RCGP WPBA Guidance

1. *Read through each and every PROFESSIONAL CAPABILITY. Do not automatically assume you understand them all; trust me - you will not. Getting a true understanding of each professional capability EARLY ON -which will help you "hit the mark" when writing your reflections as well as aiding deeper learning.*

WPBA capabilities

2. *I have highlighted the common capabilities that trainees find difficult in yellow. Please re-read these several times to ensure you have a super-good understanding of them. Then. keep revisiting them because each revisit will deepen your understanding.*

3. *Also read through RAM'S NOTES for extra guidance, hot tips and examples. You will find RAM'S NOTES at the bottom of every page.*

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4. *If your write-ups are very long or too short - they are unlikely to be of good quality and unlikely to "hit the mark" or be meaningful. Very long entries are likely to be full of waffle and go off at a tangent, and very short ones will not have enough "meat" on the bone! So, read RAM'S NOTES and keep referring back to this document to make your log entry and CBD write-ups a breeze.*

Fitness to practice

This is about professionalism and the actions expected to protect people from harm. This includes the awareness of when an individual's performance, conduct or health, or that of others, might put patients, themselves or their colleagues at risk.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Fails to respect the requirements of the organisation e.g. meeting deadlines, producing documentation, observing contractual obligations Has repeated unexplained or unplanned absences from professional commitments Prioritises his/her own interests above those of the patient Fails to cope adequately with pressure e.g. dealing with stress or managing time Is the subject of multiple complaints Fails to respect the requirements of the organisation e.g. meeting deadlines, producing documentation, observing contractual obligations Has repeated unexplained or unplanned absences from professional commitments Prioritises his/her own interests above those of the patient Fails to cope adequately with pressure e.g. dealing with stress or managing time Is the subject of multiple complaints.	Understands the GMC document, "Duties of a Doctor". Attends to their professional duties. Awareness that physical or mental illness, or personal habits, might interfere with the competent delivery of patient care. Identifies and notifies an appropriate person when their own or a colleague's performance, conduct or health might be putting others at risk. Responds to complaints or performance issues appropriately.	Demonstrates the accepted codes of practice in order to promote patient safety and effective team-working. Achieves a balance between their professional and personal demands that meets their work commitments and maintains their health. Takes effective steps to address any personal health issue or habit that is impacting on their performance as a doctor. Demonstrates insight into any personal health issues. Reacts promptly, discreetly and impartially when there are concerns about self or colleagues. Takes advice from appropriate people and, if necessary, engages in a referral procedure. Uses mechanisms to reflect on and learn from complaints or performance issues in order to improve patient care.	Encourages scrutiny of professional behaviour, is open to feedback and demonstrates a willingness to change. Anticipates situations that might damage their work-life balance and seeks to minimise any adverse effects on themself or their patients. Takes a proactive approach to promote personal health. Encourages an organisational culture in which the health of its members is valued and supported. Provides positive support to colleagues who have made mistakes or whose performance gives cause for concern. Actively seeks to anticipate and rectify where systems and practice may require improvement in order to improve patient care.

RAM'S NOTES

Fitness to practise is about YOU and/or OTHERS AROUND YOU.In other words,it's about turning the "reflective eye"onto yourself or others to see what might reduce or prevent patient harm. It's not about whether you are clinically good enough to be fit as a doctor but rather other factors in your life that might reduce your effectiveness as a doctor. For example -looking at your work-life balance because it is a well-known fact, the doctors that do not have balance are more likely to make mistakes. The same goes for doctors who are unhappy, stressed, financially struggling, moonlighting or struggling in some other way.

Maintaining an ethical approach

This is about practising ethically with integrity and a respect for equality and diversity.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Does not consider ethical principles, such as good vs harm, and use this to make balanced decisions Fails to show willingness to reflect on own attitudes	Awareness of the professional codes of practice as described in the GMC document "Good Medical Practice". Understands the need to treat everyone with respect for their beliefs, preferences, dignity and rights. Recognises that people are different and does not discriminate against them because of those differences. Understands that "Good Medical Practice" requires reference to ethical principles.	Demonstrates the application of "Good Medical Practice" in their own clinical practice. Reflects on how their values, attitudes and ethics might influence professional behaviour. Demonstrates equality, fairness and respect in their day-to-day practice. Values and appreciates different cultures and personal attributes, both in patients and colleagues. Reflects on and discusses moral dilemmas encountered in the course of their work.	Anticipates the potential for conflicts of interest and takes appropriate action to avoid these. Anticipates situations where indirect discrimination might occur. Awareness of current legislation as it applies to clinical work and practice management. Actively supports diversity and harnesses differences between people for the benefit of the organisation and patients alike. Able to analyse ethical issues with reference to specific ethical theory.

