RACGP
Royal Australian College
of General Practitioners

Progressive assessment and workplace-based assessment program

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Overview

Introducing progressive assessment

With the return to profession-led community-based training, the RACGP has developed a nationally consistent progressive assessment framework, informed by current best practice in medical education and with input from a range of stakeholders. It builds on what has been working well in the vocational training programs, and aligns with the *RACGP profession-led community-based training* position paper and the *RACGP educational framework*.

To date, the focus has been on assessment *of* learning with the successful completion of the end point Fellowship exams being the corner stone of determining whether a candidate is competent to practice safely in unsupervised general practice. However, in keeping with current best practice in medical assessment more focus needs to be placed on assessment *for* learning and the integration of assessment within the training program. The introduction of a progressive assessment framework supports assessment *for* learning with frequent low-stakes assessments occurring over the course of training so that there are multiple opportunities for feedback and for registrars to demonstrate evidence of learning. Progressive assessment provides a more comprehensive review of the registrar's capabilities and overall progress so that subsequent assessments can focus on areas of identified learning need.

A competency-based approach to medical education requires the assessment of a diverse range of competencies and professional attributes in addition to discipline-specific clinical knowledge and skills. This means that a greater emphasis needs to be placed on workplace-based assessment (WBA) as the main strength of WBA is its capacity to assess performance at the highest level of Miller's pyramid, which represents the development of clinical competence according to a hierarchy beginning with knowledge and progressing to clinical performance.

A registrar needs to demonstrate sufficient progress in their competency development to advance from one stage of training to the next, acknowledging that each registrar will develop different competencies at different rates during training. A clear definition of the desired competency outcomes and progressive, frequent assessments throughout training will identify whether a registrar has made sufficient progress to advance to the next stage. Although our assessment framework will still assess across the full continuum of Miller's pyramid of 'knows' to 'does', the focus of our assessments will be on the higher levels of Miller's pyramid to support competency based medical education.

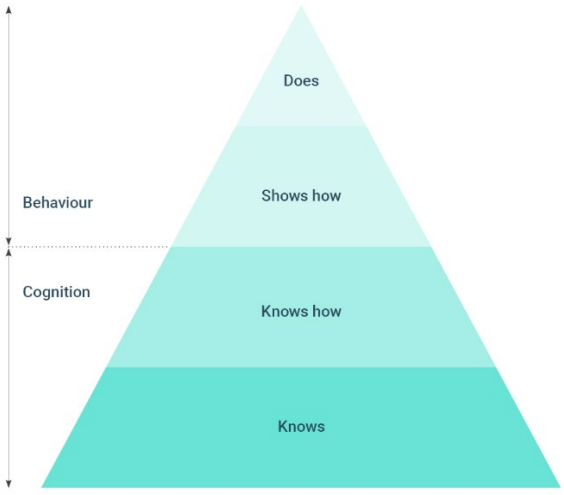


Figure 1. Miller's pyramid - represents development of clinical competence as a hierarchy with progression from the cognitive components through to the behavioural components of competence.

Progressive assessment framework

The RACGP has developed a progressive assessment framework that aligns with the Australian Medical Council (AMC) *Standards for assessment and accreditation of specialist medical programs and professional development programs* and the RACGP *Standards for general practice training*.

An integral and critical part of the education and training in the program will be high-quality, regular low-stakes assessment with constructive feedback to registrars on their performance. It is important to assess the registrar's progress towards becoming a safe independent general practitioner throughout training and to provide information to guide the registrar's future learning activities.

The progressive assessment framework (Figure 2) applies to the entire general practice training journey, from the selection of registrars into the training program to the awarding of RACGP Fellowship. Assessment occurs frequently over the course of training, with multiple opportunities for the registrar to demonstrate the knowledge, skills and attitudes required to practise unsupervised in comprehensive Australian general practice.

The framework includes a combination of low-stakes and high-stakes assessments and incorporates both assessment *for* learning and assessment *of* learning.

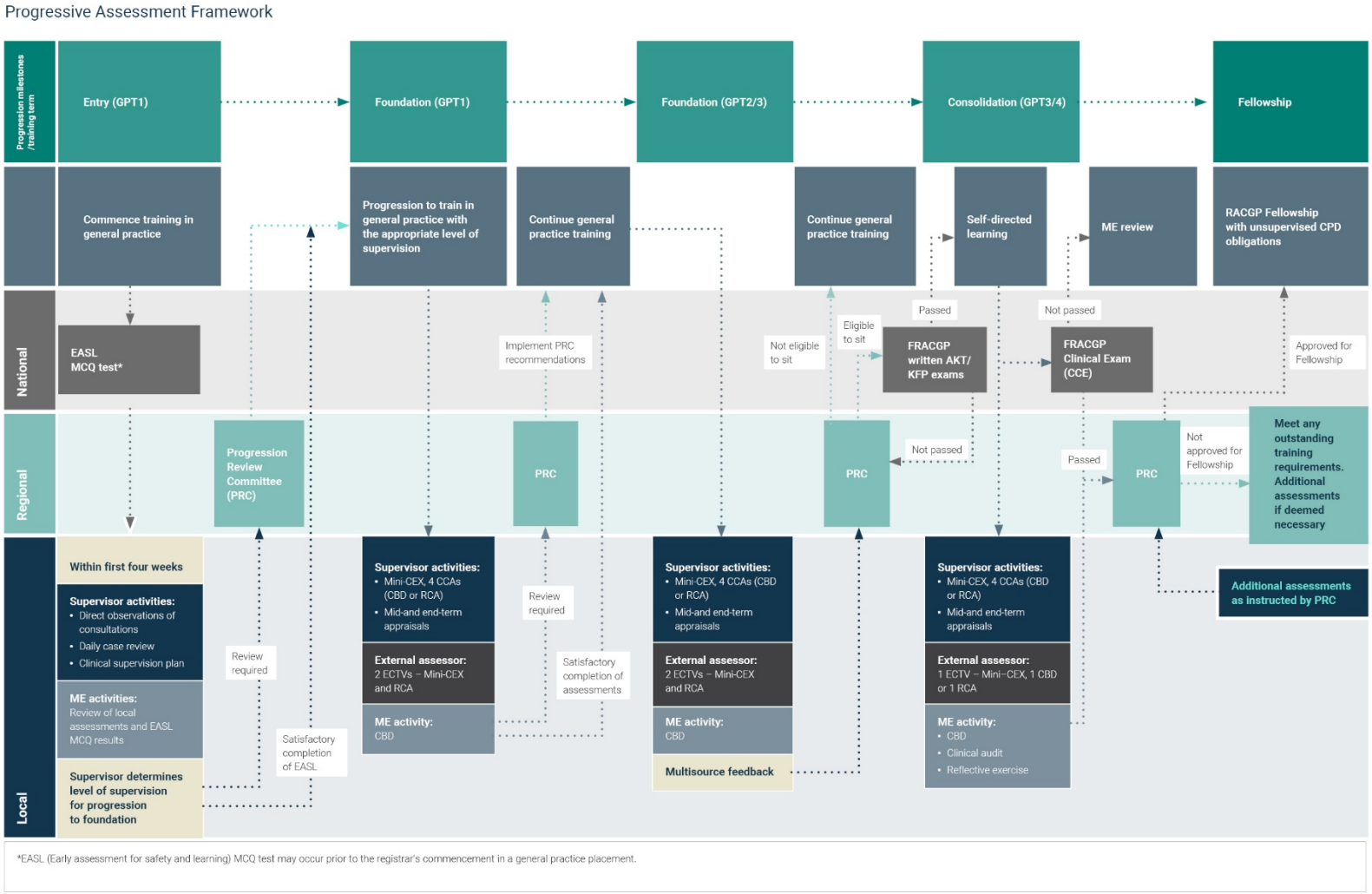
Low-stakes assessments primarily serve to provide feedback on performance and guidance for registrar learning. Information from multiple low-stakes assessments over time will build a picture of a registrar's progress towards the desired competency outcomes and will contribute to decisions on progression at key points through the training program. Development of learning goals, engagement with appropriate learning activities and subsequent demonstration of effective learning and competency development by the registrar will also be considered. High-stakes assessments, such as the Fellowship exams, are important for final certification purposes.

