

The Friendly Guide to

e-Portfolio

and the

MRCGP

including Educational

Reviews and ARCP

Unofficial and Straight-talking

DP revised 10/2021

Section 1

RCGP Curriculum (2019)

The RCGP came up with a document that tries to identify the knowledge and skills that are needed to be a GP. This is known as the RCGP curriculum and has recently been updated in 2019 in order to shares aspects with the Generic Capabilities that all specialities require.

At the centre of the Curriculum are the basic skills or capabilities required to be a GP. These skills are based on knowledge obtained from * Clinical Experience Groups which cover many Professional, Life Stage and Clinical Topics.

Using this knowledge the doctor has the basic skills to be a Primary Care Clinician but will need to acquire additional skills or capabilities to develop into a General Practitioner.

What were previously called Competence Areas were redefined as Core Capabilities as an acceptance that competence is fluctuating as medical knowledge is ever increasing and developing.

Capability Areas:

Capabilities required for “Being a GP” with the 13 capabilities (previously competences) attached.

A Knowing yourself and relating to others

- 1 *Communication and Consultation Skills*
- 2 *Maintaining an ethical approach*
- 3 *Fitness to practice*

B Applying clinical knowledge and skill

- 4 *Data gathering and interpretation*
- 5 *Clinical examination and procedural skills*
- 6 *Making a diagnosis and decisions*
- 7 *Clinical management*

C Managing complex and long term care

- 8 *Managing medical complexity and long term care*
- 9 *Working with colleagues and in teams*

D Working well in organisations and systems of care

- 10 *Improving performance, learning and teaching*
- 11 *Organisation, management, and leadership*

E Caring for the whole person and the wider community

- 12 *Practising holistically, promoting health and safeguarding*
- 13 *Community orientation*

Curriculum Areas:

These Capabilities are built upon a solid foundation of clinical knowledge and expertise

9 Clinical Experience Groups,

1. Infants, children and young people under the age of 19
2. People with mental health needs (including addictions)
3. People with long-term conditions and disability
4. Frail and/or elderly people (including multiple morbidity and care of the dying)
5. Gender health (women’s, men’s and LGBTQ health)
6. People requiring urgent and unscheduled care
7. People with health disadvantages and vulnerabilities (eg veterans, mental capacity difficulties, safeguarding issues and those with communication difficulties)
8. Health promotion and people with non-acute and/or non-chronic health problems
9. Clinical problem; not linked to a specific clinical experience group

These Clinical Experience Groups will cover the following Curriculum Areas:

Professional Topics Guides:

1. *Equality, Diversity and Inclusion*
2. *Evidence Based Practice, Research and Sharing Knowledge*
3. *Improving Quality, Safety and Prescribing*
4. *Leadership and Management*
5. *Urgent and Unscheduled Care*

Life Stage Topic Guides

1. *Children and Young People*
2. *Reproductive Health and Maternity*
3. *People Living with Long Term Conditions including Cancer*
4. *Older Adults*
5. *People at the End of Life*

Clinical Topic Guides

1. *Allergy and Immunology*
2. *Cardiovascular Health*
3. *Dermatology*
4. *Ear, Nose, Throat, Speech and Hearing*
5. *Eyes and Vision*
6. *Gastroenterology*
7. *Genomic Medicine*
8. *Gynaecology and Breast*
9. *Haematology*
10. *Infectious Disease and Travel Health*
11. *Kidney and Urology*
12. *Mental Health*
13. *Metabolic Problems and Endocrinology*
14. *Musculoskeletal Health*
15. *Neurodevelopmental disorders, Intellectual and Social Disability*
16. *Neurology*
17. *Population Health*
18. *Sexual Health*
19. *Smoking, Alcohol and Substance Misuse*

It is expected that during training the GP registrar/trainee should have evidence from all the Clinical Experience Groups and cover the breadth of the Curriculum Topic Guides if at all possible. There should be at least 5-6 pieces of evidence that demonstrate their skill in each capability area. The trainee links the evidence in their learning log to these curriculum statements. The educational supervisor has to accept or reject these linkages as providing sufficient justification. The ES is responsible for linking the evidence against the capability areas.