RAM'S NOTES

To truly understand ethics, you need to understand some of the medical ethical frameworks. It is really important It's crucial that you know the theory because it then helps you understand what you are doing and whether or not you need to move to a different position. In your write-ups about an ethical approach, don't just say what you did - instead, relate what you did to the theory. Use the theory to justify what you did. Show that you understand what you are doing from an ethical perspective.

Ethical Frameworks To Know About:

1. Consent 2. Confidentiality 3. Autonomy 4. Non-maleficence 5. Malfeasance 6. Beneficence 6. Justice

7. Aristotle's principle of morality 8. Principle of Utility 9. Rights-based ethics 10. Rationing

Communication and consultation skills

This is about communication with patients, the use of recognised consultation techniques, establishing patient partnership, managing challenging consultations, third-party consultations and the use of interpreters.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Does not establish rapport with the patient Makes inappropriate assumptions about the patients agenda	Develops a working relationship with the patient, but one in which the problem rather than the person is the focus. Uses a rigid or formulaic approach to achieve the main tasks of the consultation. Provides explanations that are relevant and understandable to the patient, using appropriate language. The use of language is technically correct but not well adapted to the needs and characteristics of the patient. Provides explanations that are medically correct but doctor-centred. Communicates management plans but without negotiating with, or involving, the patient. Consults to an acceptable standard but lacks focus and requires longer consulting times. Aware of when there is a language barrier and can access interpreters either in person or by telephone.	Explores the patient's agenda, health beliefs and preferences. Elicits psychological and social information to place the patient's problem in context. Achieves the tasks of the consultation, responding to the preferences of the patient in an efficient manner Explores the patient's understanding of what has taken place The use of language is fluent and takes into consideration the needs and characteristics of the patient, for instance when talking to children or patients with learning disabilities. Uses the patient's understanding to help improve the explanation offered. Works in partnership with the patient, negotiating a mutually acceptable plan that respects the patient's agenda and preference for involvement. Consults in an organised and structured way, achieving the main tasks of the consultation in a timely manner. Manages consultations effectively with patients who have different languages, cultures, beliefs and educational backgrounds.	Incorporates the patient's perspective and context when negotiating the management plan Appropriately uses advanced consultation skills, such as confrontation or catharsis, to achieve better patient outcomes. Uses a variety of communication techniques and materials to adapt explanations to the needs of the patient Employs a full range of fluent communication skills, both verbal and non-verbal, including active listening skills. Uses a variety of communication techniques and materials (e.g. written or electronic) to adapt explanations to the needs of the patient. Whenever possible, adopts plans that respect the patient's autonomy. When there is a difference of opinion the patient's autonomy is respected and a positive relationship is maintained. Consults effectively in a focussed manner moving beyond the essential to take a holistic view of the patient's needs within the time-frame of a normal consultation. Uses a variety of communication and consultation techniques that demonstrates respect for, and values, diversity.
Misses / ignores significant cues Does not give space and time to the patient when this is needed Has a blinkered approach and is unable to adapt the consultation despite cues or new information Is unable to consult within time scales that are appropriate to the stage of training Uses stock phrases / inappropriate medical jargon rather than tailoring the language to the patients' needs and context The approach is inappropriately doctor-centred			

RAM'S NOTES

In their book "Communicating with Patients", Silverman, Kurtz and Draper outline 72 communication skills. So don't be vague by saying, "I explained x, y and z to the patient". Instead, describe HOW you explained things. Why did you explain in that particular way? Focus on both the content and the process of each communication skill like EXPLANATIONS. Show the " intelligence" behind the "doing".

Data gathering and interpretation

This is about the gathering, interpretation, and use of data for clinical judgement, including information gathered from the history, clinical records, examination and investigations.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Has an approach which is disorganised, chaotic, inflexible or inefficient Does not use significant data as a prompt to gather further information Does not look for red flags appropriately Fails to identify normality Examination technique is poor Fails to identify significant physical or psychological signs	Accumulates information from the patient that is relevant to their problem. Uses existing information in the patient records. Employs examinations and investigations that are in line with the patient's problems. Identifies abnormal findings and results.	Systematically gathers information, using questions appropriately targeted to the problem without affecting patient safety. Understands the importance of, and makes appropriate use of, existing information about the problem and the patient's context. Chooses examinations and targets investigations appropriately and efficiently. Understands the significance and implications of findings and results, and takes appropriate action.	Expertly identifies the nature and scope of enquiry needed to investigate the problem, or multiple problems, within a short time-frame. Prioritises problems in a way that enhances patient satisfaction. Uses a stepwise approach, basing further enquiries, examinations and tests on what is already known and what is later discovered.

RAM'S NOTES

Data about a patient comes from the (1) History, (2) Clinical Examination and (3) Test Results. But this particular capability focuses on the history and test results because there is already a separate capability devoted to Clinical Examination (see next page). However, if you don't plan to write about CEPS in detail, write about it here.

