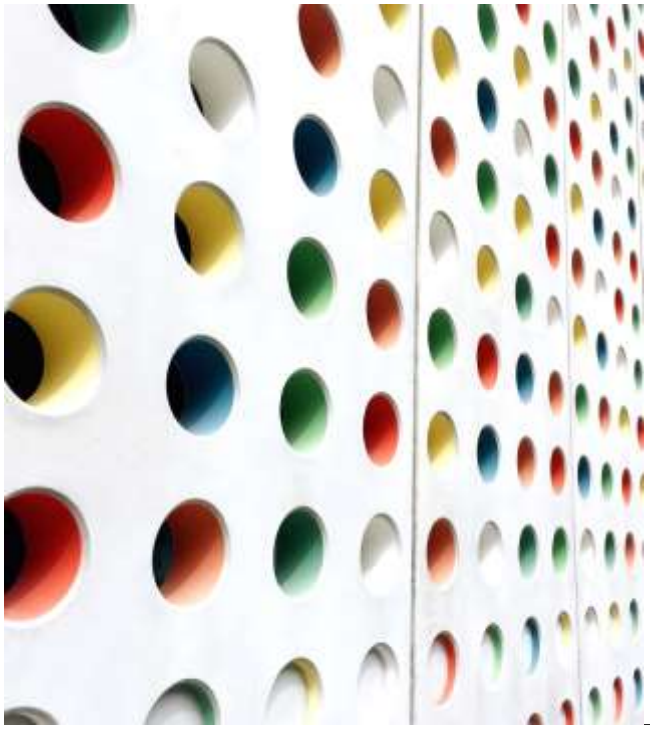


Recorded Consultation Assessment

BOLTON GP ST 3

1

RCGP.org.uk

Royal College of General Practitioners

2

Format of the RCA

- The RCA will provide an objective assessment of clinical skills from real life settings provided across 13 consultations and undertaken by the candidate from their own current working environment.
  - Due to the response to the pandemic situation it is likely that the majority of these will be conducted remotely.
- The RCA will be sat during the ST3 year or beyond of training and recordings will be made during this time.
- They may be any combination of audio, video or face to face consultations.
- Cases will be submitted to a central facility - the FourteenFish RCA Platform.
- Cases submitted should be of an appropriate level of challenge for an ST3 trainee to demonstrate safe and independent practice.

13 quality consultations.. not the best of many consultations hastily recorded one after another

You can't use consultations from pre-ST3

If you can use a combination – do so

- One of our successful ST3s did 13 face-to-face consults and scored highly, why do you think that is?

Record how you like, but they all have to end up on FourteenFish

You are training to be a GP, not a nurse practitioner, a paramedic, a 111 Health Advisor or any other role. Make your consultations things that only GPs do well.

3

Format of the RCA

These cases will be assessed by trained and calibrated examiners who are experienced GPs.

Each consultation will be viewed independently by at least one examiner who will make a global judgement of that consultation, attributing marks in three domains and blind to other marks the candidate receives for that or any other consultation.

It is the responsibility of the candidate to obtain consent from the patient under the usual guidance for training and GDPR. This may be on the FourteenFish RCA Platform directly where this is used to record the consultation, in written form kept by the practice (paper/electronic) or verbally (on camera, the timing of which will not be counted as part of the ten minutes to be assessed or off camera, but a record kept).

Recordings of individual consultations must be continuous.

The camera should not be turned off during consultations and recordings must NOT be edited in anyway.

Practise being an examiner – what is it like to review your consultations?

The individual examiner won't know that you did a good job before or after the consult, they can only go off what you submit.

Remember that your score comes from three domains – you need to score well in each.

Consent is key. Have a robust system in place to ensure you have consent recorded somewhere.

Don't edit, or make it look like you might have edited your consult.

4

Important Rules

As per RCA Policy and in line with GDPR

- No candidate should share their recordings for submission or potential submission to the RCA with anyone outside of their own Training Programme.
- Candidates must not share their recordings in any preparation course for the RCA (Including RCGP preparation Courses).
- The use of any service to screen cases prior to submission to the RCA is expressly prohibited.

Failure to adhere to this Guidance may result in referral to the GMC.

You can share recordings in our teaching, with Trainers and SOX educators, and with each other, with the assumption that those present maintain patient confidentiality.

Be careful what you share, once it leaves your inbox, you no longer have control.

