NHS West Midlands

General Practice Specialist Training

Trainer - Survival guide -

Electronic pack

Sandwell VTS

Website: 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.

Complied by Dr. Sarbjit Saini
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 tranquility 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 GP’s." – Dr. Sunil Bath (ST2, 2013).
## Contents

Meet the team ................................................................. 4  
Escalating Concerns .................................................... 5  
Acronyms ........................................................................ 6  
Teaching ........................................................................ 7  
GP Curriculum ............................................................... 8  
Assessments .................................................................... 10  
Calendar .......................................................................... 12  
Important issues ............................................................. 13  
Eportfolio entries ............................................................ 14  
Exams ............................................................................. 23  
Educational supervisor reports ......................................... 24  
Trainees in difficulty ....................................................... 25  

**Appendix:**

Useful form/books and websites.
Meet the team

VTS Committee (Junior Doctors Forum – JDF):

AiT Rep (ST3) Dr. Suneil Bath (suneil.bath@nhs.net)
(ST3) Dr. Aisha Budhwani (ali7star@yahoo.com)
(ST2) Dr. Rebecca Hartwell (rhartwell@doctors.org.uk)
(ST2) Dr. Rupert Millard (rupertmillard@doctors.org.uk)
(ST2) Dr. Emma Radford (emma.radford@doctors.org.uk)
(ST2) Dr. Deborah Endersby (deborah.endersby@doctors.org.uk)

For the first time this year we have a JDF – this enthusiastic group of trainees will hopefully help us to improve the scheme by getting feedback from trainees as well as play a key role in ensuring the trainee concerns can be aired.

Sandwell VTS website: www.scvts.co.uk

Training Programme Directors (TPD’s)

The trainees are split up into three clusters, each with a lead TPD:

Dr. Charanpal Sikka (csikka@nhs.net)
Dr. Rod Macrorie (rod.macrorie@nhs.net)
Dr. Sarbjit Saini (sarbjit.saini@nhs.net)

The practices and the trainers in the Sandwell area have been split into three groups, with a TPD responsible for each group:

<table>
<thead>
<tr>
<th>Dr. Charanpal Sikka</th>
<th>Dr. Rod Macrorie</th>
<th>Dr. Sarbjit Saini</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carters Green Medical Centre,</td>
<td>Malling Heath,</td>
<td>Oldbury Health Centre,</td>
</tr>
<tr>
<td>Oakeswell Health Centre,</td>
<td>Cape Hill Medical Centre,</td>
<td>Linksway Medical Practice,</td>
</tr>
<tr>
<td>Great Bridge Partnership,</td>
<td>Sherwood House,</td>
<td>Towerhill Surgery,</td>
</tr>
<tr>
<td></td>
<td>Warley Medical Centre.</td>
<td>Regis Medical Centre.</td>
</tr>
</tbody>
</table>

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

The first step would be to speak to the trainee. You may also wish to get information from the trainee’s clinical supervisor. If this is not helpful, then you should speak to your TPD.

- Please also see section on trainees in difficulty.
Acronyms

In 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

ARCP – Annual Review of Competency Progress

TPDs – Training Programme Directors.
CBD’s – Case Based Discussion.

RCGP – Royal College of General Practitioners.

LTFT – Less Than Full Time Training.
AiT – Associate in Training.

AD – Associate Dean.
COT – Consultation Observation tool.

AKT – Applied Knowledge Test.
CSA – Clinical Skills Assessment.

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 (MANDATORY):

Thursday 15th August 2013, 1-3pm. City Postgraduate Centre. ST1's only.
Thursday 26th September 2013 – All day, All years at The MAC –Birmingham.

Term time (VTS Half day sessions):

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.

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

Cluster learning: NEW to Sandwell!

Out of term cluster sessions have been running successfully at other Black Country VTS schemes for the past few years. We are now bringing Sandwell on board.

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

Trainees are expected to lead in the cluster sessions, in order to help develop leadership skills as well as independent learning skills.

Cluster sessions will be taking place outside of term time. Exceptions will be summer, Easter and Christmas – when there will be no VTS and no cluster sessions. When there are no sessions running, it is thought that they trainees may benefit from educational activities during the Thursday afternoon spent at the surgery e.g.: joint surgeries with the ES or video consultations.

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

› If a trainee cannot attend teaching they MUST email their TPD to let them 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.</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. The RCGP curriculum is composed of a number of curriculum statements relating to general practice, clinical areas and also special groups.

Helping familiarise yourself and your trainee with the curriculum is a great starting point as this is what guides CSA cases and AKT questions.

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

These are also the areas that are used by you when completing a trainee’s ESR.  
- *Please see section on ’ESR’ later for further details.*
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 ensure that all your new ST1’s 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 their training log (WPBA). If it is not completed regularly and properly they will not be able to progress with their training and be eligible for your Certificate of Completion of Training (CCT) at the end of their training scheme.

The e-portfolio serves two main purposes:

1. Primarily HELPING YOU to identify what they are doing well at and what needs further development.
2. Providing evidence for others that the trainee is 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 the trainees to complete as many as possible of the mandatory DOPs in hospital, it gets difficult in GP placements.
- CBD – Case based discussion
- COT – Consultation observation tool (when in hospital, aka: 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>1</td>
<td>1</td>
<td>n/a</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**NOTE**

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

Also, for less than full time trainees (LTFT) the requirements are pro-rata.