So, in your write-ups about data gathering, please be concise and to the point about the history you have gathered. Start by writing a little bit of narrative to put the whole case into context. Then show us a focussed yet comprehensive history - one that is organised and concise that includes a coverage of red flags. Let's take depression - we would want to see some narrative followed by a coverage of most of the biological features of depression (sleep, irritability, anhedonia, concentration, apetite, weight loss/gain etc) rather than just mentioning one or two. Of course, there should be a suicidal risk assessment too.

Also, mention where you are getting the data from. If you imagine the patient's case as a jigsaw puzzle, the individual jigsaw pieces can come from a variety of sources. You get information from (1) the patient themselves, (2) their relatives, (3) other health professionals involved in their care, (4) the medical records, (5) clinical letters.

An example write-up might be...
52y man with known COPD, very chest with green phlegm for 10d. Getting worse and now feeling SOB and unwell. No rigors/chills. Known smoker. No chest pain. No haemoptysis. No hoarseness. No weight loss, night sweats or anorexia. Appetite good. Wife says "smokes like a chimney" and refuses to open the windows! Says quite stubborn. From notes - 5 admissions with acute infective exacerbation of COPD - last one 2 months ago. Once needed ventilating! Has been offered pulm rehab - but has declined.

Clinical examination and procedural skills

This is about clinical examination and procedural skills. By the end of training, the trainee must have demonstrated competence in general and systemic examinations of all of the clinical curriculum areas, this includes the 5 mandatory examinations and a range of skills relevant to General Practice.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Patient shows no understanding as to the purpose of examination Fails to examine when the history suggests conditions that might be confirmed or excluded by examination Inappropriate over examination Fails to obtain informed consent for the procedure Patient appears unnecessarily upset by the examination	Chooses examinations in line with the patient's problem(s). Identifies abnormal signs Suggests appropriate procedures related to the patient's problem(s). Observes the professional codes of practice including the use of chaperones. Arranges the place of the examination to give the patient privacy and to respect their dignity. Examination is carried out sensitively and without causing the patient harm Performs procedures and examinations with the patient's consent and with a clinically justifiable reason to do so.	Chooses examinations appropriately targeted to the patient's problem(s) Has a systematic approach to clinical examination and able to interpret physical signs accurately to reach the correct diagnosis or possible diagnosis Varies options of procedures according to circumstances and the preferences of the patient. Identifies and reflects on ethical issues with regard to examination and procedural skills. Recognises and acknowledges the patients concerns before and during the examination and puts them at ease. Shows awareness of the medico- legal background, informed consent, mental capacity and the best interests of the patient.	Proficiently identifies and performs the scope of examination necessary to investigate the patient's problem(s). Uses a step-wise approach to examination, basing further examinations on what is known already and is later discovered. Demonstrates a wide range of procedural skills to a high standard. Engages with quality improvement initiatives with regard to examination and procedural skills. Recognises the verbal and non- verbal clues that the patient is not comfortable with an intrusion into their personal space especially the prospect or conduct of intimate examinations. Is able to help the patient to accept and feel safe during the examination. Helps to develop systems that reduce risk in clinical examination and procedural skills.

RAM'S NOTES

For the capability of CEPs, we want to see that you can do a competent examination. Therefore, spell out the OUTCOMES of the examinations you made. We can tell from that whether you did a good enough examination or not. Don't be too lengthy: don't write things like *"I then proceeded to measure the respiratory rate, which was 32 and with a pulse oximeter - I was surprised to see that his oxygen saturations was 95%"* Be concise and direct yet comprehensive and to the point. Write in the similar fashion to how you would write up examination findings in the hospital medical notes as an FY doctor.

For example, you might write...

Chest: Apyrexial 37.1C, no cyanosis, BS vesicular, but creps notes left lower base with some significant wheeze. RR=32 No s/c nor i/c recession. Auscultation & percussion normal & equal both sides.

Making a diagnosis/decisions

This is about a conscious, structured approach to making diagnoses and decision-making.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Is indecisive, illogical or incorrect in decision-making Fails to consider the serious possibilities Is dogmatic/closed to other ideas Too frequently has late or missed diagnoses	Generates an adequate differential diagnosis based on the information available. Generates and tests appropriate hypotheses. Makes decisions by applying rules, plans or protocols. Is starting to develop independent skills in decision making and uses the support of others to confirm these are correct.	Makes diagnoses in a structured way using a problem-solving method. Uses an understanding of probability based on prevalence, incidence and natural history of illness to aid decision-making. Addresses problems that present early and/or in an undifferentiated way by integrating all the available information to help generate a differential diagnosis. Revises hypotheses in the light of additional information. Thinks flexibly around problems generating functional solutions. Has confidence in, and takes ownership of own decisions whilst being aware of their own limitations. Keeps an open mind and is able to adjust and revise decisions in the light of relevant new information.	Uses pattern recognition to identify diagnoses quickly, safely and reliably. Remains aware of the limitations of pattern recognition and when to revert to an analytical approach. No longer relies on rules or protocols but is able to use and justify discretionary judgement in situations of uncertainty or complexity, for example in patients with multiple problems. Continues to reflect appropriately on difficult decisions. Develops mechanisms to be comfortable with these choices.