Doctors shouldn't cheat.

5

Changes for the RCA to take effect from the September 2021 diet

Breast lumps (apart from those associated with the postnatal period) will no longer be considered for the mandatory criteria of maternal and reproductive health

The mandatory criterion was in place to ensure that candidates have the clinical skills to manage obstetrics and gynaecology. We have found that breast lumps score poorly as the management is a straightforward (but appropriate) referral to a fast-track clinic of a breast surgeon with no other management skills that align with the original intention of the criterion. There have also been many submissions of male breast lumps.

Clinical examination will no longer be a mandatory criterion

In trying to explain to patients what examinations will be carried out in the proposed subsequent face to face consultation, candidates appear to feel that they are required to talk to the examiner rather than the patient. Even in a video recording, the examination takes place behind a curtain. Hence, clinical examination will no longer be a mandatory criterion in the RCA, but clinical examination skills will continue to be assessed in Workplace Based Assessment.

6

Changes for the RCA to take effect from the September 2021 diet

The feedback statements and descriptors around safety netting will be changed to include the words 'appropriate' and 'realistic' safety netting

It has become apparent that some 'generic' safety netting by candidates such as 'phone 999' or 'go straight to A&E' can confuse and even upset patients. This clarification to the feedback statements and descriptors is intended to ensure candidates' safety netting is contextually appropriate to patients presenting complaints.

Increase the allowed length of time of the submissions from 10 minutes to 12 minutes for all cases

An increase in allowed time for every case was one of the biggest requests from the training community. It is recognised that 'real life' consultations can extend beyond 10 minutes, especially as the challenges of COVID continue. It is hoped that this increase in time for all cases will make candidates' RCA case selection easier, thus supporting them, their GP trainers and their practices.

7

Role of your ES

It is the responsibility of the candidate and their Educational or Clinical Supervisor to verify both the candidates identity and that the patients recorded are from genuine consultations within the candidate's approved general practice environment.

The choice of 13 consultations should be the candidates' own.

The Educational Supervisor is **neither expected nor obliged to review these consultations**.

8

Mark Scheme

I. Data Gathering, Technical and Assessment Skills

1. Takes a focussed history to allow for a safe assessment to take place
2. Elicits and develops relevant new information
3. Rules in or out serious or significant disease
4. Considers and/or generates any appropriate diagnostic hypotheses
5. Explores where appropriate the impact and psychosocial context of the presenting problem
6. Plans, explains and where possible, performs appropriate physical/mental examinations and tests
7. Appears to recognise the issues or priorities in the consultation

9

Mark Scheme

II. Decision Making and Clinical Management Skills

1. Appears to make a safe and appropriate working diagnosis/es
2. Offers appropriate and safe management options for the presenting problem
3. Where possible, makes evidence-based decisions re prescribing, referral and co-ordinating care with other health care professionals
4. Makes appropriate use of time and resources whilst attending to risks
5. Provides realistic safety netting and follow up instructions appropriate to the nature of the consultation

10

Mark Scheme

III. Interpersonal Skills

1. Encourages the patient's contribution, identifying and responding to cues appropriate to the consultation
2. Explores where appropriate, patient's agenda, health beliefs & preferences
3. Offers the opportunity to be involved in significant management decisions reaching a shared understanding
4. When undertaken, explains and conducts examinations with sensitivity and obtains valid consent
5. Provides explanations that are relevant, necessary and understandable to the patient

11

Grade Descriptors

Clear Pass

The candidate demonstrates a high level of competence, with a justifiable clinical approach that is fluent, appropriately focussed and technically proficient.

There is sufficient evidence provided to demonstrate capability in this domain.

The candidate shows sensitivity, actively shares ideas and may empower the patient

Pass

The candidate demonstrates an adequate level of competence, with a clinical approach that may not be fluent but is justifiable and technically proficient. The lack of complexity in the case presented restricts the achievement of a Clear Pass grade.

The candidate shows sensitivity and tries to involve the patient.

Fail

The candidate fails to demonstrate adequate competence, with a clinical approach that is at times unsystematic or inconsistent with accepted practice. Technical proficiency may be of concern.

There is limited (new) evidence provided to demonstrate capability of a doctor sufficient for safe independent UK General Practice.

The patient is treated with sensitivity and respect, but the doctor does not sufficiently facilitate or respond to the patient's contribution.