Out of Hours
- OOH (Out Of Hours –GP work)
  - This forms part of the WPBA.
  - Trainees are required to do 108 hours of OOH (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!)
  - Trainees are not currently permitted to do OOH in ST1.
  - Please ask trainees to log each session on their e-portfolio and total the hours for each entry.
  - OOH can ONLY be done during a trainees GP placement:
    - This is to comply with EWTD as well as Defence union cover.
Calendars

These calendars are designed to help trainees and trainers 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>
<th>External</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>
<td></td>
</tr>
<tr>
<td>Hospital – POST 1</td>
<td>September</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Attend VTS inductions.</td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 1</td>
<td>October</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Start making log entries</td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 1</td>
<td>December</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Meet ES – arrange December meeting date.</td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 1</td>
<td>January</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td>Complete self rating for 6 month review with ES.</td>
<td>ARCP: Interim</td>
</tr>
<tr>
<td>Hospital – POST 2</td>
<td>February</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 2</td>
<td>March</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 2</td>
<td>April</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 2</td>
<td>May</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 2</td>
<td>June</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – POST 2</td>
<td>July</td>
<td>E-portfolio logs/DOPS/CBD’S/COTs</td>
<td></td>
<td></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 the e-portfolio assessments for that year must be completed by **MAY**. This means all CBD's, Mini-cex's, COT's, DOP's, CSR and ESR.

**Educational Supervisor Review (ESR)**

It is the trainee’s responsibility to contact their educational supervisor to arrange the meeting. All our new ST1 from August 2013 were given and envelope containing the details of their ES and TPD – we have asked the trainees to email you ASAP so they can introduce themselves to you as well as arrange their December ESR date with you.

**Job Evaluation Survey Tool (JEST)**

This is a very important survey that needs to be completed by all trainees in all years – as per the Deaneries instructions. Trainees will receive an email in Jan-April each year with a password to complete this survey. It is important that they complete this and then attached the certificate of completion to their e-portfolio.

**No certificate can mean that they get a negative outcome at your ARCP (Outcome 2).**
E-portfolio entries

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

- 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)
      - 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 for 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.
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 an 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 *(help for trainees)*

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:

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**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, and 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
- Only allowed 4 attempts.
- 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 4 attempts.

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

AKT:

CSA:
Educational supervisor reports (ESR)

For the final ST3 review, please ensure that all 12 competencies are rated as ‘Competent for licensing’ or ‘excellent’.

The ESR needs to be completed no more than 8 weeks before the ARCP. You need to generate a review before they can do their self rating, generate the review for the next one at the end of your review and you will not forget.

Make sure your trainee does their self rating before they come to see you. Make sure your trainee realises they need to have evidence for self rating e.g. case of Breaking bad news CBD 06.01.13.

Get the trainee to look at word pictures for self rating at your first meeting with them.

The following link helps to show which pieces (e.g. COTs, CBD’s, MSF etc) of evidence can be used for each competency rating:


Examples of ESR’s

➔ Good ESR

![Competence Areas - Educational Supervisor Feedback](image)
What are RCGP word pictures?

Word pictures give a detailed description of each of the 12 competencies and what is required to rate a trainee at the different levels of competence.

See the following for details:


When to refer to a trainee for a panel opinion or grade as unsatisfactory progress?

- If a trainee has ...
  
  o Not completed the minimum number of WPBA assessments.
  o Not engaging with the e-portfolio.
  o Poor or low number of log entries.
  o Concerns re: professionalism/revalidation.

What happens after you refer to panel?

- Please inform the relevant TPD if you have referred a trainee for a panel opinion at their ESR, as this is not always highlighted to us and so we do not review the ARCP outcomes/recommendations.

ARCP outcomes:

- 1. Achieving progress at the expected rate.
- 2. Development of specific competencies required additional time not required.
- 3. Inadequate progress by trainee additional time required.
- 4. Released from training programme.
- 5. Incomplete evidence presented additional time may be required.
- 6. Recommended as having completed training.
- 7. Outcome for FTSTA (not normally applicable to GP training)
- 8. Out of programme for research, approved training or career break.
- 9. Outcome for doctors taking top up training in a training post. (This normally applies to article 11 trainees)
Trainees in difficulty

It is important that these doctors are highlighted early and you may wish to speak to your TPD early.

This section of the guide is used to highlight and summarise some of the resources that are available widely on the West Midlands Deanery website, these resources can be accessed via the following link:

http://www.westmidlandsdeanery.nhs.uk/ProfessionalSupport.aspx

E-learning for trainers on this subject can be accessed via:

http://www.faculty.londondeanery.ac.uk/e-learning/managing-poor-performance/

What is the Professional support unit:

Important

Enjoy your training!

GOOD LUCK!
Useful forms

Performers’ List

Trainees must join the Medical Performers’ list – before they begin their GP attachments (i.e. at the end of ST1 if starting GP at the beginning of ST2, or at the end of their ST2 hospital post if the first post in ST2 is a hospital post).

Please ask them to 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 a trainee is not registered on the performers list, they are working illegally!**
- Specific documents will be required from the trainee, so contact them before their GP placement with you.

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

Form R7

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

Form R

- Needs to be completed every year, to continue their training.

**Travel expenses**

- In order to claim for home visits + petrol.
- Forms available on the deanery website.
Useful Books for trainees:
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.