RAM'S NOTES

This is a capability that trainees often struggle with. The first mistake they make is to write only about the working diagnosis they made and not their thinking about how they honed into that diagnosis. In other words, the "intelligence" behind the diagnosis is missing. The other mistake they make is to think this is only about making a diagnosis. It is not! It's about any decision-making that you make in the consultation. So for example, you might change your clinical management plan based on the social circumstances or the patient's wishes. Remember - detail the intelligence behind your decision-making - i.e. the justification behind it.

And where possible, try and link that intelligence/justification to the decision-making theoretical concepts and frameworks. You can find more on www.bradfordvts.co.uk/clinical-skills/decisions-diagnoses-uncertainty. If you don't do this now, you will never learn about them. Concepts like...

1. Dual Process Theory = System 1 & 2 thinking = Fast/Slow thinking , 2. Cognitive Biases, 3. Using Time as a Diagnostic Tool
4. Managing/Reducing Uncertainty 5. Complexity Theory 6. Pattern recognition 7. Prioritisation
8. Six Category Intervention analysis 9. SWOT analysis 10. What when there is no diagnostic label?

Clinical management

This is about the recognition and management of patients' problems.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Asks for help inappropriately: either too much or too little Does not think ahead, safety net appropriately or follow-through adequately	Uses appropriate management options Suggests possible interventions in all cases. Arranges follow up for patients Makes safe prescribing decisions, routinely checking on drug interactions and side effects. Refers safely, acting within the limits of their competence. Recognises medical emergencies and responds to them safely. Ensures that continuity of care can be provided for the patient's problem, e.g. through adequate record keeping.	Varies management options responsively according to the circumstances, priorities and preferences of those involved. Considers a "wait and see" approach where appropriate. Uses effective prioritisation of problems when the patient presents with multiple issues. Suggests a variety of follow-up arrangements that are safe and appropriate, whilst also enhancing patient autonomy. In addition to prescribing safely is aware of and applies local and national guidelines including drug and non-drug therapies. Maintains awareness of the legal framework for appropriate prescribing. Refers appropriately, taking into account all available resources. Responds rapidly and skilfully to emergencies, with appropriate follow- up for the patient and their family. Ensures that care is co-ordinated both within the practice team and with other services. Provides comprehensive continuity of care, taking into account all of the patient's problems and their social situation.	Provides patient-centred management plans whilst taking account of local and national guidelines in a timely manner. Empowers the patient with confidence to manage problems independently together with knowledge of when to seek further help. Able to challenge unrealistic patient expectations and consulting patterns with regard to follow up of current and future problems. Regularly reviews all of the patient's medication in terms of evidence- based prescribing, cost- effectiveness and patient understanding. Has confidence in stopping or stepping down medication where this is appropriate. Identifies areas for improvement in referral processes and pathways and contributes to quality improvement. Contributes to reflection on emergencies as significant events and how these can be used to improve patient care in the future. Takes active steps within the organisation to improve continuity of care for the patients.

RAM'S NOTES

This one is pretty straightforward. Just write out your management plan as you would do in the medical records. We want to see whether your management plan is medically "sound". As experienced GPs, we can tell. It is often obvious to us why you decided on a particular management plan (esp. when it is standard practice). But other times, you may need to provide a reason or justification for your chosen plan. In your write-up, try not to be unnecessarily verbose. Be concise, perhaps even using bullet points. Oh, and don't forget, SAFETY NETTING is always part of the management plan - so include it WHERE IT IS APPROPRIATE and REALISTIC to do so. Not everything needs safety-netting.

For example, for acute infective exacerbation of COPD, you might write...

1. Start antibiotics (Amoxicillin as per guidelines
2. Prednisolone 40mg od 5 days
3. Safety netted -
4. Safety netted - worsening of SOB or feeling unwell or rigors/chills... go to A&E/999
5. I will review next week (try and use motivational interviewing to stop smoking and enagage with pulm. rehab and review inhaler use).