Clear Fail

The candidate clearly fails to demonstrate competence, with a clinical approach that is incompatible with accepted practice, arbitrary or technically incompetent.

There is no evidence or very limited evidence provided to demonstrate capability of a doctor sufficient for safe independent UK General Practice in this domain.

The patient is not treated with adequate attention, sensitivity or respect for their contribution.

12

Mandatory Case Selections

Mandatory case selection criteria	Requirement
One case involving a child aged 16 years or younger (including by proxy)	At least one case involving a child aged 16 years or younger (can be by proxy) The consultation should reflect the impact of the patient being a child, rather than simply incidental to the clinical scenario
Minimum of one older adult (over 65 years)	Minimum of **one** older adult (age 65 years and older)
Essential clinical areas. These consultations should reflect the impact of the condition on the patient, rather than it simply being incidental to the clinical scenario.	Minimum of one case involving each of: A - An **acute problem** that needs urgent investigation or referral B - Maternal and reproductive health C - A Mental Health Condition within the DSM or ICD classifications D - A **long-term condition** e.g. cancer, multimorbidity or disability

13

Recommended Case Selections

Recommended case selection criteria	Requirement
No more than 2 cases where the focus of the consultation lies in any one of the Clinical Topic Areas as listed in the GP curriculum	The spread of cases should be broad to demonstrate competence across the GP curriculum. The main focus of each case should be within a different clinical topic area of the curriculum.
Varying spread of clinical cases and levels of challenge in the consultation	Consideration should be given to the complexity of the consultations submitted, for example in terms of patient expectations, beliefs, social situation, psychological issues, hidden agendas.
(Minimum of 2 cases requiring either a clinical examination or an explanation of the clinical examination required to the patient [psychiatric examinations are included in this definition])	*(Clinical Examination is still considered an important component of the assessment and remains essential within the practical and ethical constraints of a recorded consultation.* *However - explanations should be relevant to the patient in the context of this consultation, helpful and understandable to them.)*

14

Case selection

What's the worst way to gather 13 cases?

- Randomly pick 13 patients and just record them
- Record every consultation in a set period of time
- Select certain patients who you've consulted before and would be good
- Come in on days off to carefully curate a list of 13 perfect-sounding patients
- Record only during duty or acute-patient sessions to get new case presentations
- Leave any recording until a few weeks before submission to make sure you're well rehearsed

15

Case selection

What's the worst way to gather 13 cases?

- Randomly pick 13 patients and just record them
- Record every consultation in a set period of time
- Select certain patients who you've consulted before and would be good
- Come in on days off to carefully curate a list of 13 perfect-sounding patients
- Record only during duty or acute-patient sessions to get new case presentations
- Leave any recording until a few weeks before submission to make sure you're well rehearsed

Who knows what will call in?

Exhausting & unfocussed

Risks poor data gathering

Time off is important/What is perfect?

Might miss long-term conditions

Reviewing recordings is vital to develop your consultations

16

How to approach the RCA

17

Tips from an ST3

1. Formulate a crib sheet and have a print out in front of you- refer to this so you know you are sticking to a good structure.
2. Have a table of the curriculum areas to hand so you know what kind of cases you still have yet to record.
3. Record everything at first- they won't all be ready for submission, but review them and pick up on things to improve.
4. Ask your trainer to be brutally honest when reviewing your recordings! If you find a certain area within the interpersonal skills domain that you aren't particularly strong in, think of some good statements you can say in that situation
5. Have a buddy or a small group of friends who you can meet regularly with to review each other's recordings and give constructive feedback - you can also use the RCA mark scheme for this
6. Something I found useful, especially towards the end when I knew I needed better cases and had limited time, was coming into work and asking reception to open a list for me but not to book any patients in. On the day I would look through everyone else's lists, and pick out any cases that looked like they could give me good recordings.

18

Tips from an ST3

8. Consent -Fourteen Fish is really great for this as it will sort out the consenting for you both before and after the recording
9. Do your best to stay within 10 minutes, use a timer, and try to get to management by 6-7 minutes.
10. It can feel overwhelming and time-consuming when you are recording every consultation. Consider how to structure your clinics and when you'll be recording
11. Duty days are great for recording: urgent care cases are sometimes simpler to record as there will generally be one issue, and a fairly straightforward/differential.
12. Try not to type or use your mouse during appointments, you'll find it can be very distracting when watching the recordings back afterwards.
13. Always pick up on cues and probe into them. If a patient sounds unsure of something or worried about something, verbalise this and explore it further. Addressing this will make the consultation run (and sound) much smoother, more patient-centred, and much more caring.
14. Lastly, this was a really good piece of advice I was given by a colleague at the time – if you are doing an audio recording, smile while you talk to the patient! You'll be surprised what a difference it makes to the tone of your voice and your interpersonal skills.

