competency areas

Your clinical or educational supervisor can only validate your entries if they are of sufficient quality.

A good quality log entry is one that shows good reflection, which means that it demonstrates your insight into how you are performing and how you are learning from your everyday experiences.

A good reflective log entry will show:

- Some evidence of critical thinking and analysis, describing your own thought processes;
- Some self-awareness demonstrating openness and honesty about performance along with some consideration of your own feelings;
- Some evidence of learning, appropriately describing what needs to be learned, why and how.

Look at the example below: can you see where these attributes are demonstrated?

No one is going to expect you to produce perfect log entries from Day One of your training programme. Your Supervisor will expect to see improvement in the quality of your log entries and more importantly, your insight, as you proceed through your training.

Writing reflectively:

Examples from the Bradford VTS website:

**Example 1 – descriptive account**
Lucy B is a 38 year old single mother, who lives with her 7 year old son. She is new to the practice and works as a legal secretary.

She presented with a 4 week history of headache and visual disturbance. She had a past medical history recorded of a moderate depression 10 years ago and a past history and family history of classical migraine

There were no ‘red flag’ symptoms or signs at the time of initial presentation. As she had not tried any painkillers, I asked her to take simple analgesia and asked her to return if she became worse. My working diagnosis was of tension headache or possibly a variation of migraine

She next presented 3 weeks later, tearful and stating she had to give up her job because of the pains in her head and neck, also symptoms of photophobia. On examination she looked unwell, ad fundoscopy revealed papilloedema.

I referred her urgently as a medical emergency, a CT scan revealed the presence of a frontal lobe tumour, and she was transferred to Frenchay.

She is now waiting for a follow-up with the neurosurgeon, and has consulted me again this week with symptoms of depression and anxiety.
Example 2 Reflective Account

Lucy B is a 38 year old who has been at the practice for only a few months. She is a single mum, and lives with her 7 year old son. Her past records revealed a history of migraine and one episode of depression 10 years ago.

At our first meeting, 9 weeks ago, she was complaining of a severe headache, which had been troubling her for 4 weeks, and was severe enough to ‘frighten her’. As she described her symptoms, she appeared anxious and tense, and frequently held her forehead.

Although she had suffered migraines for years and came from a family of ‘migraineurs’ she felt that this was unlike any headache she had ever suffered before. It was frontal, constant and unaffected by moving her head. She had not tried any painkillers.

We discussed her social situation – Lucy was the sole breadwinner for herself and little boy, and was worried about missing work as she was a legal secretary for a local law firm and felt they would not be sympathetic about her missing work as they were so busy at the moment. She appeared visibly tense.

There were no worrying features on examination, her blood pressure was 130/70 and the quick neurological examination that I performed revealed a nothing abnormal

We agreed a plan that Lucy would try simple analgesia, and take some time off work, and that she would come back if things did not improve.

Lucy did indeed come back after 3 weeks, this time in tears. I knew as soon as she walked in that something was seriously wrong. She looked drawn and pale, and between sobs she told me that she had given up work because she couldn’t cope with the pain, as well as new symptoms of nausea, photophobia and neck stiffness.

I repeated my neurological examination, and this time could discern definite changes of papilloedema.

I arranged for her to be seen urgently that afternoon by the medical registrar at the local DGH who arranged a CT scan which suggested a frontal lobe tumour following which she was admitted to Frenchay Hospital straight away, and has now been discharged with a follow-up appointment to see a neurosurgeon in 2 weeks.

She consulted me again this week, very anxious about the future for her and her son. Although I have tried to be reassuring and give her some grounds to be positive, I am aware that I feel pessimistic about the outcome, and do not have enough knowledge about her tumour in particular or brain tumours in general to be able to advise her properly.

This series of clinical encounters with Lucy has highlighted for me the underlying pressure I feel to make sure I do not miss an important and potentially curable serious illness amongst the many patients who consult me with self-limiting or non-serious conditions.

