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- Out with the old
- In with the new

- Why the changes ?

- https://www.rcgp.org.uk/-/media/Files/GP-training-and-exams/WPBA/WPBA-Handbook.ashx?la=en

WPBA Headline Changes

- CAT's in ST3
- Requirement for less number of formal assessments
- At least 1 LLE in each capability per phase of training
- CSR in ST3
- QIAs, LEAs, SG adult and children reflection each year
- BLS each year.
- Prescribing review now mandatory
- Minimum number of clinical case reviews each year
- Light touch mid point esr
- Focus on leadership in ST3

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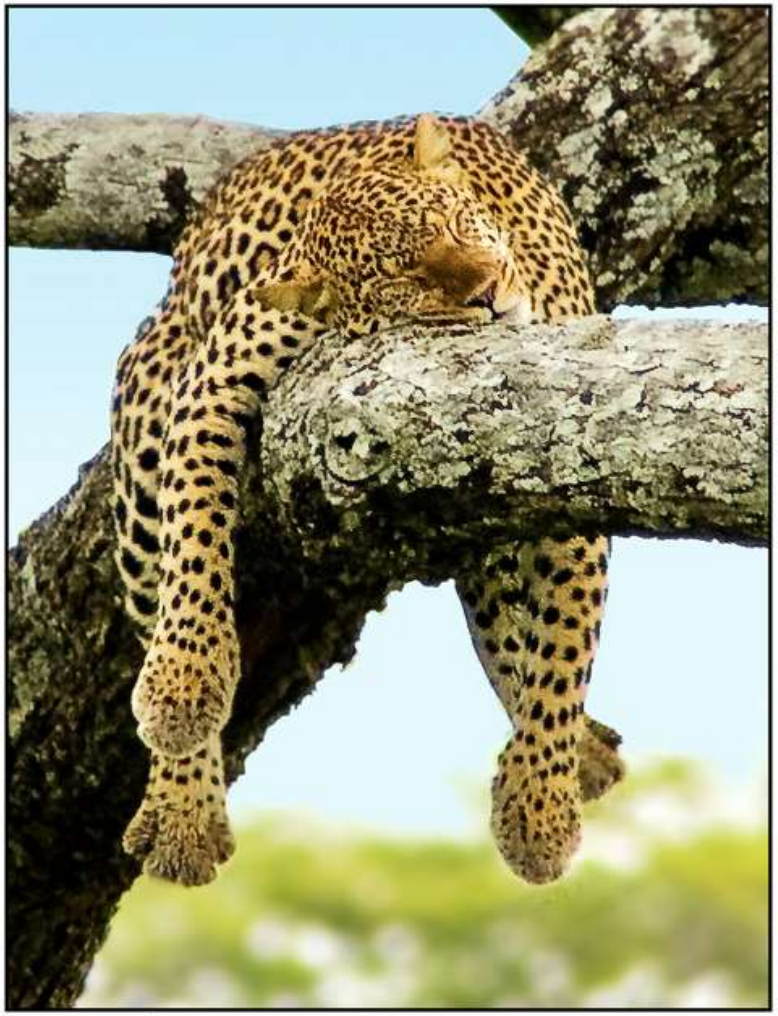

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- New Regime ST1
- 4 x COT (GP) or 4 x mini-CEX (hospitals)
- 4 x CbD
- 1 x Learning Event Analysis
- 1 x MSF
- CEPS as appropriate
- CSR for every post
- QI if in GP
- 36 Case Reviews

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- New Regime ST2
- 4 x COT (GP) or 4 x mini-CEX (hospital)
- 4 x CbD
- 1 x Learning Event Analysis
- 1 x MSF
- CEPS as appropriate
- CSR for every post
- 36 Case Reviews

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- New Regime ST3
- 6 x COT + 1 x Audio-COT
- 5 x CATS
- 1 x Learning Event Analysis
- 2 x MSF (1x MSF, 1x Leadership MSF)
- 1 x PSQ
- CEPs (5 mandatory ones)
- CSR for every post
- Leadership activity
- Prescribing Review
- 36 Case Reviews

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- Numbers are absolute minimum
- 36 case reviews each phase of training
- Other LE are needed – reflection on learning, teaching, conversations etc.
- Placement planning meeting

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- CAT
- RCA, CBD, Leadership, Prescribing Review FU, debriefs, review of investigation or imaging use, follow up of QIP.

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- RCA
- RCA provides opportunities to explore cases where the trainee does not recognise a problem, or where they may be avoiding having to deal with a problem.
- This obviously requires sensitivity on the part of the trainer.
- Review 1 case, several patients from same CEG, several patients looking at 1 capability

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- RCA
- Involvement of other doctors or team members may also be reviewed
- How much health promotion was undertaken? Holistic care and managing medical complexity.
- Did the trainee see a range of patient types, conditions and mix of urgent and unscheduled care and routine appointments? Are there actions that need to be planned in response to the balance of their work across clinical experience groups and medical specialities?