19

Advice from an examiner

Examiners need to see evidence of focused history taking, making a diagnosis/es, and formulation of a management plan.
You'll often need to present new acute undifferentiated cases to demonstrate this eg headache, fatigue, back pain, shoulder pain, sore throat, cough etc, and to actively take a focused history

- So, beware follow ups, avoid medication reviews, and no cases where there is no diagnosis to make and the management is straightforward
- A patient with sciatica who says **'I think I have sciatica, I had it two years ago and I would like some physio as that helped before**' is going to be difficult to score well compared with a patient who just says they have back pain.

Make sure there is "A beginning, a middle and an end."

- Remember 1/3 of your marks are for clinical management.
- Don't video an overly long clinical history which ends with a plan to bring the patient down to the surgery to examine them (unless you can set out your intended management plan clearly beforehand)

Don't bring back patients you've already seen for a review once you've read up on their condition. It's obvious and it doesn't score highly.

Do show new problems with some depth.

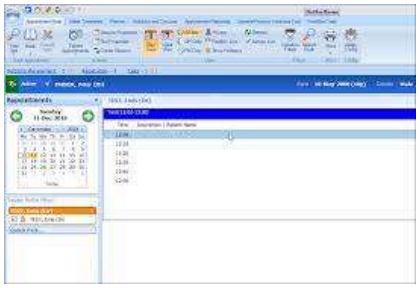
- You might perform brilliantly giving antibiotics for otitis externa, but you won't earn many marks.

Do watch yourself consulting, learn what you could improve on and adjust your consulting style accordingly.