The principles underlying the progressive assessment framework

The framework ensures a national approach to assessment, with assessments delivered by national, regional and local RACGP teams. The principles are:

- A nationally consistent approach to assessment.
- Applies to all training pathways
- Applies to all general practice settings (remote, rural and metropolitan).
- Assessments are mapped to the RACGP *Curriculum and syllabus*.
- Recognises that registrars progress at different rates, depending on their previous clinical experience and learning opportunities.
- Evidence of competence is gathered from different sources.
- Registrars are given feedback to encourage self-reflection and to provide guidance for future learning activities through assessment *for* learning.
- Registrar progress is reviewed and tracked throughout training to support achievement of learning goals
- Registrars are rated against the standard required at the point of Fellowship at every stage of community-based training following the early assessment for safety and learning (EASL).
- A clear understanding is gained of a registrar's progress towards Fellowship through assessment *of* learning.
- Decisions about progress to the next stage of training are made by considering all available data.

Figure 2. The RACGP progressive assessment framework



The Framework shows assessments that are required to be completed at various stages of the training program. All assessments will be mapped to the competency outcomes outlined in the RACGP curriculum and syllabus. The WBA program is integral to the progressive assessment framework as the frequent assessments provide information about the competencies that have been demonstrated at the key training milestones of the Progressive Capability Profile of a GP.

Workplace-based assessment

Workplace-based assessment (WBA) allows observation of what a registrar actually does in their own workplace and thereby enables assessment of a registrar's performance at the highest level of Miller's pyramid. The main strength of WBA is its capacity to assess performance that requires multiple capabilities and competencies. There are several well-established, validated WBA tools to assess a range of competencies, including clinical reasoning and patient management where there may be diagnostic uncertainty, multi-morbidity and varied resource availability and social contexts.

WBA tools also allow for assessment of more complex competencies, such as professionalism and the ethical and legal considerations inherent to clinical practice, which may not be adequately assessed by traditional assessment methods

The RACGP assessments that correspond to the levels of Miller's pyramid are shown in Figure 3.

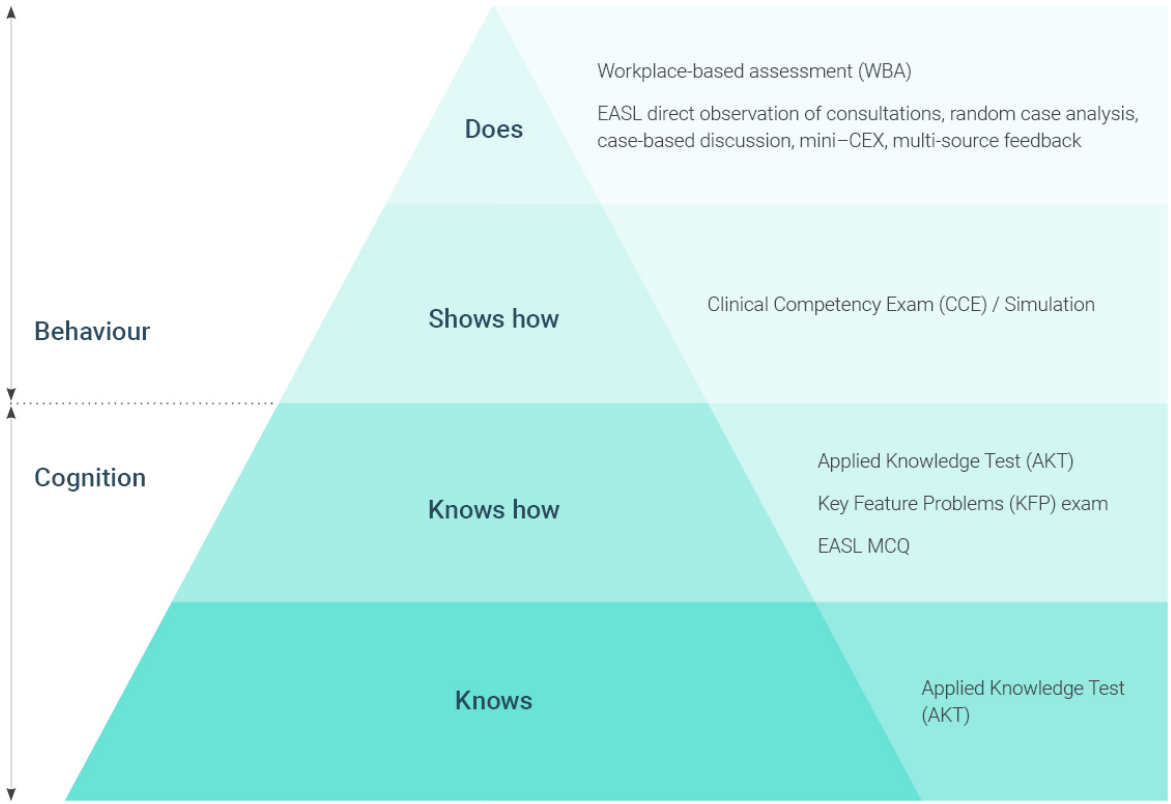


Figure 3. Miller's pyramid and corresponding RACGP assessments

The RACGP WBA program

The WBA program enables assessment of registrar performance throughout training and the provision of feedback to guide future learning activities. A key aspect of the assessment *for* learning that underpins the WBA program is that the registrar needs to develop learning goals and learning activities based on the feedback provided and demonstrate that the feedback has been effectively incorporated in their performance during subsequent assessments.

Program objectives

The objectives of the RACGP WBA program are to:

- drive self-directed learning and reflective practice through formative feedback and self-assessment[1]
- inform decisions on the appropriate supervision needed to support patient and registrar safety[2,3]
- track a registrar's development and progress towards becoming a safe clinical practitioner suitable for independent practice as a general practitioner in Australia[1,4]
- identify registrars in difficulty and inform decisions about additional or mandated educational activities for those registrars needing extra support[1,4]
- evaluate those areas of professional practice and behaviour that are difficult to assess in high-stakes summative exams and are best tested through real experiences in the workplace
- determine eligibility to sit the Fellowship summative written assessments
- determine eligibility for the award of Fellowship of the RACGP.

Embedding assessment within the workplace provides data that can be used for both educational purposes and to support high-stakes decisions. To date, WBA has been used predominantly in a formative manner to facilitate and direct learning through self-reflection and feedback. It has also been used to identify a registrar's learning and supervision needs and to determine the amount of support required.