IMPORTANT

It is the responsibility of the Educational Supervisor to link the learning log evidence to these Professional Capabilities. It is suggested that a maximum of 3 Capabilities are usually linked. The ES can also add or remove linkage to Curriculum Statements if necessary.

Becoming a GP

In order to become a GP a trainee must complete the following:

- 1. A satisfactory portfolio of evidence showing progression and development against the GP Curriculum**
- 2. Capabilities assessed as being Fit for Licensing or Excellent**
- 3. Compliance with Mandatory Training (currently BLS with AED, Child Safeguarding Level 3, Adult Safeguarding Level 3)**
- 4. The trainee must also have passed the examination components of MRCGP, namely**
 - a) The Applied Knowledge Test (AKT) and**
 - b) Consultation Assessment (either Clinical Skills Assessment (CSA) or currently Recorded Consultations Assessment (RCA)).**

Each ARCP will look at quantity and quality of workplace based assessments (WPBA), self-assessment, professional development plans and learning activity that meets identified learning needs.

Once these objectives have been completed and an Outcome 6 has been awarded, the trainee can apply for their Certificate of Completion of Training from the RCGP Certification Unit.

Section 2

e-Portfolio

The e-portfolio is an electronic document that is constructed by the trainee, then edited and assessed by the educational supervisor.

The e-portfolio is useful for the trainee, the clinical supervisor (consultant or GP), the educational supervisor (GP trainer), the Deanery and also the Royal College. The current portfolio is administered by Fourteen Fish.

The e-portfolio log in page is accessed from the RCGP website under the trainee e-portfolio tab of the website <http://www.rcgp.org.uk>.

By the end of the first month of starting GP, every trainee should apply training on-line to RCGP in order to be accepted into GP training and MRCGP assessment. This should enable you to access the e-portfolio. Most will also become Associate Members of RCGP known as Associates in Training (AiT) and will then receive additional advice and information from RCGP including the magazine InnovAiT.

The e-portfolio provides evidence that a trainee is good enough to be signed up and qualify as a GP. It also importantly provides evidence of poor performance, identifying areas where additional work is required or for failing trainees to provide evidence to allow them to leave GP training and look at alternative career paths.

The e-portfolio has a number of purposes:

- *A record of all attachments*
- *A record of clinical supervisors and educational supervisors*
- *An educational log of educational activity*
- *Logging this activity against RCGP Curriculum Statement Headings*
- *Educational Supervisor logging this activity against Professional Competences*

- A message board for sending confidential messages
- An unofficial system to make comments about progress and offer advice
- A system to advertise meetings and courses to trainees across the region
- A record of MRCGP examination attempts and passes
- A record of Work Place Based Assessments forms
- A record of CPR and AED Certificate
- A record of Out of Hours Attendance
- Personal Development Plan
- Self-Assessment of Competence
- Educational supervisors review of professional competencies
- Review of Educational Reviews and Annual Review of Competence Progression