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- RCA
- Wide ranging
- Limited preparation
- Opportunity to harvest wide range of evidence

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- Prescribing Review Follow Up
- **Clinical management.** Has the trainee prescribed safely? Are they aware of and are they applying local and national guidelines including drug and non-drug therapies? Are they aware of legal frameworks for appropriate prescribing?

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- **Prescribing Review**
- **Managing medical complexity.** Has the trainee simultaneously managed patients' health problems, both acute and chronic (e.g. by taking into account comorbidities, existing medication and allergies), communicated risk effectively to patients (from documentation in the clinical records), recognised the inevitable conflicts that arise when managing patients with multiple problems and taken steps to address these.

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- Prescribing Review
- **Community orientation.** Has the trainee demonstrated how they have adapted their own clinical practice to take into account their local resources, for example colleagues with GPSPI experience; or in cost-effective prescribing by following local protocols?

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- Prescribing Review
- **Maintaining performance Learning and teaching**. Has the trainee shown a commitment to professional development through reflection on performance and the identification of personal learning needs?

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- **Prescribing Review**
- **Fitness to practice.** Has the trainee reflected on and learnt from performance issues (e.g. drug errors) in order to improve patient care?

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- Referrals Review
- What could you do ?
- What capabilities could you explore?

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- Other CATS

- Review of investigations / imaging
- Clinical debrief
- Follow up of QIP

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- Leadership Activity

1. A Leadership Activity will be undertaken in ST3. The activity will be recorded in the TeP by writing a reflective entry using the specific leadership log entry template.
2. The second MSF in ST3 will be a Leadership MSF with questions specifically focused on obtaining feedback around leadership skills. Ten respondents are required (ideally 5 clinicians and 5 non-clinicians), these should be people who were involved or included in your Leadership Activity

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- Leadership activity Reflective Log Entry

1. State your role in relation to the activity
2. How did you approach this activity? *[what planning you undertook for the activity]*
3. How did you demonstrate your ability to work with colleagues, patients, learners and/or users?
4. How effective were you within this role? *[reflect on your achievements and feedback received]*
5. Reflection: what will I maintain, improve or stop?
6. What have you learnt about yourself? *[consider what motivates you, your core beliefs and areas to develop]*

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- Leadership

- What activities might be suitable?

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- QIP

- Must be completed when in primary care at ST1 / 2
- SMART
- Model for improvement

1. Aim – What are we trying to accomplish?
2. Measure - How will we know if a change is an improvement?
3. Change - What changes can we make that will result in improvement

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- QIP

- What might be suitable as a QIP?

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- QIP
- What might be suitable as a QIP?

- Green impact - ? Reduce carbon footprint
- Introduce a scoring assessment for an acute illness
- Monitoring of a drug
- Use of antibiotics
- Management of B12
- Etc.

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- QIA

- ST's must demonstrate involvement in QIA in each phase of training via a QIA log entry

- The definition of QIA covers a wide range of activities including Quality Improvement Projects, Audits, Significant Event and Learning Event Analysis

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- Mid point ESR
- The Interim ESR is a ‘light touch’ ESR which can be completed instead of a full ESR at the midpoint of each training year, providing there have been no concerns raised

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- Who can do the assessments?
- Trainees in GP (primary care) placements – CATs, COTs/Audio-COTs and CSRs
- A GP ES or an approved CS should complete all assessments.
- Assessments should be conducted by more than one such person in each post and MUST be conducted by more than one described person whilst in training. This allows for triangulation of evidence and is recommended by the GMC.

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- Who can do the assessments?
- Trainees in non-primary care placements – CSRs, CbDs and MiniCEXs
- The Clinical Supervisors Report should be completed by the named Clinical Supervisor, who needs to have met the educator requirements of the GMC.
- At least one assessment and ideally one CbD and one MiniCEX should be completed by the doctor completing the CSR.

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- New format of log entries
- Clinical Case Reviews replace Clinical Encounters and Professional Conversations. For a full time GP trainee there is a requirement for a minimum of 3 in each calendar month.
- Supporting Documentation (CPD) replaces reading, eLearning, lecture/seminar, course/certificate, OOH attendance sheets.

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- Significant Event Analysis template has been rewritten to enable you to reflect to make it clear whether the event relates to revalidation.
- There is now an explicit difference between a Learning Event Analysis and a Significant Event (GMC level). A Learning Event Analysis is required in each year of training.

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- A Quality Improvement Activity reflection log has been introduced. This is separate to the required Quality Improvement Project in ST1/2 and meets the GMC guidance that all doctors should reflect annually on Quality Improvement Activities

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- A new entry for Leadership, Management and Professionalism.

- The GMC is clear that all trainees in all specialties should engage in and reflect on their developments in these areas.

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- How many ? The old chestnut
- THREE Clinical Case Reviews per month on average
- A placement-planning meeting at the start of each new post.
- Expected to have more than one log entry which addresses each Capability in each phase of training.

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