WBAs will continue to be used primarily as assessment *for* learning but will now also provide valuable information to support decisions about progression through training. Data from WBAs can be used to assess if a registrar has met the appropriate clinical competencies and skills to progress to the next stage of training, to be considered eligible to sit the written Fellowship exams, and ultimately to be deemed as safe to practice independently in comprehensive general practice.

Qualities of the program

- A nationally consistent, standardised assessment program with a requirement for a minimum data set that:
  - enables defensible decisions to be made
  - promotes equity for all registrars
  - overcomes the current variability in the type and frequency of WBA tools used across different training regions and in different pathways to Fellowship.
- The risk of assessor bias is minimised by:
  - adequate assessor training

[1] RACGP Standards for general practice training – Standard 3.2, AMC Standard 5

[2] RACGP Standards for general practice training – Standard 1.1, AMC Standard 5

[3] RACGP Standards for general practice training – Standard 1.3, AMC Standard 5

[4] RACGP Standards for general practice training – Standard 2.3, AMC Standard 5

  - the use of multiple assessors and multiple sources of information.[1,5]

- The impact of variability across different practices is minimised by:
  - wide sampling across clinical content by different assessors. Acceptable levels of reliability can be achieved provided sufficient judgements are combined from multiple clinical encounters over multiple occasions.[1,5]

WBA will be integrated into the progressive assessment framework to ensure that there is adequate assessment across the breadth of competencies described in the RACGP *Curriculum and syllabus* with an emphasis on assessing those core competencies that are required for a doctor to work as an independent general practitioner (GP) in comprehensive general practice.

WBA competencies

The progressive assessment framework recognises that individual registrars develop competencies at different rates and at different stages. For this reason, all assessments in the WBA program are criterion referenced, allowing registrars to demonstrate progress over time and at different rates against defined criteria that describes the performance expected at the level of Fellowship.[1]

The defined endpoint is the point at which a doctor is deemed competent for unsupervised practice in Australia – the RACGP standard for Fellowship. All assessments in the WBA program will be rated against the standard for Fellowship.

The *Curriculum and syllabus* is a key instrument in WBA. Its seven core units represent the knowledge, skills and attitudes expected of all Australian general practitioners. They include the five domains of general practice together with the Aboriginal and Torres Strait Islander health and rural health units. Within the five domains of general practice there are fifteen core competencies that describe what is expected of a competent GP.

Specific WBA competencies have been developed and described to enable assessment in the workplace.[6] These WBA competencies have been mapped to the core competency framework (core competencies and core competency outcomes of the *Curriculum and syllabus*) and span all five domains of general practice, incorporating several competency outcomes. The WBA competencies focus on the clinical consultation, including clinical and therapeutic reasoning as well as areas that are often not adequately assessed by the Fellowship exams, such as professionalism, general practice systems and regulatory requirements.[1]

Within each WBA competency there are performance descriptors outlining what is expected at the level of Fellowship, the point at which the registrar is ready to demonstrate competence for unsupervised practice in Australia. Performance descriptors outlining observable behaviours as the registrar progresses from substantially below the expected standard through to the standard expected at Fellowship are provided to guide assessors and provide narrative anchors for rating performance and providing feedback during in-practice assessments.[1]

[5] RACGP Standards for general practice training – Standard 2.1, AMC Standard 5

[6] AMC Standard 5.2.1

WBA tools

Early assessment for safety and learning (EASL)

Standard 1.1 of the *Standards for general practice training* requires that: 'Supervision is matched to the individual registrar's level of competence and learning needs in the context of their training post'. Registrars enter their first general practice placement (GPT1) with varying levels of experience and clinical competency and may be unfamiliar with working in Australian general practice. Supervisors cannot assume they are competent and safe to manage patients in all areas of practice without direct supervision at the start of their training.

The EASL suite of tools assesses the level of competence of a registrar in early GPT1, identifying areas where closer supervision and guidance may be needed, and if the registrar is able to recognise their limitations and seek help appropriately when required (Figures 4 and 5). Data from the EASL tools inform the development of an appropriate supervision plan tailored to the individual registrar's level of competence and learning needs in the context of the training practice.

The main objectives of the EASL are to:

- support patient and registrar safety
- collect evidence of the registrar's performance and current level of competence
- begin to identify learning needs and potential knowledge gaps
- match supervision to the registrar's level of competence and learning needs
- inform the development of the registrar's supervision and teaching plan
- identify if a registrar is performing below the level expected at the beginning of their first general practice placement to enable appropriate support to be given.

Timing for completion of EASL activities is driven by the supervisor.

The EASL can be completed at any time within the first four weeks of GPT1. This allows time for orientation of the registrar to the practice and practice processes; for the registrar to gain an understanding of local patient demographics, resources, and services; and for the initial workplace-based assessment to be completed.

Supervisors have the authority to determine the appropriate supervision requirements at any time during this four-week period using the EASL suite of tools and any other data available to them to support the decision. Additional data might include but not be limited to feedback from practice staff and patients, discussions with the registrar, and a 'call for help' list. The EASL may identify the need for closer supervision for certain areas of practice such as paediatrics, mental health or women's health, or certain procedures.

The EASL comprises three components:

- a multiple-choice question (MCQ) assessment with an integrated self-confidence rating
- direct observation of consultations by the supervisor
- daily case review and debriefing conducted by the supervisor.

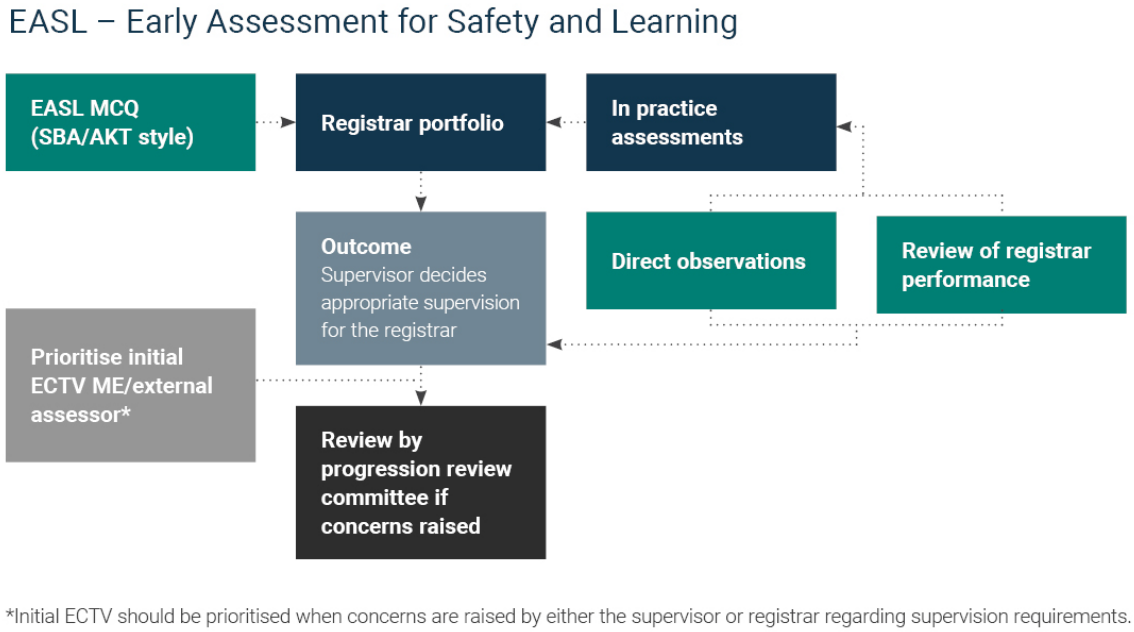


Figure 4. Overview of the EASL

EASL MCQ

The first component of the EASL is the MCQ, which comprises an assessment of applied knowledge and self-confidence through 70 multiple-choice questions, delivered online and preferably completed prior to commencing the first general practice placement. The questions focus on acute and serious illness and common presentations in general practice. The test is blueprinted against BEACH and ReCEnT data and the 'call for help' list, which was developed through qualitative research involving supervisors, registrars, and medical educators. A self-assessment confidence rating grid is embedded into the test to provide insight into the registrar's self-awareness and potentially reveal any unconscious incompetence. Knowing when to ask for help is an important aspect of patient safety.