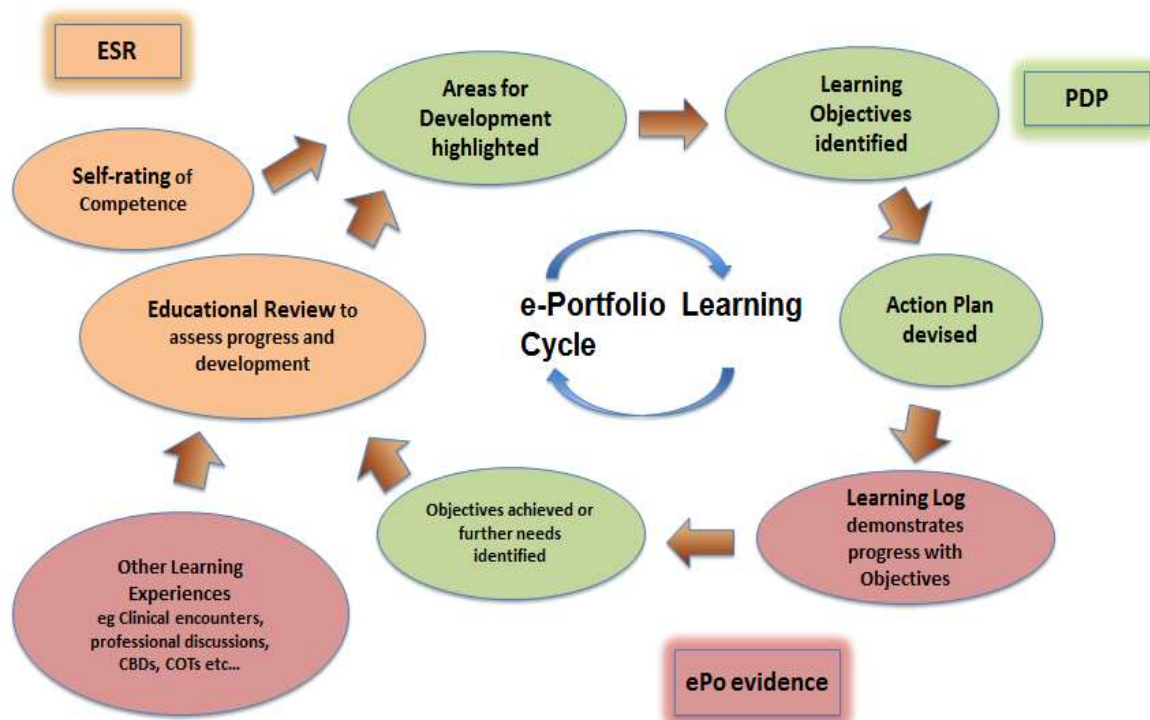
Setting up the e-portfolio

All attachments and associated clinical and educational supervisors need to be added to the e-portfolio. Trainees are able to add their CS and ES to their attachments. The Programme Administrators can help if there are problems. Trainers and educational supervisors are unable to add themselves.

The dates for each attachment need to be accurate.

It should be possible for a trainee to add the appropriate clinical supervisor (including hospital consultants) but if not the trainee may need to inform the local administrator to add the clinical supervisor.

e-Portfolio Learning Cycle



Adding Evidence of Learning to the e-Portfolio Learning Log

It is up to the trainee to add and importantly reflect on learning activity, complete the self-assessment and compile a useful and coherent PDP.

The process should start with a “self-assessment of competence”. This will identify some learning needs which should appear in PDP (Professional Development Plan). These needs need to have an action plan devised to try and meet these needs.

The PDP should be a well thought out and well-constructed document with specific needs and appropriate action plans.

Goals should be SMART (Specific, Measurable, Achievable, Realistic/Relevant and Timely).

One potential drawback of new version of e-portfolio is that it is easy to link evidence from learning log to the PDP. The PDP may then become cluttered and incoherent.

The PDP on the trainee’s page is in landscape format, whilst it is converted into long thin column in the portrait format on the educators’ and administrators’ pages. This means that a wordy PDP becomes very elongated and hard to comprehend.

Action Plans which are generated at the time of the Educational Supervisors Review by discussion with trainee and the ES, need editing and acting on.

Learning obviously happens in a planned way in order to meet learning needs but also in an unplanned experiential way. The trainee documents the learning activity and describes what learning has taken place and if any further learning is required. It may lead back to the PDP but not necessarily so. It may lead on to other learning activity which is documented later in learning log.

IMPORTANT

It is expected that there will be evidence of coverage in all the areas of the curriculum and competence demonstrated in all the 13 competence areas. In order to achieve this there should be adequate naturally occurring evidence provided by the log entries. Realistically in order to do this there needs to be roughly 2 entries a week documented on learning log. One of which is likely to be a Clinical Case Review as all the training attachments have a clinical focus. The portfolio suggests 3 CCR over 4 months or 12 per year.