Her subsequent diagnosis has caused me to re-examine my notes and question the thoroughness of my neurological examination at her first presentation. I was concerned that I may have missed some indication of the serious underlying cause for the headache. Although I have recorded that her fundi were normal then, I wonder how thoroughly I examined her eyes. It was not recorded whether I darkened the room (I usually do) or dilated her pupils (I usually don’t).
I remember, at first presentation, feeling admiration for her coping ability, but surprise and frustration that she had not tried any medication for her headaches. In retrospect, I wonder if our agreed plan for her to try analgesia may have slowed down the subsequent urgent referral. At the time of her second presentation the sinking feeling which I can recall began early in the consultation and may have been as a reaction to her changed appearance and demeanour. This may have directed my actions quickly towards a thorough examination at which stage her papilloedema was revealed. This finding, coupled with my unease at her rapidly worsening symptoms, resulted in a rapid urgent referral for investigations, which turned out to be an appropriate response.

The pessimism I felt when Lucy presented following the finding of her tumour is likely to arise from my own past experiences in caring for patients with brain tumours, I have been involved with 2 young patients before, and the disease progressed rapidly in both cases.

In conclusion, this has been an illuminating series of clinical encounters. The new presentation of cerebral tumour is a rare occurrence for most GPs, whereas headache is extremely common. This case illustrates the need to remain constantly vigilant and respond to subtle signals and respond accordingly.

In particular this case has highlighted for me personally a number of points:

- the importance of recording the features of examination (including negative findings) contemporaneously,
- safety netting, encouraging the patient to come back, whether or not they have complied fully with treatment
- My own emotional response to a patient's plight may not always be helpful, indeed may hinder my ability to advise and explain their clinical situation
- I need to refresh my knowledge about the diagnosis, prognosis and management of cerebral tumours.

But, remember it is about quality not quantity.
Exams!

AKT (Applied Knowledge test)
- 200 MCQ/EMQ Paper
- Can be sat at ST2 or ST3 during GP training, but recommended to do only after a GP placement.
- Costs around £400.00
- Revision aids:
  - Oxford handbook of GP
  - Oxford handbook of Specialties
  - Oxford handbook of Medicine
  - Passmedicine.com
  - Derm.net
  - Advice from colleagues that have sat exam!

CSA (Clinical Skills Assessment)
- 12 OSCE style stations, with actors
- Exam held in London only at the Royal College
- Can only attempt during your ST3 year
- Costs around £1500.00
- Only allowed 3 attempts

The RCGP website has an excellent powerpoint presentation and summary of the above examinations:

AKT:  

CSA:  
Important

Enjoy your training and learn lots!

Ask if you’re not sure, everyone is very friendly and willing to help.

GOOD LUCK!
Useful forms

Performers’ List

Join the Medical Performers’ list – you must apply to join the Performers’ List before you begin your GP attachments (i.e. at the end of ST1 if you are starting GP at the beginning of your ST2, or at the end of your ST2 hospital post if your first post in ST2 is a hospital post.

Please contact the area co-ordinator in which your practice is based well in advance of starting in your practice. (Details can be found on the West Midlands Deanery Website).

- If you are not registered, you are working illegally.
- Specific documents will be required from you, so contact them before your GP placement.

The following forms are very important. You can download them from your e-portfolio, if you select ‘DOWNLOADS’ from the left hand menu on your e-portfolio.

Form R7

- Needs to be completed, signed by your educational supervisor, at least one month before your GP placements. Need a new form for each GP placement.
- Late completion means that you may not be paid on time.

Form R

- Needs to be completed every year before your ARCP, it is a GMC requirement; it is required to continue your training.

Travel expenses

- In order to claim for home visits + petrol
- Ask your practice about these
**Useful Books:**
The Condensed Curriculum Guide- Ben Riley ISBN 9780850843163

Oxford Handbooks: GP, Specialities and Medicine

**Useful websites:**
http://www.blackcountryvtsnorth.nhs.uk

www.bradfordvts.co.uk

PULSE online

www.cks.nhs.uk

www.mims.co.uk

Guildford VTS website: reflective learning