At the completion of the MCQ test, a report is generated for use by the registrar, supervisor, and medical educator. This report allows the registrar and medical educator to identify learning needs early in training, especially in areas that are critical to patient safety. It can be used as a baseline measure to prompt discussion, facilitate self-reflection and allow monitoring of performance over time. The supervisor may find this report useful to identify areas to include in in-practice teaching and where the registrar may require closer supervision.[2]

Note that the MCQ is not a WBA but has been included as it is part of the EASL.

EASL direct observation of consultations

Direct observation of consultations takes place early in the first general practice placement. Direct observation allows the supervisor to assess registrar performance especially in areas with an increased risk of adverse outcomes.[7] Supervisors are required to complete and document direct observation of the registrar performing a minimum of four consultations.[8]

[7] AMC notes – Direct observation of registrars with real or simulated patients should form a significant component of the assessment.

[8] RACGP Standards for general practice training – Standard 1.1 – Guidance: The supervisor conducts and records the assessment activities and other means of determining a registrar's competencies during their time in placement.

Supervisors should consider the following areas during the EASL direct observation:

- communication skills
- consultation skills
- clinical management and therapeutic reasoning
- general practice systems and regulatory requirements.

Direct observation includes review of the registrar's clinical notes, scripts and referrals. Additional direct observation may be required to enable the supervisor to assess registrar safety and competency across a broad range of consultations, such as paediatrics, mental health or other areas considered relevant to the practice setting. The need for additional direct observations will be determined by the supervisor.[2]

EASL daily case review

When a registrar begins their first general practice term, it is recommended that each day the supervisor and registrar discuss the care of a selection of the registrar's patients seen that day. This can take place either during or at the end of the day. These case reviews will provide useful information to the supervisor about the registrar's level of competence and learning needs and inform the supervision plan. These discussions do not need to be formally documented unless the supervisor considers it necessary.

It is recommended that the registrar take notes about the cases reviewed and the feedback received during these sessions. This will allow the registrar to record, analyse and set learning goals and to review their performance and progression in the future.

The supervisor determines when routine daily review of cases is no longer required.

Using the EASL

The EASL suite of tools has been designed to provide valuable information about a registrar's current clinical competence as they undertake their first general practice placement. Registrars will be provided with formative feedback on all components of the EASL. The data from the three components of the EASL will help the supervisor and registrar plan learning, develop the supervision plan and identify if the registrar needs additional support.[2]

The local medical educator is also available to guide the registrar and support the supervisor in this process. If the supervisor is unable to decide on the level of supervision the registrar requires then further assessment, such as an early external clinical teaching visit (ECTV), can be undertaken in discussion with the local team.

The EASL is considered completed when the supervisor has decided the appropriate supervision required to support both patient and registrar safety, or when the registrar is identified as requiring further assistance. At this stage, the supervision plan is completed.

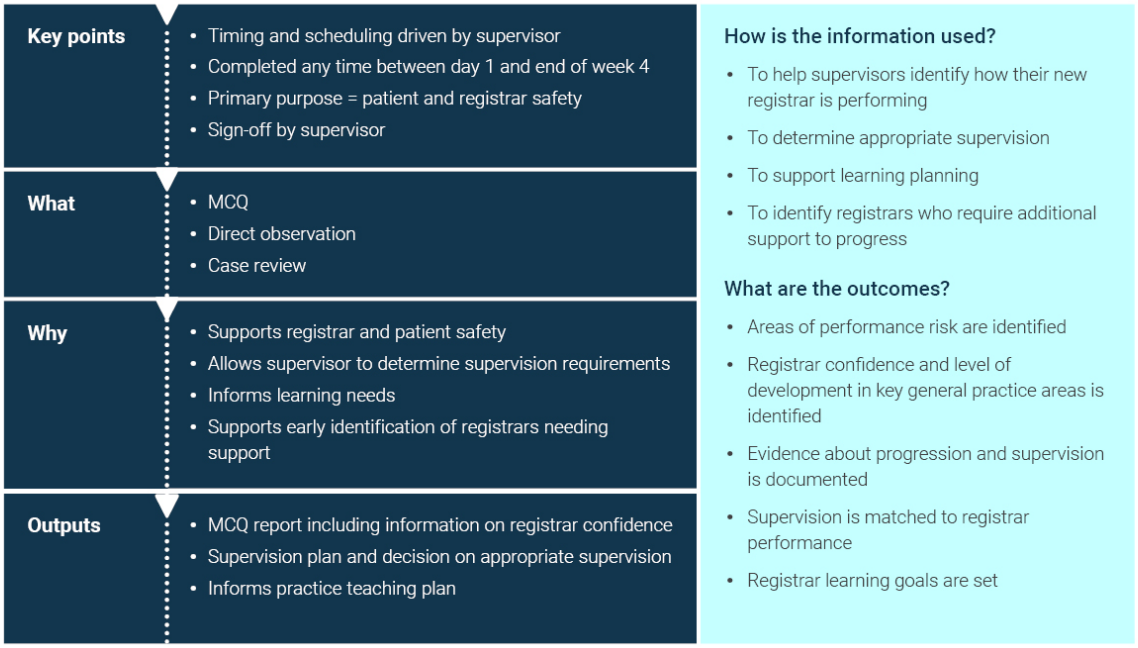


Figure 5. The EASL at a glance

Mini-clinical evaluation exercise

Observing a registrar in practice allows the supervisor to assess their performance over an entire consultation. The supervisor gives immediate feedback on what the registrar is doing well and any concerns or areas for further development. Research suggests that registrars respond better to immediate feedback as they see it as more credible.

A mini-clinical evaluation exercise (mini–CEX) is a type of direct observation and is one of the WBA tools with the strongest validity evidence. It is an authentic assessment method that lends itself to a wide range of clinical presentations across the curriculum and syllabus. It involves observation of real-life clinical encounters and may involve observation of all WBA competencies or may focus on particular competency areas. The focus of each mini–CEX can be varied depending on the registrar's self-identified areas of need and feedback from previous assessments.

The assessor has the opportunity to observe the registrar’s interactions with the patient and assess specific clinical skills that are otherwise difficult to accurately assess, including communication, professionalism, attitudes and behaviours.