It would be sensible to have at least 50 log entries including 36 CCR over each training year. Less than this may mean that there is a lack of evidence of competence and insufficient curriculum coverage by the Annual Review at the end of the training year.

IMPORTANT

Each entry should be linked to a maximum of 3 appropriate Curriculum Statement Headings. This is done by the trainee, **but the educational supervisor can and should remove any unjustified curriculum statement linkages.**

The educational supervisor must also link the learning log entry usually up to 3 appropriate Professional Capability Areas. This linking must be justifiable and capability in that area should be adequately demonstrated.

If this is not happening then the trainee should encourage the educational supervisor to do so.

The trainee can access a table of Curriculum Coverage and the associated linked log entries. It is hoped that there should be a broad coverage in all areas and there should be at least 4-5 entries in every Curriculum Area by the end of ST3, much more in common areas.

By ST3 evidence should be targeted at achieving this spread.

During the Educational Review, the educational supervisor can bring up a table of Professional Capabilities. It can be useful to the trainee if the educational supervisor prints off this page to allow the trainee to target evidence appropriately. The trainee at present cannot access this spread sheet directly.

Reflective Practice

The e-portfolio should present a record of learning that demonstrates that the learner has gained experience to demonstrate ability as a 'reflective practitioner'. With careful thought and application it will enhance learning from experience by compelling the trainee to pause and think about the things they are seeing and doing on a daily basis.

Important experiences that might be lost in the 'white heat' of a week full of clinical demands and other pressures, can be recognised and captured, then used as springboards for further learning.

Tips for Demonstrating Good Reflective Practice

Don't fill e-portfolio with masses of long and wordy log entries. The reflection and learning process is lost in the jungle of words.

Think about each entry, think about what are the learning needs and how you would address these. If appropriate add these to the PDP without cluttering the PDP.

Make the educational supervisor's job easier by clearly explaining how any learning needs have been met and highlighting which curriculum areas and professional competencies have been demonstrated.

The good trainee should produce a clear and concise e-portfolio that demonstrates good reflection and active learning. This will stand the trainee in good stead for future independent practice.

WPBA Evidence

As well as the Learning Log, the e-portfolio also provides the evidence of Work Place Based Assessments.

There are several types of WPBA;

CSR	Clinical Supervisor's Report	<i>After every hospital and any GP attachment in ST1 or ST2.</i>
PPM	Placement Planning Meeting	<i>This should be completed by the trainee after meeting the CS at the beginning of each placement.</i>
MSF	Multi-Source Feedback	<i>Feedback from 10 colleagues, completed in every year ie. ST1, ST2 and also in ST3. In addition there should be a Leadership MSF in ST3.</i>
COT	Consultation Observation Tool	<i>Consultation Tool in GP using live consultations or video. Audio-COT is reviewing a telephone consultation. Mini-CEX is the hospital based equivalent to COT using a hospital consultation Requirement as a minimum is 4 in ST1 and 2 and 7 in ST3 of any type including audio-COT and mini-CEX.</i>
Audio-COT	Audio or Telephone COT	
miniCEX	Mini Clinical Evaluation Exercise	
CBD	Case-Based Discussions	<i>Discussion about an aspect of clinical management. A CAT is a CBD undertaken in ST3. Requirements are 4 CBDs in ST1 and ST2 and 5 CATs in ST3</i>
CAT	Clinical Assessment Tools	
CEPS	Clinical Examination and Procedural Skills	<i>These are witnessed and assessed examination and procedure events. It is expected that trainees should demonstrate competence generally but there <u>must</u> be evidence with rectal, prostate, breast, male and female genital examinations (speculum and bimanual).</i>
PSQ	Patient Satisfaction Questionnaire	<i>1 is required just in ST3 GP attachment. There is no longer any need in ST1/2. Must be no less than 40 patients.</i>
PA	Prescribing Assessment	<i>Assessment of quality of prescribing by the trainee through self-assessment (60 prescriptions) and an appropriate Supervisor (ES, CS or pharmacists looking at 20 prescriptions).</i>
QIA	Quality Improvement Activity	<i>There should be quality improvement activity each year but there should be a QI Project at some point in ST1 or 2.</i>
QIP	Quality Improvement Project	
Leadership	Leadership Activity	<i>There should be some leadership activity during ST3</i>
SEA	Significant Event Analysis	<i>An SEA is now an event of with potentially serious implications eg a GMC investigation whilst an LEA is a less significant event which offers a learning opportunity.</i>
LEA	Learning Event Analysis	