Managing medical complexity

This is about aspects of care beyond the acute problem, including the management of co-morbidity, uncertainty, risk and health promotion.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Inappropriately burdens the patient with uncertainty Finds it difficult to suggest a way forward in unfamiliar circumstances Often gives up in complex or uncertain situations Is easily discouraged or frustrated, for example by slow progress or lack of patient engagement	Manages health problems separately, without necessarily considering the implications of co- morbidity. Identifies and tolerates uncertainties in the consultation. Attempts to prioritise management options based on an assessment of patient risk. Manages patients with multiple problems with reference to appropriate guidelines for the individual conditions. Considers the impact of the patient's lifestyle on their health.	Simultaneously manages the patient's health problems, both acute and chronic. Is able to manage uncertainty including that experienced by the patient. Communicates risk effectively to patients and involves them in its management to the appropriate degree. Recognises the inevitable conflicts that arise when managing patients with multiple problems and takes steps to adjust care appropriately. Consistently encourages improvement and rehabilitation and, where appropriate, recovery. Encourages the patient to participate in appropriate health promotion and disease prevention strategies.	Accepts responsibility for coordinating the management of the patient's acute and chronic problems over time. Anticipates and employs a variety of strategies for managing uncertainty. Uses the patient's perception of risk to enhance the management plan. Comfortable moving beyond single condition guidelines and protocols in situations of multi-morbidity and polypharmacy, whilst maintaining the patient's trust. Coordinates a team based approach to health promotion in its widest sense. Maintains a positive attitude to the patient's health even when the situation is very challenging.

RAM'S NOTES

Another big one that trainees struggle with. Trainees think that if a condition is complicated, it is complex - BUT IT IS NOT! For example, the CKD management pathway is somewhat complicated, but if you slow down, it becomes straightforward to follow. It is not complex. Complicated and Complex mean different things. Complicated is something that might have lots of parts to it but everything follows a logical order and is therefore quite easy to follow or fix. A non-functioning electrical device might look COMPLICATED by having loads of components, but because everything has a logical placement, it should be easy for most technicians to fix. The weather is an example of something COMPLEX - where one little change can have a massive and sometimes unpredictable effect elsewhere. Do you see the difference between complex and complicated? Trainees think that if they manage 2 or 3 problems together - it demonstrated Managing Medical Complexity - but IT DOES NOT! If they are four simple things (sticky eye, sore throat, a mole and a fungal toenail infection, having four things COMPLICATES matters but does not make the consultation COMPLEX. Yet someone who has both hypertension and CKD is complex because the drug management of the BP might have adversely affect the renal function.

So think Medical Complexity when...

1. two or more COMPLEX medical problems to juggle (acute or chronic), 2. you're stepping in to improve coordination (e.g. too many specialists involved and the patient is confused) 3. The Collusion of Anonymity (look it up - coined by Balint) 4. Methods to handle uncertainty, 5. When explaining about Risk.

I see that the RCGP has included Health Promotion in this capability, but there is a separate capability for this! So, if you want to focus on this, I suggest writing it with that capability. However, if the health promotion is part of a bigger picture of medical complexity, then you may wish to write about it here. You decide.

Working with colleagues and in teams

This is about working effectively with other professionals to ensure good patient care and includes the sharing of information with colleagues.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Works in isolation Gives little support to team members Doesn't appreciate the value of the team Inappropriately leaves their work for others to pick up Feedback (formal or informal) from colleagues raises concerns	Shows basic awareness of working within a team rather than in isolation. Understands the different roles, skills and responsibilities that each member brings to a primary health care team. Respects other team members and their contribution but has yet to grasp the advantages of harnessing the potential within the team. Responds to the communications from other team members in a timely and constructive manner. Understands the importance of integrating themselves into the various teams in which they participate.	Is an effective team member, working flexibly with the various teams involved in day to day primary care. Understands the context within which different team members are working, e.g. Health Visitors and their role in safeguarding. Appreciates the increased efficacy in delivering patient care when teams work collaboratively rather than as individuals. Communicates proactively with team members so that patient care is enhanced using an appropriate mode of communication for the circumstances. Contributes positively to their various teams and reflects on how the teams work and members interact.	Helps to coordinate a team-based approach to enhance patient care, with a positive and creative approach to team development. Shows awareness of the strengths and weaknesses of each team member and considers how this can be used to improve the effectiveness of a team. Encourages the contribution of others employing a range of skills including active listening. Assertive but doesn't insist on own views. Shows some understanding of how group dynamics work and the theoretical work underpinning this. Has demonstrated this in a practical way, for example in chairing a meeting.

RAM'S NOTES

This one is more straightforward. It's all about how you work with others. Remember, this is not about you being the "superhero" but how you work other others in a team. Remember: "there is no I in teams". If you want to write about a team you felt you led well (perhaps on a crash call in hospital or say a project in GP), then write this under the Leadership capability in OML(Organisation, Management & Leadership).