It is recommended that the first two mini–CEX be undertaken early in the term with further observations occurring after the registrar has had sufficient time to reflect on their performance and respond to feedback.

The registrar’s competency is rated in the following areas:

- communication and consultation skills
- ability to gather and interpret information
- diagnosis, decision making and clinical reasoning
- ability to develop an appropriate management plan
- ability to manage uncertainty
- understanding and application of population health initiatives
- general practice systems and regulatory requirements
- professionalism

- ability to identify and manage the seriously ill patient.

Clinical case analysis

Clinical case analysis (CCA) is an assessment format comprising review of clinical notes or case reports and oral questioning and discussion. CCA assessment tools include random case analysis (RCA) and case-based discussion (CBD).

Both RCA and CBD are powerful tools for identifying and addressing learning and supervision needs. They enable deep exploration of the application of a registrar's clinical reasoning, management, and decision-making skills using real clinical cases that the registrar has managed. These assessment modalities evaluate what the registrar did during the clinical encounter. Feedback is immediate, which encourages learning and reflection.

In both assessments, the assessor proceeds with a structured discussion of a case, using targeted questions to elicit evidence of the registrar's competency in specified curriculum areas, and to explore issues relating to the case, which may identify any clinical knowledge gaps.

The assessor also uses targeted questions to explore the selected case from four perspectives: the doctor, the patient, the problem and the system – asking how a case changes when any of these elements changes. By proposing hypothetical scenarios through 'what if' questions, unidentified learning needs may be uncovered.

It is recommended the first two CCA be undertaken prior to the supervisor mid-term appraisal and the remaining two completed in the second half of the term prior to the supervisor end- term appraisal. This will allow the registrar sufficient time to reflect on their performance and respond to feedback.

The registrar's competency is rated in the following areas:

- ability to gather and interpret information
- diagnosis, decision making and clinical reasoning
- ability to develop an appropriate management plan
- ability to manage uncertainty
- understanding and application of population health initiatives
- general practice systems and regulatory requirements
- professionalism
- ability to identify and manage the seriously ill patient.

Case-based discussions

In a CBD, the registrar presents a recent clinical case to the assessor, providing clinical notes, relevant investigations or results, and details of referrals or preventive healthcare plans. The case must be one that the registrar has been primarily responsible for and that is of a medium level of complexity; for example, where clinical reasoning is complicated by uncertainty or where decision making requires multiple issues to be considered.

An assessor may request a case be presented that focuses on a specific area, particularly one in which the registrar has been identified as needing further support. As the assessor works through the case with the registrar, they may pose questions from varying perspectives to explore clinical reasoning further. The registrar may also highlight aspects of the chosen case for discussion, depending on their self-identified learning needs.

A CBD may be completed as part of an ECTV or in-practice teaching session by the supervisor, or in any other context that supports or enables the assessment, such as by video.

In some instances, simulated cases may be used for CBD. This will allow for discussion around clinical presentations that may be uncommon in a general practice to be discussed, such as domestic violence or drug and alcohol misuse. Simulated cases may also be used for assessing cultural competency with respect to Aboriginal and Torres Strait Islander peoples.

Random case analysis

For an RCA, the assessor randomly selects a case from the registrar's consultation records to discuss. This method may uncover gaps in knowledge and skills that a registrar may not have identified or been actively avoiding when self-selecting cases for CBD.

An RCA is generally conducted through the lens of the five domains of general practice of the curriculum and syllabus, and explores the development of clinical reasoning by considering changes to four contextual influences: the doctor, the patient, the problem and the system. By proposing hypothetical scenarios through 'what if' questions, unidentified learning needs may be uncovered.

Multi-source feedback

Multisource feedback (MSF) is well recognised as a valid and reliable method of assessing interpersonal skills, professional behaviour, and clinical skills. The MSF is often referred to as a 360-degree assessment. A questionnaire about observable behaviours is given to both patients and colleagues. Self-evaluation is also included.

The MSF Interpersonal Skills Questionnaire (patient survey) is used to collect data from at least 30 patients post-consultation about the registrar's behaviours, such as listening skills, clarity of explanations, respect for the patient and involving the patient in decision making, as well as the patient's confidence in the registrar's ability.

A colleague feedback evaluation tool (CFET) focuses on the registrar's professionalism and workplace behaviours. Perceptions are collected from at least twelve colleagues about areas such as working relationships, competence, and professional development.

Results are presented in a report that displays the registrar's self-assessed competency against their benchmarked score across a range of routine performance competencies. The registrar will be required to reflect on the details of the feedback report with their medical educator to identify areas of strength and weakness. Studies have shown that MSF is a good predictor of the need for assistance in non-clinical domains of practice, highlighting areas on which to focus learning.

Clinical audit

A clinical audit is a quality improvement activity designed to improve patient care and outcomes. It's a systematic review of aspects of clinical performance against explicit predetermined criteria, and the implementation of change when the results indicate standards aren't being met.

A clinical audit is valuable for reviewing elements of clinical performance and for developing a registrar's skills in self-reflection and self-directed learning. The results of the audit can lead to changes in an individual's clinical practice or changes in practice processes, or it may simply confirm that current practice meets the expected standard. The impact of the audit depends on the quality of self-reflection and the provision of effective feedback. A clinical audit is also a useful tool for continuing professional development post-Fellowship.

The clinical audit may explore areas such as:

- rational prescribing of investigations (radiology/pathology)
- management/prescribing
- preventative medicine activities

A clinical audit may be developed and carried out by a registrar with the guidance of their medical educator or supervisor. Although it can be completed at any stage of training, it is recommended the audit be undertaken in GPT3.

Once an audit is completed the registrar analyses the results and discusses the findings with their medical educator who will provide feedback and support the registrar to plan for further skills development in areas identified by the audit.

Reflective exercise

Reflective practice is an important aspect of continuing professional development and effective self-directed lifelong learning. It can help clinicians to review and improve their own practice by identifying their strengths and weaknesses and specific learning needs. The reflective exercise has been designed to explore and assess the competency of professionalism and general practice systems and regulatory requirements. The activity involves discussion of challenging general practice encounters relating to these competency areas with the registrar's medical educator. It is recommended that this activity takes place early in GPT3.

External clinical teaching visits

External clinical teaching visits (ECTVs) involve in-practice observation of a registrar, providing an opportunity for the registrar to receive teaching and feedback on their individual performance and consultation skills from someone other than their regular supervisor. Assessments performed during ECTVs, like other WBA activities, are considered low-stakes assessments for the purpose of learning.

ECTVs are generally undertaken by an ME or experienced GP who has received appropriate training in conducting a clinical teaching visit. They may be conducted in person or remotely.

During the visit, the external clinical teacher will:

- observe and assess at least four consultations
- conduct one CCA
- provide feedback to the registrar
- talk to the registrar about their placement
- talk to the registrar about their learning
- talk to the supervisor about the assessment and the registrar's progress
- talk with the practice manager about the registrar (optional)
- complete reporting requirements.

It is impossible for ECT visitors to plan cases for observation in the clinical teaching session. For this reason, they may use a variety of assessments such as mini-CEX, RCA and CBD during each visit.

During GPT 1 and 2, two ECTVs are conducted. The assessor uses both the mini–CEX and RCA tools to assess and provide direct feedback on the registrar's performance.