There are 2 types of External Assessments;

AKT	Applied Knowledge Test	<i>This occurs 3 times yearly. Arranged at Pearson Vue driving test labs using computer marked questions. This can be taken in ST2/3.</i>
CSA	Clinical Skills Assessment	<i>Simulated surgery of 13x10 minute consultations using trained role-players held at RCGP Euston. This occurs 3 times yearly. This can only be taken in ST3. This is currently suspended and replaced by the RCA.</i>
RCA	Recorded Consultation Assessment	<i>This is an assessment of recorded consultations (either Face-to-Face, Telephone or Video Consultations) which was introduced during Covid to replace the CSA.</i>

The results of the WPBA and the External Assessments are documented in the e-portfolio.
The requirements for WPBA are as documented for each 12 month period broken into 6 month ES Review periods where applicable. (DOPs do not apply after August 2015)

	COT or mini-CEX	CBD	MSF	PSQ	CEPS	CSR
ST1	4	4	1 10 responses	0	Yes	CSR in every attachment
ST2	4	4	Nil	0	Yes	CSR in every attachment incl GP
ST3	7	5	1MSF +1 leadership MSF	1	Yes	None but can be completed

Clinical Supervisors Report (CSR)

The Clinical Supervisor's Report (CSR) is increasingly valuable as an assessment tool. It shows that ST1 and ST2 attachments in hospital or the community have been successfully completed. An unsatisfactory CSR will mean that this attachment is not completed and so an additional attachment may need to be completed.

The clinical supervisors are being added as the named consultant/GP for the attachments. This allows the CS to access the whole of the trainee's e-portfolio in order to allow CS to access additional information. It is though up to the clinical directorate or the general practice to decide who will be the CS. The trainee can add the CS themselves or inform the e-portfolio administrator of the training scheme so that the CS can be added.

The form has been re-designed to provide useful structured information but is no substitute for dialogue between the Clinical Supervisor and Educational Supervisor. It is the Educational Supervisor who makes the judgement of a trainee's progression towards competence. The CSR is one of several sources of evidence that he or she will use to reach this judgement.

The clinical supervisor (consultant or GP) will assess competence against trainees at a similar stage of their training. It is a useful way of giving constructive feedback whether positive or negative about a trainee. If possible objective evidence of good or unsatisfactory performance should be provided.

The final feedback box can also be used for further elaboration or any recommendations that you may have to help either the trainee or Educational Supervisor. Any concerns should be discussed with the Educational Supervisor directly (e.g. phone / email).

The Clinical Supervisor should have a discussion with trainee (and perhaps the Educational Supervisor) at the beginning of the training attachment, to plan the educational objectives for the following attachment period and to identify the specific opportunities that that particular post may provide for the trainee. The trainee should add this as a **Placement Planning Meeting** log entry for each attachment. Contact should be made again before completion of the CSR and at any other time if there are additional concerns.

Significant positive or negative comments from either CSR's or other conversations should be highlighted on Educator's Notes by the Educational Supervisor.

Section 3

Educational Supervisor's Review

The Educational Supervisor's Review should take place every 6 months. This should be a full ESR before any ARCP but can be an interim review which does not need so much feedback on the 13 Capabilities provided progress is satisfactory. If there are any concerns about engagement or development then a full ESR should be completed.