Examples of Working With Teams
(1) Referring or speaking to specialist health professionals to help with patient care (2) Involving other health professionals in a team-based approach to managing a patient (2) Coordinating existing specialist involvement in a more team-based approach to enhance patient care, rather than silo working (4)Working on a project with others (5) Involvement in a training/teaching workshop with others (6) QoF/DES/LES/Audit work

Teamwork Principles You Can Write About...
(i) Understand how teams work (Tuckman & Group Dynamics) (ii) Facilitation skills (including how to encourage participation & managing conflict) (iii)Having clear Goals (iv) Being Organised - Clear Roles & Tasks (read about Belbin's Teams Roles), Delegation (v) Communicating well (SBAR, handover, referral letters, discharge letters) (vi) Listening well (including allowing people to express feelings) (vii) Making good decisions together (viii) Mutual Trust, Respect (ix) Being Flexible (x) Providing Skills training & Support (xi) Enjoying the process & Celebrating Success (xii)Communities of Practice (Wenger)- look it up.

Maintaining performance, learning and teaching

This is about maintaining the performance and effective continuing professional development (CPD) of oneself and others. The evidence for these activities should be shared in a timely manner within the appropriate electronic Portfolio.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Fails to engage adequately with the portfolio e.g. the entries are scant, reflection is poor, plans are made but not acted on or the PDP is not used effectively Reacts with resistance to feedback that is perceived as critical Fails to make adequate educational progress	Knows how to access the available evidence, including the medical literature, clinical performance standards and guidelines for patient care. Engages in some study reacting to immediate clinical learning needs. Changes behaviour appropriately in response to the clinical governance activities of the practice, in particular to the agreed outcomes of the practice's audits, quality improvement activities and significant event analyses. Recognises situations, e.g. through risk assessment, where patient safety could be compromised. Contributes to the education of others.	Judges the weight of evidence, using critical appraisal skills and an understanding of basic statistical terms, to inform decision-making. Shows a commitment to professional development through reflection on performance and the identification of personal learning needs. Addresses learning needs and demonstrates the application of these in future practice. Personally, participates in audits and quality improvement activities and uses these to evaluate and suggest improvements in personal and practice performance. Engages in learning event reviews, in a timely and effective manner, and learns from them as a team- based exercise. Identifies learning objectives and uses teaching methods appropriate to these. Assists in making assessments of learners where appropriate.	Uses professional judgement to decide when to initiate and develop protocols and when to challenge their use. Moves beyond the use of existing evidence toward initiating and collaborating in research that addresses unanswered questions. Systematically evaluates performance against external standards. Demonstrates how elements of personal development impact upon career planning and the needs of the organisation. Encourages and facilitates participation and application of clinical governance activities, by involving the practice, the wider primary care team and other organisations. Evaluates outcomes of teaching, seeking feedback on performance, and reflects on this. Actively facilitates the development of others. Ensures students and junior colleagues are appropriately supervised.

RAM'S NOTES

Another straightforward one, but do remember to be specific when you write about what you have or are planning to learn.

For example, when writing about your learning needs, don't just write,"I will read up about facet joint arthritis". Instead, be specific. Show us that you have thought about it and are definitely planning to do it. For example, you might write: "I plan to read more about facet joint arthritis -great health professional article on patient.info". Likewise, instead of "a course on Motivational Interviewing", write "a course on Motivational Interviewing - one in Manchester run by xxx on July 22".

Also, when writing about teaching you have delivered, don't just write about what you did (i.e. don't just be descriptive). Tell us did it that particular way and try and relate it to (i) educational theory and (ii) facilitation theory - plenty of www.bradfordvts.co.uk (click on TEACHING). In other words, tell us "the intelligence behind your doing". Don't forget to evaluate your teaching - it's the only way to get insight & improve!

Oh, and don't cut and paste things from online learning material. That will not help you learn, and it also does NOT show us that you are learning. We are more interested in what exactly is new for you and will change the way you do things in the future. What are the key take-home messages for you?

Organisation, management and leadership

This is about understanding how primary care is organised within the NHS, how teams are managed and the development of clinical leadership skills.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Consults with the computer rather than the patient Records show poor entries e.g. too short, too long, unfocused, failing to code properly or respond to prompts	Demonstrates a basic understanding of the organisation of primary care and the use of clinical computer systems. Uses the patient record and on-line information during patient contacts, routinely recording each clinical contact in a timely manner following the record-keeping standards of the organisation. Personal organisational and time-management skills are sufficient that patients and colleagues are not inconvenienced or come to any harm. Responds positively to change in the organisation. Manages own workload responsibly.	Uses the primary care organisational systems routinely and appropriately in patient care for acute problems, chronic disease and health promotion. This includes the use of computerised information management and technology (IM&T). Uses the computer during consultations whilst maintaining rapport with the patient to produce records that are succinct, comprehensive, appropriately coded and understandable. Is consistently well organised with due consideration for colleagues as well as patients. Demonstrates effective: time-management, hand-over skills, prioritisation, delegation Helps to support change in the organisation. This may include making constructive suggestions. Responds positively when services are under pressure in a responsible and considered way.	Uses and modifies organisational and IM&T systems to facilitate: Clinical care to individuals and communities, Clinical governance Practice administration Uses IM&T systems to improve patient care in the consultation, in supportive care planning and communication across all the health care professionals involved with the patient. Manages own work effectively whilst maintaining awareness of other people's workload. Offers help sensitively but recognises own limitations. Actively facilitates change in the organisation. This will include the evaluation of the effectiveness of any changes implemented. Willing to take a lead role in helping the organisation to respond to exceptional demand.