During GPT3, only one ECTV is performed, and the assessor uses the mini–CEX and either the CBD or RCA tool (determined by the assessor).

Feedback

Providing feedback

Feedback is an important aspect of all WBA activities and should be given to the registrar promptly to help them plan for their learning. Feedback should include identified learning needs and specific areas for improvement; suggestions for activities and resources to facilitate learning in these areas is also helpful.

Feedback about a registrar's performance should be thoroughly documented including narrative comments, as these can be used to verify performance ratings and provide valuable information to help direct the focus of future assessments. Registrars are encouraged to reflect on each assessment and the feedback provided to guide their learning.

All assessors are responsible for creating an environment of mutual trust, respect, and honesty to help foster the registrar's learning and self-reflection.

Progression

Monitoring and flagging performance

Frequent workplace-based assessments can help to identify registrars in need of additional educational support. Ongoing monitoring of registrars in difficulty is important to ensure they progress through training as expected.

Research indicates that early 'flagging' of a registrar as being in difficulty may be a predictor of positive exam performance, whilst flagging them late in training may reduce the effectiveness of remediation. Early detection and intervention minimises the risk of poor patient outcomes, avoids the need for resource-intensive formal remediation, and improves end-of-training summative assessment results. Early flagging also gives the registrar the opportunity to consider a career change.

WBA uses a traffic light system to flag a registrar's performance as green, amber or red (Figure 6). It's a useful way to establish the assessor's level of concern about the registrar's performance and the timeframe for action.

Registrars should be made aware of any concerns about their performance as early as possible so that they can tailor their learning to address these concerns.

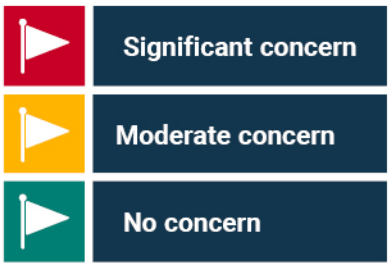


Figure 6. Levels of concern about registrar performance

Most registrars progress through training with green flags for all their assessments. For those who are flagged amber or red, the assessor provides feedback to the registrar at the time of the assessment and documents descriptive comments about how the performance elicited the flag.

If an amber or red flag is raised during an in-practice assessment by an external assessor, it is important that the assessor notify the supervisor so that appropriate and immediate action can be taken by the practice to address the issue. Additionally, a formal diagnostic process should be initiated by the registrar's ME to identify the areas of concern. This may involve a discussion with the registrar and their supervisor, a review of data from previous WBAs, and review of previous flags. Sometimes the underlying problem may be a practice incident or a personal issue for the registrar. In the case of a red flag this process needs to be undertaken as soon as practical whereas with an amber flag this process can be undertaken within the fortnight.

If a red or amber flag has been raised, the registrar needs to be referred to the progression review committee using the PRC referral form. For an amber flag, the local team can decide if the registrar needs referral to the PRC for noting or discussion depending on the nature of the concern. The referral should include the areas of concern identified via the formal diagnostic process as well as recommendations for addressing those concerns.

The progression review committee

A registrar's progression and performance are discussed regularly throughout training with input from their supervisor, ME, ECT visitors, training coordinator or other local training program team members. These discussions help with planning learning, tracking a registrar's progression and competency attainment, and enable early identification of the need for additional support. These discussions are generally held at the local team level.

Following these discussions, if the local team has identified a significant issue and raised a red flag, the registrar will need to be referred to the progression review committee (PRC). In the case of an amber flag, the local team can decide if referral to the PRC is for noting or discussion depending on the nature and significance of the concern. It is not unusual for details about a registrar's progression to be referred to the PRC for noting, review or discussion throughout training. The PRC referral process is depicted in Figure 7.

The role of the PRC is to:

- oversee registrar progression
- provide support and/or advice to the local team when the team has recommended educational support, remediation and supervision
- conduct ongoing review of registrars who have been flagged by their local team
- determine eligibility for progression to Fellowship exams and application for Fellowship
- conduct random quality assurance reviews of registrar portfolios.

The PRC meets every two months or as appropriate to the needs of each region.

Recommendations from the PRC are communicated to and implemented by the local team (Figure 8).

Circumstances that commonly trigger a referral to the PRC include:

- WBA activities indicate that an area of performance is consistently significantly below the standard
- feedback from the supervisor, practice, or ME indicates a concern including significant personal issues that may impact on training
- concerns about a registrar's professionalism
- placement of restrictions on the registrar's medical registration by AHPRA

If a registrar's progress through training has been discussed at the PRC and a recommendation has been made, the registrar's ME will discuss this with them. The outcome of the PRC review will also be communicated to the supervisor if they are involved in providing educational support. This process and communication provide an excellent opportunity to develop a plan to address any training or learning needs and ensure registrars receive the most appropriate support.

Figure 7. PRC referral process

Figure 8. PRC at a glance

Delivery of WBAs

Assessors

A range of assessors deliver WBA activities, including the registrar's supervisor, local and regional MEs, and ECT visitors. Assessors may also have multiple roles. Each assessor uses a variety of standardised tools to collect information about the registrar's competency as prescribed in the WBA program and as appropriate to the registrar's stage of training.

The supervisor

Supervisors play a pivotal role in assessing registrar performance in the workplace, providing feedback, coaching, and mentoring, and teaching and encouraging planning for learning. Using the WBA tools, observations and other evidence gathered at the practice or through other sources, the supervisor makes expert judgements about a registrar's competency. These judgements support decisions about safety, the appropriate level of supervision, registrar progression and education needs.

Following each assessment or observation, the supervisor should engage with their registrar, outline their observations, and provide clear, meaningful, and supportive feedback alongside recommendations to support attainment of competency in areas identified as gaps.

Supervisors should be aware of issues or changes that indicate that a registrar requires additional support either educationally or psychologically and may need to escalate these to the local ME and team for further assistance. Table 1 and Figure 10 provide an overview of the assessments and activities conducted by the supervisor.

Table 1. WBAs to be completed by the supervisor per term (GPT1–3)

WBA requirement	Number of assessments/activities	Time requirement*	When assessment/ activity should occur	GPT1 week 1–4	GPT1	GPT2	GPT3
EASL direct observation^	Min. 4	Up to 2 hours	As soon as practicable, but within first 4 weeks	x	-	-	-
Daily case review	Daily	Part of supervision requirement	Until appropriate level of supervision has been determined	x	-	-	-
EASL MCQ report review	Optional	30 minutes	Before end week 4	x	-	-	-
Mini–CEX	Min. 4	Up to 4 hours	Throughout term	-	x	x	x
Clinical case analysis (CCA) – RCA or CBD	4	4 hours	Throughout term	-	x	x	x
Mid-term appraisal	1	Up to 1 hour	Middle of each term	-	x	x	x
End-term appraisal	1	Up to 1 hour	End of each term	-	x	x	x

^The outcome of the EASL is a decision by the supervisor as to the appropriate level of supervision required by the registrar. The number of observations required for the supervisor to reach a decision will vary depending on the competence level of the registrar.

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting, and following up (unless listed as a separate requirement).