For many trainees starting in August, the first ESR is in December or January with a full ESR in May/June, no later than 2 weeks but no sooner than 8 weeks before ARCP in June/July. This pattern is disrupted by changes in ARCP dates, periods out of training or extensions to the training period. Going Less Than Full-Time does not alter the Annual Review of Competence and Progression or the pattern of 6 monthly ESRs.

An informal review should also take place when trainees return from absence such as prolonged illness or maternity leave.

Prior to the ESR the trainee should have completed the Self-Assessment of Competence. Evidence from the log entries can now be tagged to the competence which should help justify the self-rating.

The Educational Assessor needs to log in as such and not as the Trainer/Clinical Supervisor.

The Educational Review Process:

1. *Log in as Educational Supervisor*
2. *Review any un-read log entries,*
3. *Remove any unjustified curriculum statements*
4. *Link to justified Professional Competencies*
5. *Review Evidence, check adequate WPBA have been completed since last review*
6. *Review PDP, check areas have been updated, and new entries have been added. Targets and goals should be SMART (Specific, Measurable, Achievable, Realistic/Relevant and Timely)*
7. *Comment on any evidence of adult learning and reflective practice taking place within PDP and links to the learning log*
8. *Begin appropriate Review*
9. *Check self-assessments of 13 Capabilities have all been updated*
10. *Educational Supervisor's assessment of progress in all 13 Capabilities with highlighted examples of progression to competence*
11. *Check adequate Curriculum Coverage*
12. *Make appropriate comments*
13. *Check skills log and mandatory CEPS (or any remaining DOPS)*
14. *Make appropriate comments*
15. *Comment about naturally occurring evidence in the Learning Log.*
16. *Comment about evidence of reflective practice*
17. *Progression to Certification*
18. *CSA/AKT CPR/AED Safeguarding Child/Adult Level 3*
19. *Previous Reviews and ARCP's*

20. *Comment on quality of evidence*
21. *Areas for future development can then be added as Agreed Learning Plans which are then also attached to the PDP (but need not be). The trainee can then edit the Learning Plan in the PDP to make it understandable*
22. *Set time period for the dates of the Review; usually from the start date of attachment until the actual date of the ESR. This is different to the previous portfolio when the end date was the last date of the attachment.*
23. *For the final ESR it is worth setting up a buffer review period until the last date of training.*
24. *Create a new review from one day after the ESR date and provisionally running for 6 months. This end date will need adjusting according to the actual date of the next review.*
25. *Before the Annual Review of Capability Progression or any additional ARCP, there should be a full ESR. If progress is concerning then there should be a full ESR. If progress is satisfactory and there are no concerns and no subsequent ARCP then it is permissible to complete an interim ESR which does not require such intensive reflections on the 13 Capabilities.*
26. *Ensure the review is the appropriate ST year with the appropriate number.*

IMPORTANT:

- The ES is assessing performance in workplace as well evidence on e-portfolio. ESR outcome should not necessarily be affected by failure to pass CSA or AKT unless there are communication or knowledge issues in the practice.
- Submit Review electronically by pressing “Save and Complete” (do not leave as just “Save”)
- Trainee needs to accept the review otherwise it is not visible to Deanery Administrators or the ARCP
- The Trainee must have provided sufficient quality evidence for the Educational Supervisor to justify a trainee being either “Excellent” or “Competent for Licensing” by the end of ST3.

ARCP Panel

The ARCP panel usually review each e-portfolio annually in June/July. If the Educational review has highlighted any concerns, then the educational supervisor should email the Area Director and/or the Assessments Team prior to the ARCP. Their email is Assessments.wm@hee.nhs.uk There is no automatic alerting system.

One of the panel members will have pre-screened the evidence prior to ARCP in order to identify any concerns. The ESR must be completed prior to the review (2-4 weeks but less than 8 weeks before ARCP).