RAM'S NOTES

This capability covers lots of things! So best to think in terms of 3 things:
(1) Organisation (2) Management (3) Leadership

ORGANISATION: understanding primary & secondary care organisational systems. Computerised medical records & medical software - how you use them to facilitate patient care; your medical notes - organised, comprehensive, logical?

MANAGEMENT: This is about managing yourself and/or others. Managing yourself - things like what method are you employing to keep on top of things. Please detail what you are doing rather than being vague with words like "I am being more productive and efficient". We want to know how. If you can't tell us how, then it's likely you don't see what you are doing. So please tell us how. Again, it is about "the intelligence behind the doing". For example, you may want to write about how you keep on top of your blood results, letters and other admin work amongst the daily duties of a GP.

LEADERSHIP: You may have led a team or project or a change in the way of working at the practice you are working in. But don't think of leadership as that top person in an organisation that leads the others below. That's a leader, not leadership. Leadership is broader than that. You can even show leadership qualities when you manage a complex patient - let's say where lots of specialists are involved but doing their own thing (silo working) - and you step in to coordinate the care in order to provide optimal patient care. But if you are going to talk about leadership, you should relate what you are doing (the description) to the theory (i.e. "the intelligence").

Leadership principles

(i) believing in the purpose, committing to the project, taking responsibility & developing a vision (ii) developing/enhancing skills needed for the job, (iii) making sound & timely decisions, (iv) communicating well, (v) leading by example (& showing humility), (vi) knowing your team, valuing them, forgiving them & looking out for their welfare, (vii)skills - delegation, motivation, prioritisation, facilitation, influencing others, negotiation, empathy (viii) learning agility, learning to be curious, being innovative, (ix) showing self-awareness, (x) O-HIT core values - Open, Honest, Integrity & Trust.

Practicing holistically, promoting health and safeguarding

This is about the ability of the doctor to operate in physical, psychological, socio-economic and cultural dimensions. The doctor is able to take into account patient's feelings and opinions. The doctor encourages health improvement, self-management, preventative medicine and shared care planning with patients and their carers. The doctor has the skills and knowledge to consider and take appropriate safeguarding actions.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Treats the disease, not the patient Does not recognise possible signs of adult and child abuse, harm and neglect or engage with safeguarding processes.	Enquires into physical, psychological and social aspects of the patient's problem. Recognises the impact of the problem on the patient. Offers treatment and support for the physical, psychological and social aspects of the patient's problem. Recognises the role of the GP in health promotion. Understands and demonstrates principles of adult and child safeguarding, recognising potential indicators of abuse, harm and neglect, taking some appropriate action.	Demonstrates understanding of the patient in relation to their socio-economic and cultural background. The doctor uses this understanding to inform discussion and to generate practical suggestions for the management of the patient. Recognises the impact of the problem on the patient, their family and/or carers. Utilises appropriate support agencies (including primary health care team members) targeted to the needs of the patient and/or their family and carers. Demonstrates the skills and assertiveness to challenge unhelpful health beliefs or behaviours, whilst maintaining a continuing and productive relationship. Demonstrates appropriate responses to adult and child safeguarding concerns including ensuring information is shared/referrals made appropriately. Practises in a manner that seeks to reduce the risk of abuse, harm or neglect.	Accesses information about the patient's psycho-social history in a fluent and non-judgemental manner that puts the patient at ease. Recognises and shows understanding of the limits of the doctor's ability to intervene in the holistic care of the patient. Facilitates appropriate long term support for patients, their families and carers that is realistic and avoids doctor dependence. Makes effective use of tools in health promotion, such as decision aids, to improve health understanding. Demonstrates skills and knowledge to contribute effectively to safeguarding processes including identifying risks and contributing to/formulating policy documents and communicating effective safeguarding plans for adults/children at risk of abuse, harm or neglect with wider inter-agencies.

RAM'S NOTES

There are 3 parts to this capability. You can write about any of them.

PRACTISING HOLISTICALLY - is straightforward for most of you. It's about looking at the problem in a wider context rather than just a medical one. How is it affecting the patient's life, family, work, and mental sanity? Exploring ICE (Ideas, Concerns, Expectations) & PSO (Psycho-Social-Occupational) aspects of the problem. Understanding the problem in relation to the patient's cultural & socio-economic background.

Why do we encourage this? Because the management of the problem in many instances needs more than just the quick "plaster" fix of a drug. So - write about the additional measures you have put in place to help - like daycare, nursing support, referral to counselling and so on.