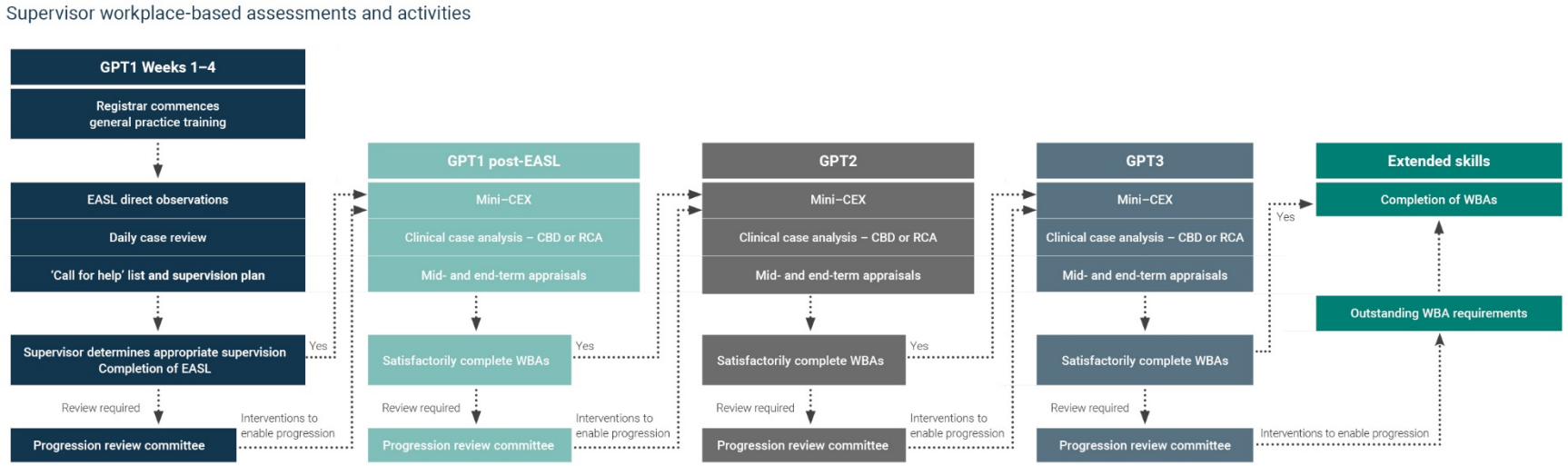


Figure 9. Schematic of the WBAs to be completed by the supervisor per term (GPT1–3)

The medical educator

Medical educators (MEs) provide a link between the training and assessment programs for registrars. Their focus is both from an educational and pastoral viewpoint, ensuring that each registrar is supported with training planning, advice and mentoring as they progress through the training program.

They are key to the provision of feedback and training support prior to and following the completion of WBAs. As assessors, MEs make expert judgements about a registrar's competency, supporting their progression where appropriate and flagging concerns to enable early educational intervention for those registrars needing additional support.

MEs also work closely with the registrar's supervisor to ensure that the environment for training is appropriate and supportive for the registrar.

Table 2 and Figure 10 provide an overview of ME assessments and activities.

Table 2. WBAs to be completed by the ME per term (GPT1–3)

WBA requirement		Number of assessments/activities	Time requirement*	When assessment/ activity should occur	GPT1 Week 1–4	GPT1	GP2	GPT3
EASL MCQ review and discussion with registrar		1	30 minutes	Before end week 4	x	-	-	-
Clinical case analysis (CCA)	**Case based discussion (CBD)**	1	2 hours	Week 9–12 of each term (approx.)	-	x	x	x
Clinical audit review		1	1 hour	During GPT3	-	-	-	x
MSF review and discussion with registrar		1	2 hours	During GPT2	-	-	x	-
Reflective exercise		1	2 hours	Prior to CCE	-	-	-	x
Review WBAs submitted for registrar including mid- and end-term appraisal		1	1 hour	Throughout term	-	x	x	x

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

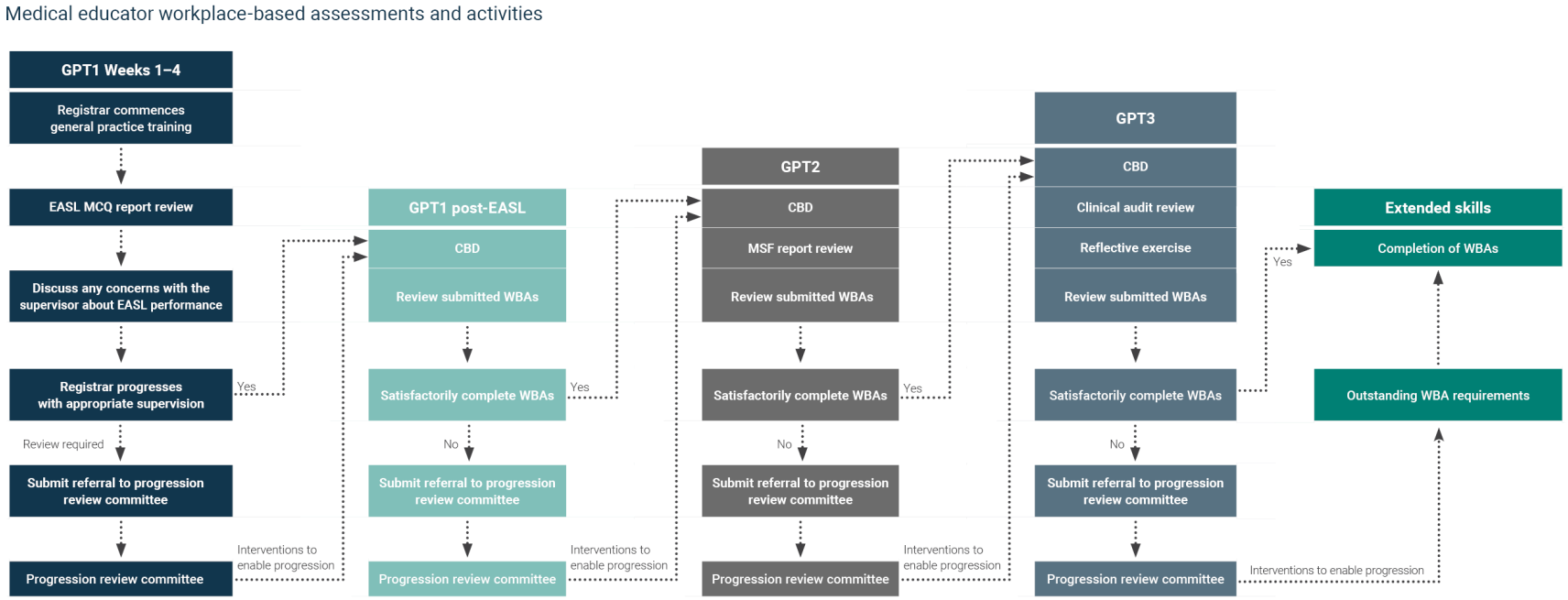


Figure 10. Schematic of the WBAs to be completed by the ME per term (GPT1–3)

The external clinical teaching visitor

External clinical teaching visitors provide an arms-length expert assessment of a registrar's competency, using multiple WBA tools to review and observe the registrar in practice. Through the observation of patient consultations in conjunction with either an RCA or CBD, the external clinical teaching visitor assesses the registrar's competency, providing feedback to both the registrar and the supervisor.

