Developments in WPBA

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Introduction
GMC’s General Professional Capabilities

Curriculum must align by August 2019
GMC Professional Capabilities

- 9 Domains, 20 subsections, 200 linked descriptors
- Articulates GMP

- Colleges required to map to GPC not GMP
- Excellence by Design – Standards for postgraduate curricula
- Five themes – Purpose, governance and support, programme of learning mapped to GPC, programme of assessment and quality assurance
- Outcome based; must explicitly assess the 20 subsections
Prescribing Safely

Doctors in training must be able to:

- prescribe safely and use appropriate therapeutic approaches and strategies to make sure medicines are managed effectively and used safely†
- review and monitor therapeutic interventions appropriate to their scope of clinical practice
- prescribe antimicrobial drugs appropriately
- prescribe medications and use other therapies in line with the latest evidence
- comply with safety checks, contributing to medication reporting systems, and following other monitoring processes as necessary
- understand the challenges of safe prescribing in people at extremes of age, which includes neonates, children and older people with frailty
- assess a clinical situation to recognise a drug reaction
- manage adverse incidents,* therapeutic interactions and report adverse drug reactions appropriately
Leadership

Doctors in training must show by:

demonstrating an understanding of why leadership and team working is important in their role as a clinician

- showing awareness of their leadership responsibilities as a clinician and why effective clinical leadership is central to safe and effective care

- demonstrating an understanding of a range of leadership principles, approaches and techniques and applying them in practice

- demonstrating appropriate leadership behaviour and an ability to adapt their leadership behaviour to improve engagement and outcomes

- appreciating their leadership style and its impact on others

- actively participating and contributing to the work and success of a team (appropriate followership)
Quality Improvement

Design and implement quality improvement projects or interventions that improve clinical effectiveness, patient safety and patient experience by:

- using data to identify areas for improvement
- critically appraising information from audit, inquiries, critical incidents or complaints, and implementing appropriate changes
- deploying quality improvement methods (eg plan, do, study, act or action research) and repeat quality improvement cycles to refine practice
- involving patients and public in decision making at group or community level
- engaging with stakeholders, including patients, doctors and managers, to plan and implement service change
- effectively evaluating the impact of quality improvement interventions.
Population Groups

1. Infants, children and young people
2. People with mental health needs
3. People with long-term conditions and disability
4. Frail and elderly (including multiple morbidity and palliative care)
5. People requiring urgent and unscheduled care
6. People with vulnerabilities (e.g. veterans, addictions, safeguarding issues, communication difficulties)
7. Gender health (Women, Men and LGBTI)
Other capabilities…. 

• Dealing with complexity and uncertainty 
• Scholarship and academic activities 
• Humane interventions 
• Legislative requirements 
• The health service and systems in the four UK countries 
• Health promotion and illness prevention 
• Multi-professional team working 
• Patient safety 
• Education and training
And.....
Problems of competence based education

- Analytic competence description suboptimal
- Assessment instruments inadequate
- Bureaucracy in collecting learner data
- Calibration
- Reliability
## CbD ratings against competency headings and global judgement

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>Needing Further Development</th>
<th>total</th>
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</thead>
<tbody>
<tr>
<td>SASG/StR n= 51</td>
<td>182</td>
<td>14</td>
<td>196</td>
</tr>
<tr>
<td>Consultant n=66</td>
<td>97</td>
<td>57</td>
<td>154</td>
</tr>
<tr>
<td>GP n=45</td>
<td>1</td>
<td>188</td>
<td>189</td>
</tr>
<tr>
<td>total</td>
<td>280</td>
<td>259</td>
<td>539</td>
</tr>
</tbody>
</table>

Chi Squared = 305.118 1 df  
*p* < 0.0001
Miller’s problem....

<table>
<thead>
<tr>
<th>DOES</th>
<th>In the clinical workplace</th>
<th>Cannot meet reliability requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>SHOWS HOW</td>
<td>In a simulated environment</td>
<td>May be reliable with much effort and cost</td>
</tr>
<tr>
<td>KNOWS HOW</td>
<td>In a written test (SJT)</td>
<td>Can have acceptable reliability</td>
</tr>
<tr>
<td>KNOWS</td>
<td>In a written test (MCQ)</td>
<td>Often very reliable</td>
</tr>
</tbody>
</table>

We need reliable assessments which allow discrimination, are standardised, and are reproducible.
Entrustable Professional Activities