PROMOTING HEALTH - please don't try and squeeze in health promotion just for trying to impress us. Health Promotion has to be appropriate and realistic. Of course, if someone smokes, you'd want to explore if they're open to cessation. BUT give it the time and space it deserves. AND only do it when appropriate to do so. So, if a patient comes in with depression you would want to spend a good time on their low mood and suicidal ideation. Talking about smoking cessation would NOT be the right thing to do here - best left for another day, when the patient is in a more happier part of their life (and more likely to succeed too). When promoting health, tell us what tools you used, if any, like Cates' plots, decision-aids, health leaflets, risk tools, Motivational Interviewing skills.

SAFEGUARDING - a patient may come in with a problem which necessitates an enquiry into safeguarding, even though that might not have been part of their agenda. But doctors have to make doctoring decisions and, if someone is at risk of harm - that has to become part of the agenda. So, if a lady comes in and reveals Domestic Violence, which occurs in the presence of young children, then safeguarding has to be part of the discussion and management plan. So detail how you did it, why you did it, show an understanding of safeguarding systems and try to do it in a manner that attempts to minimise an angry response.

Community orientation

This is about the management of the health and social care of the practice population and local community.

Indicators of Potential Underperformance	Needs further development	Competent	Excellent
Fails to take responsibility for using resources in line with local and national guidance.	Demonstrates understanding of important characteristics of the local population, e.g. patient demography, ethnic minorities, socio-economic differences and disease prevalence, etc. Demonstrates understanding of the range of available services in their particular locality. Understands limited resources within the local community, e.g. the availability of certain drugs, counselling, physiotherapy or child support services. Takes steps to understand local resources in the community – e.g. school nurses, pharmacists, funeral directors, district nurses, local hospices, care homes, social services including child protection, patient participation groups, etc.	Demonstrates understanding of how the characteristics of the local population shapes the provision of care in the setting in which the doctor is working. Shows how this understanding has informed referral practices they have utilised for their patients. This could include formal referral to a service or directing patients to other local resources. Demonstrates how they have adapted their own clinical practice to take into account the local resources, for example in referrals, cost-effective prescribing and following local protocols. Demonstrates how local resources have been used to enhance patient care.	Takes an active part in helping to develop services in their workplace or locality that are relevant to the local population. Understands the local processes that are used to shape service delivery and how they can influence them, e.g. through Health Boards and CCGs. Reflects on the requirement to balance the needs of individual patients, the health needs of the local community and the available resources. Considers local and national protocols, e.g. SIGN or NICE guidelines. Develops and improves local services including collaborating with private and voluntary sectors, e.g. taking part in patient participation groups, improving the communication between practices and care homes, etc.

RAM'S NOTES

Another capability trainees struggle with and what they write about often fails to "hit the mark". So please re-read this capability to get the true definition of what it means firmly grounded into your head. For example, many trainees think referring a patient to a service in the community is a demonstration of this capability. IT IS NOT.

This capability is about THE COMMUNITY rather than individuals, hence the term COMMUNITY orientation. It's about populations rather than individual patients. It's about population medicine and health rather than individual medicine and health. In dealing with an individual patient, many of us come across issues that apply more widely to other patients who share a similar characteristic. For example, you may have a poorly controlled diabetic in front of you. You realise he knows nothing about diabetes or dietary management because all of your leaflets are in English and not in Punjabi - his mother tongue. You then realise you have a significant Punjabi community and thus the notion that this issue might be a wider problem. So, you source some leaflets in Punjabi and by doing that, you are being COMMUNITY ORIENTATED.

Other Examples: You decide not to prescribe an expensive branded version of a drug (that a consultant wants you to prescribe) but a generic one because the money saved could provide more NHS services to the population at large. You have a patient in front of you who you feel could do with some Mindfulness therapy but are not sure if this is available.In your research, you find something available on the NHS and you let other doctors and patients know. A patient wants an MRI of their back (no red flags). You decide to follow the local guidelines on MRI (developed because GPs are ordering MRIs unnecessarily) - you decide not to refer because one has to be protective of the NHS budget so that the greater population can be served better. You get involved with the CCG lead on sexual health to help deliver a better service. You notice that chlamydia is rife in your practice population, but screening uptake is low, so you work with one of the partners to develop a "Get Tested" campaign. You attend a patient participation group because you want to hear what patients want. You attend LMC meetings because you want to help shape health at a population level.

HOSPITAL POSTS: It is often difficult to show evidence for this capability in a secondary care (hospital) post. But it is not impossible! Just remember - it has to relate to the community at large. For instance, you decide to join a hospital diabetic team that are trying to improve education in the community. Or perhaps the department is doing a campaign to encourage breastfeeding to new mothers. Or your General Medicine department wants your help on how to write more effective discharge letters that will help GPs (and thus ultimately patients) better.