The ARCP undertakes the review of the e-portfolio in a similar fashion to the educational review:

1. *Evidence of competence is sought from WPBA, adequate reviews, positive CSR's, good MSF's etc... all help to provide evidence of competence. These WPBA's must be appropriate in numbers and be of satisfactory outcome and quality.*
2. *Trainee Self-Assessment of 13 Capability Areas should be recent and include good referenced examples of progression towards competence*
3. *Educational Assessor Assessment of 13 Capability Areas should be recent and include good referenced examples of progression towards competence*
4. *PDP should be thoughtfully constructed with recent and relevant entries. There should be at least one PDP entry for every attachment or 6 months. There should be at least one entry at the final ARCP identifying learning objectives for the following year after CCT.*
5. *Each attachment should ideally have a Placement Planning Meeting with the CS in all attachments.*
6. *Learning log should demonstrate justifiable links to curriculum statements and also professional competency areas.*
7. *Curriculum coverage should be adequate*
8. *Professional competency coverage should be adequate (this will be dependent on the linking of the educational supervisor as well as the quality of the evidence).*
9. *Skills log should have DOPS for all the mandatory skills.*
10. *Progress to Certification should be assessed*

11. *There is no contractual or educational requirement for any OOHs. There must be evidence for capability in Urgent and Unscheduled Care. Evidence should be collected from secondary and primary care. Working with the OOHs provider is a good way of collating evidence for UUC. If any OOH sessions are completed then they should be added as a reflective log entry.*
12. *Educator's notes should be reviewed*
13. *ES Recommendations concerning progress and any review comments should be checked.*
14. *Panel should make a recommendation about the candidate. This should be added onto the e-portfolio at the time of the review.*
15. *Additional requirement in the W Midlands Deanery are for a completed Form R and evidence of a complete JEST survey at each transition ARCP. There is a professional requirement to give feedback on the value of training posts.*

Options following the ARCP are as below;

Satisfactory Progress

1. *Achieving progress and competences at the expected rate (clinical)*

Unsatisfactory or insufficient evidence (trainee must meet with panel for outcome 2, 3, 4 but if Outcome 5 incomplete evidence can be discussed over the phone)

2. *Development of specific competences required – additional training time not required*
3. *Inadequate progress by the trainee – additional training time required*
4. *Released from training programme with or without specified competences*
5. *Incomplete evidence presented – additional training time may be required*

The Ultimate Goal of Training is Outcome 6

6. *Has gained all the required competences for the completion of training (clinical/academic)*

For outcome 2, where no additional time is required, the trainee should be reviewed at a future ARCP panel set at an appropriate interval to make sure the trainee is back on track. Reviews happen every 2 months, but it may be more appropriate to leave for 4-6 months.

All unsatisfactory trainees will receive feedback in person.

Less than full time trainees

For less than full time trainees (flexible trainees) the requirements are now established as pro-rata; the same number of Work-Place Base Assessments are required for each training year equivalent. For a trainee on 60% full time equivalent, the appropriate assessments for that 6 month period should be achieved by 10 months (eg in ST3 6 COT/miniCEX and CBDs 1PSQ 1MSF) or by the 6 month ESR then a minimum pro-rata equivalent should have been successfully completed (eg in ST3 4 COT/miniCEX and CBDs, possibly 1PSQ 1MSF).

There should be a CSR for each ST1 and ST2 clinical attachment. The MSF and PSQ should be completed by the first half of each the Speciality Training Stage (ie mid-point of ST1/2/3 attachments).

It would though be sensible for a LTFT trainee to try and exceed the minimum requirements. ARCPs will occur before transition to the next training grade (ST2-ST3) and also not more than 12 months since the last review. The ESR should therefore occur before the transitional ARCP and any additional ARCP, but also not more than 6 months since the last ESR. If in doubt check with the local TPD and administrators and have requirements documented on Educators' Notes.

Academic Trainees

Academic trainees have to complete an Academic Progress Report each year in addition to the e-portfolio requirements. The ST3 WBPA are spread over the ST3 and ST4 years as the 2 years are split between clinical and academic attachments.

During an Extension Period:

If a trainee is unable to complete the requirements of MRCGP in the usual 3 years they will usually be awarded an extension unless there is a widespread and significant concern.