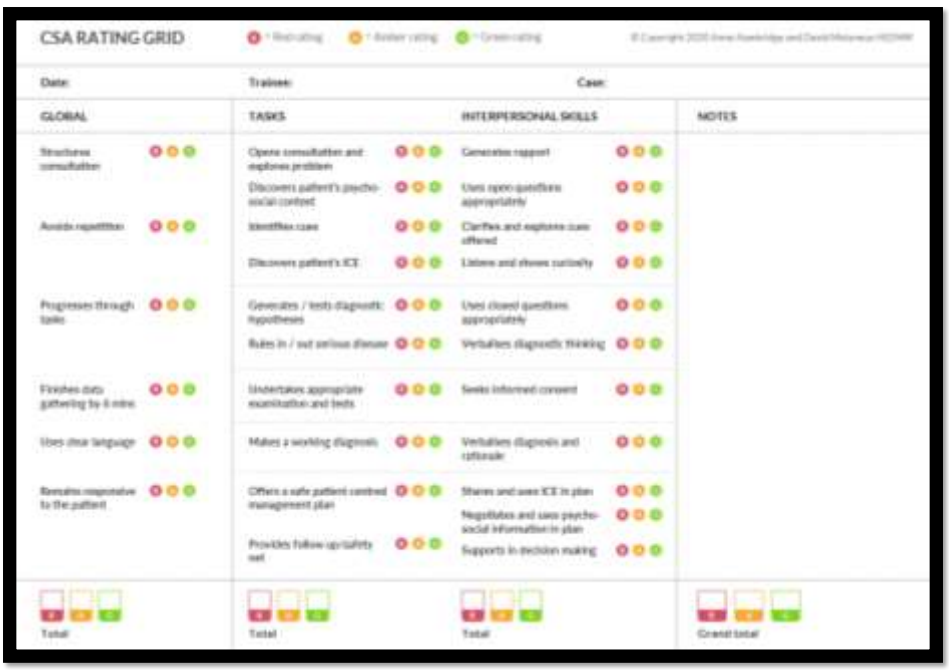
20


DO NOT
DISTURB


Record
Review
Revise



21


CSA RATING GRID
Date:
Trainee:
Case:
GLOBAL
TASKS
INTERPERSONAL SKILLS
NOTES
Structures consultation
Avoids repetition
Progresses through tasks
Finishes data gathering by 6 mins
Uses clear language
Remains responsive to the patient
Opens consultation and explores problem
Discovers patient's psycho-social context
Identifies cues
Discovers patient's ICE
Generates / tests diagnostic hypotheses
Rules in / out serious disease
Undertakes appropriate examination and tests
Makes a working diagnosis
Offers a safe patient centred management plan
Provides follow up/safety net
Generates rapport
Uses open questions appropriately
Clarifies and explores cues offered
Listens and shows curiosity
Uses closed questions appropriately
Verbalises diagnostic thinking
Seeks informed consent
Verbalises diagnosis and rationale
Shares and uses ICE in plan
Negotiates and uses psycho-social information in plan
Supports in decision making
Total
Total
Total
Grand total

22

Low challenge cases

Low challenge cases are unlikely to give you the opportunity to demonstrate your consultation skills fully and will make it difficult for examiners to find evidence to meet the required performance criteria.

- Examples of low challenge consultations might include simple lower urinary tract infections, straightforward skin conditions such as viral warts, uncomplicated upper respiratory tract infections and some follow up consultations.

However, any of these apparently low challenge cases can become more complex if, for example, significant psychosocial factors become apparent during the consultation. In general, more complex consultations are likely to give you the opportunity to demonstrate your consultation skills fully and meet the performance criteria required.

- Examples of complex might include consultations with patients who are new to you, those with a significant psychosocial component, patients presenting with more than one problem, patients with multimorbidity, and consultations with more than one person.

23

Record Consults, not Performances

Behaviour that is merely for the benefit of the examiner rather than necessary, appropriate and realistic to the patient has been observed. This is confusing to patients and is likely to negatively affect the marking in either the clinical management or the interpersonal if it increases patient uncertainty and does not enhance patient care. It may indeed be harmful to patient care.

- Such examples might include - an elaborate description of an examination which is not enhancing the patient understanding of their potential problem or might increase their anxiety.

Safety netting behaviours have also been observed which are likely to be detrimental to patient care - inappropriately increasing anxiety or suggesting inappropriate use of other resources such as out of hours or secondary care.

- An example might be a patient with a good description of Migraine type headache over 10 years who is told to dial 999 if things worsen before a scheduled examination later that day when they do not currently have a headache but are discussing prophylaxis.

24

Medical Student vs GP

25

Data Gathering

Good performers can take a **focused but full history**, embedding their enquiry in previous responses, so that a **fluent and logical progression is clear**.

Poor data gathering is seen in candidates who ask for the same information repeatedly and **do not appear to have listened** to the earlier responses.

- They use formulaic phrases in their questions that are not normal for everyday consulting (e.g. 'What are your worries?').
- Sometimes this becomes an interrogation as the open questions rapidly turn to closed biomedical history taking.
- In these consultations, the sequence of questioning does not make sense, as the doctor seeks to ensure that no information has been left out and works through a routine medical history.
- Sensitive information is asked for in the same manner as routine medical symptoms without sign-posting to the patient that one is entering potentially difficult territory.

26

Clinical Management

Clinical management should be grounded in UK medical practice, linked to recognised algorithms or modes of practice as suggested by NICE, SIGN, or other national guidelines.

- Candidates should be able to demonstrate problem-solving skills, with a range of reasonable management options to problems presented that are likely to be tailored to and acceptable to the patient.

Poor candidates may have an insufficient knowledge base to be able to think of a range of such management options, or may not be able to integrate and apply their knowledge to the situation in hand.

- Sometimes they do not appear to have a full understanding of the dilemma/problem presented, or its implications for the patient.
- A frequent sign of poor consulting skills is the candidate who puts off making a diagnosis or making clinical decisions, thus running out of time in the consultation for going through the management options properly.

27

Interpersonal Skills

Good interpersonal skills should run throughout the consultation. The candidate should show an interest, even a curiosity about the patient that is non-judgmental and caring in nature.

- He/she should be able to achieve a working relationship quickly and pick up the patient's agenda early ('connecting' with the patient).
- If the patient does not appear to understand, the candidate should pick this up and reformulate explanations.

Candidates who perform poorly in this domain tend to be doctor-centred, and while they may elicit patient concerns, they do not address or explore them properly.

- Explanations are poorly adjusted to the patient's level of understanding, and there may be inappropriate use of jargon.
- Occasionally, candidates are too patient-centred, agreeing to everything the patient requests, to the detriment of the clinical outcome.

28