Competencies – person descriptors

Knowledge, skills, attitudes and values
- Content expertise
- Health system knowledge
- Communication skills
- Data interpretation

EPAs – work descriptors

Essential tasks in professional practice
- Manage a patient OOH
- Lead a family meeting
- Undertake a significant event audit

EPAs are achieved at a variable rate by learners; they require unsupervised work as soon as the trainee is able; they allow individual paths to competence.
EPAs

- Can be routine as part of work
- Can be formal and summative

- Scale:
  1. Not ready for entrustment
  2. Ready for indirect supervision
  3. Ready for indirect supervision
  4. Ready for “unsupervised” practice
  5. Ready to supervise others
And.....

- The WPBA group is aware of the burden of assessment
- Is there equivalence of assessments?
- Is a full ESR needed every 6 months?
- Do we use clinical supervisor reports appropriately?
- PDP hasn’t been helpful
- Numbers of learning logs
I think you should be more specific here in step two.
Pause for heckling, yawns etc.....
What would you like to see?
February 26th changes

• Audio-COT introduced

• Changes to evidence – new wording about minimum requirements, removal from summary tab, consistency

• Change to trainee self-rating workflow – can add/edit PDP as floating box and new PDP functionality

• ESR – auto-scrolling fixed, PDP edited to relate to previous ESR, consistency across views, bugs etc
Current Plans for August 2019 - 1

- Minimum numbers of case reviews in learning log and reduced numbers of assessments
- Trainees will suggest links to 13 competences (capabilities) – no requirement to link to separate curriculum chapters
- Trainees will be required to link appropriate entries/assessments to population groups
- Removed PSQ in ST2
- CbDs become Supervised Learning Events (SLEs)
- Placement planning meeting to be recorded for every post
- Prescribing review – piloting currently
Current Plans for August 2019 - 2

- Leadership activity – required in ST3
- Context for learning (books, courses, tutorial) combined into single CPD entry – reduced courses/reading recorded
- Format of all learning logs changed to aid reflection
- SEA format adapted to make it clear it links to revalidation – 1x SEA per year (in line with revalidation)
- New “feedback” entry
- ESR – reduced from 6 monthly full review to annual
- New shorter “interim” ES review to be used ONLY if progress thought to be satisfactory
- CSR includes EPA question
Learning Logs

- 13 previous options reduced to 3 – CPD, review of cases, data and events and feedback
- Links to 13 GP WPBA competency areas (mapped to capabilities – max 2 per entry) and aligns with ESR
- Linkage if appropriate for logs and assessments to population groups; will allow demonstration of competency areas across population groups – no minimum numbers
- Quality improvement activity and leadership activity expected to be reflected on in review/feedback records
QIP – ST1/2

• Mandatory. Examples and tools already available. Current audit will be mapped to new learning log entry. Must be robust, systematic and relevant

• QIA reflective log entry – will include evaluation and subsequent action

• Only 1 formal QIP required but at least 1 QIA entry/reflection per year (includes SEA/LEA) (note SUIs etc to be renamed SLEs and Learning Event Analysis new term for SLEs)
Quality Improvement Project (QIP)

Trainee guidance for those undertaking an optional QI project

Engagement with Quality Improvement activities is a mandatory part of the curriculum for GP trainees (‘Gold Guide’ Reference Guide for Postgraduate Specialty Training in the UK, 7.32) and has become an established part of UK general practice.

Although it is not essential for every trainee to undertake a quality improvement project (QIP), those who have done so almost always find it a worthwhile educational experience relevant to their future everyday work as a GP. It can help to develop skills in leadership and team working as well as in quality improvement itself.

For those who wish to undertake QIP, the following guidance outlines how trainees might approach such a project, a structure for receiving formative feedback from the educational supervisor, and some tips on how to avoid common pitfalls. (This guidance was originally developed as part of our proposals for a fourth year of GP training.)

**Quality Improvement Project guidance** [PDF]

SLE guidance:

- Touchpoint 1 [PDF]
- Touchpoint 2 [PDF]
- Touchpoint 3 [PDF]
Prescribing & Leadership

- Trainee reviews 60 consecutive Px – automated list excluding flu, other minor Px
- Guidance followed and spread sheet created
- Reflection and action plan – PDP entry
- Shared with Trainer

- Leadership, management and professionalism activity yet to be created
- Log entry allows reflection
Questions, comments, clarifications……
Thank you

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