During this time the following should also be achieved:

1. *Completion of any tasks highlighted by the last ARCP panel*
2. *Continue WBPA so that there is more than the minimum 1 COT 1CBD a month. The ARCP may ask for a further MSF or PSQ during the extension.*
3. *Continue gaining experience in OOHs at the equivalent of 6 hours a month (1 session if a session is 6 hours long)*
4. *Continue with the educational process, adding reflective log entries and PDP entries at an appropriate rate. Importantly making up for any shortfall in any areas that have been highlighted previously.*

If an extension is not at the end of training but in ST1 or ST2 then usually the WBPA is appropriate for that stage of training.

Final ARCP:

There are some additional requirements for the final ARCP:

1. *Self-assessment of competence which should be "Fit for Licencing" in the majority of competence areas. It is permissible to grade competence as Needing Further Development-Satisfactory Progress if this identifies future needs in isolated areas.*
2. *Trainer assessment of competence should be either "Fit for Licencing" or "Excellent" in all areas. Any other grade is not satisfactory for the expected level at the end of training.*
3. *Pass in CSA and AKT. If the result is awaited, then an outcome 5 is awarded until the result is known.*
4. *OOHs completed and appropriately documented with a running tally so that it is clear how many hours have been completed (usually 72 hours with the OOHs provider). Reflection on the OOHs plus additional Urgent and Unscheduled Care contribute towards the evidence for UCC Capability.*
5. *Log entry showing involvement in Significant Event Analysis ideally a SEA meeting at the practice which has affected a change in practice. Ideally there should be at least one SEA log entry every year.*
6. *Log entry demonstrating an audit or quality improvement which improves patient care in a primary care setting (usually ST2-3). A full audit cycle is not necessary unless the trainee will not be able to achieve CCT within the training (eg taking CSA outside training then applying to RCGP for article 11/CEPR then the GMC requires a full audit cycle to be demonstrated)*
7. *Log entry showing ideally training in safeguarding and child-protection which should be at Level 3 (appropriate for Clinicians). This can be the on-line course from the Deanery website (valid 1 year) but can also be face-to-face training (valid 3 years)*
8. *Log entry with attached certificate showing training in adult basic life support and the use of an automated external defibrillator AED.*
9. *PDP entry that looks at development needs in the year following CCT*
10. *Completed JEST survey giving the Deanery feedback on the value of the ST3 attachment*
11. *Form R completed which will allow the trainee to declare if there are any serious incidents or reports to the GMC.*

If there is something missing and an Outcome 5 is awarded with a short period (usually 2 weeks) to add the evidence. The ES will need to add a short buffer period from the last ESR to the end of training to allow this evidence to be added.

Assuming progress has been satisfactory, once the final ARCP in ST3 has been signed off as Outcome 6, the trainee can apply for the CCT (Certificate of Completion of GP training) and will then lead to the award of Membership of the Royal College of General Practitioners. It would be worth making contact with a local First 5 group for newly qualified GPs.

Future GP career:

The RCGP trainee e-portfolio will be used for revalidation purposes providing evidence of development. Information from it will then migrate to the Revalidation e-portfolio. Keep reflecting, keep adding entries.

Once you are established, (usually after 2 years) consider becoming a trainer and passing on your knowledge to future GPs.

Best of luck with your life-long learning.

Useful email addresses

Programmes.wm@hee.nhs.uk

Please use this email address for any queries for the GP School Programme Team.

Assessments.wm@hee.nhs.uk

This is the email address to direct any queries regarding ARCPs.

Facultysupportteam.wm@hee.nhs.uk

This is the contact email address to direct any queries regarding study leave.

Leademployerwestmids@sthk.nhs.uk

This is the generic inbox for the lead employer; please direct any questions here regarding employment issues, ie annual leave, salary, indemnity, sickness absence, maternity etc.

<https://www.westmidlandsdeanery.nhs.uk/>

This is a link to the deanery website where additional information can be found, both in the support section and the GP area.