Table 3. WBAs to be completed by an external clinical teaching visitor as part of an ECTV (GPT1–3)

WBA requirement		Number of ECTVs per term[#]	Time requirement per visit*	When assessment/ activity should occur	GPT1	GPT2	GPT3
ECTV	Mini–CEX & RCA	2 (GPT1 & GPT2)	4 hours	Mid-term and end of term^	x	x	-
	Mini–CEX & RCA or CBD	1 (GPT3)		End of term	-	-	x

[#]Additional ECTVs can be arranged if needed and are approved by the local team.

*Time requirement includes preparation, conducting the activity and providing feedback, completion of reporting and following up (unless listed as a separate requirement).

^The initial ECTV in GPT1 may be requested to occur earlier in the term if concerns are raised by either the supervisor or registrar regarding the level of supervision, or if the supervisor is unable to make a determination and a further assessment is required.

The registrar's role in WBA

Registrars progress towards Fellowship at different rates. Some meet certain competencies earlier than their peers, whilst others will require more support.

The RACGP WBA program encourages a learner-centred approach to training. In keeping with the focus of assessment *for* learning, registrars are expected to reflect on their in-practice assessments to identify their learning and training needs, actively seek and respond to feedback and monitor their progress.

It is the registrar's responsibility to ensure that assessments are undertaken and that they demonstrate effective learning and progress. They're responsible for identifying competencies in which they require further development and for tailoring the WBA to focus on these competencies. For example, prior to an ECTV or a CBD with the supervisor, a registrar may outline the specific competencies they would like to focus on and receive feedback on.

Registrars are required to engage in each assessment in the timeframe set out in the WBA program. They should schedule time for assessment, feedback and reflection. They should also regularly review their training and practice, and engage with their supervisor and ME to plan learning that is aligned to the RACGP *Curriculum and syllabus* and appropriate to their needs as they work towards Fellowship.

Table 4 outlines WBA activities to be completed by the registrar and should be read together with the education and training requirements outlined in the AGPT registrar handbook.

Table 4. WBAs to be completed by the registrar per term (GPT1–3)

WBA requirement	Assessor	Number of assessments/activities	When assessment/ activity should occur	GPT1 week 1–4	GPT1	GPT2	GPT3
EASL MCQ test	Completed individually online	1	Before end week 2 of GPT1 (preferably before commencement of term)	x	-	-	-
EASL direct observation^	Supervisor	Min. 4	During first 4 weeks of GPT1	x	-	-	-
EASL MCQ report review and discussion	ME	Once only	Before end week 4	x	-	-	-
Mini–CEX	Supervisor	Min. 4	Throughout term	-	x	x	x
ECTV (mini–CEX, RCA, CBD)	External clinical teacher	2 (GPT1 & GPT2) 1 (GPT3)	Throughout term	-	x	x	x
Clinical case analysis (CCA) RCA or CBD	Supervisor	4	Throughout term	-	x	x	x
	ME	1	Week 9–12 of each term (approx.)	-	x	x	x
Clinical audit	Completed individually with guidance from ME	1	During GPT3	-	-	-	x
MSF reflective exercise	Self-reflection and review with ME	1	During GPT2	-	-	x	-
Reflective exercise	ME	1	Prior to sitting the CCE	-	-	-	x
Review of assessment outcomes and feedback	Multiple		After assessment	-	x	x	x

^The outcome of the EASL is a decision by the supervisor as to the appropriate level of supervision required by the registrar. The number of observations required for the supervisor to reach a decision will vary depending on the competence level of the registrar.

Supplementary material

Acronyms

AKT	Applied Knowledge Test
CBD	case-based discussion
CCE	Clinical Competency Exam
EASL	Early Assessment for Safety and Learning
ECTV	external clinical teaching visit
FRACGP	Fellowship of the Royal Australian College of General Practitioners
GP	general practitioner
GPT	general practice training
KFP	Key Feature Problem
MCQ	multiple-choice questionnaire
MSF	multisource feedback
ME	medical educator
PRC	progression review committee
RACGP	The Royal Australian College of General Practitioners
RCA	random case analysis
WBA	workplace-based assessment

Glossary

Term	Definition
Applied Knowledge Test	A component of the RACGP Fellowship exams designed to assess the application of knowledge in the clinical context of Australian general practice.
Assessment	The systematic process for making judgements on the participant's progress, level of achievement or competence, against defined criteria and standard.
BEACH data	Bettering the Evaluation and Care of Health (BEACH) data is a national study of GP clinical activity that is used to analyse and report on the content of GP-patient encounters
'Call for help' list	A list of patient presentations or situations in which a registrar is expected to seek help from their supervisor
Candidate	The medical practitioner eligible to sit RACGP Fellowship Exams.
Clinical audit	A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria.
Clinical Competency Exam	A component of the RACGP Fellowship exams designed to assess clinical competence and readiness for independent practice as a specialist GP.
Colleague	A professional who the doctor directly works with in the same practice or indirectly works or collaborates with through the broader healthcare system. Includes other GPs, nursing and administrative staff, allied health professionals and non-GP specialists.
Competency	An observable ability, integrating multiple components such as knowledge, skills, values, and attitudes.
Comprehensive Australian general practice	As defined in the Comprehensive Australian general practice guidance document
Core vocational training	The mandatory components of the AGPT program: three terms of general practice placements (GPT1,2,3) and an extended skills training term.
Curriculum and syllabus	The RACGP curriculum and syllabus for Australian general practice describes the key competencies and learning outcomes of general practice education. It informs the development and delivery of training programs and guides learners by detailing the scope of educational content to be learnt across the domains of general practice, with suggestions for learning modalities and educational resources.
Extended skills training	A 26-calendar week (FTE) term undertaken to extend the depth and breadth of the registrar's skill base in an area relevant to general practice.
External clinical teaching visit	An in-practice observational assessment, involving the direct observation of registrars in the context of their practice, by an external clinical teacher or medical educator. It includes the opportunity to provide education during the visit.

Feedback	Specific information about the comparison between a registrar's observed performance and a standard, given with the intent to improve the registrar's performance.
Fellowship	Admittance to either: i. Fellowship of the RACGP (FRACGP), or ii. FRACGP and Rural Generalist Fellowship (FRACGP-RG).
Fellowship exams	The exams run by the RACGP that assess competency for unsupervised general practice anywhere in Australia. They include: i. Applied Knowledge Test (AKT) ii. Key Feature Problem (KFP) test iii. Clinical Competency Exam (CCE)
Formative assessment	Described as assessment for learning that uses low-stakes assessments. Formative assessments are activities in which a judgement about a registrar's competency and learning needs is used to give feedback to the registrar on performance, encourage self-reflection and provide training.
Framework	A conceptual structure for placing things in relation to each other.
General practice training terms	In the AGPT and FSP program, referred to as GPT1, GPT2 and GPT3. The extended skills term is sometimes referred to as GPT4.
High-stakes assessment	A summative assessment with major/significant consequences for a registrar's training.
Key Feature Problem (KFP)	The KFP is one of the RACGP Fellowship exams and is designed to assess clinical decision making and clinical reasoning in practice.
Local team	RACGP staff with local knowledge and relationships who support registrars from the time they enter the AGPT program through to Fellowship. The team includes a training coordinator, medical educator, cultural mentor and an administrator.
Low-stakes assessment	A formative assessment used to give feedback on performance, encourage self-reflection and provide training.
Medical educator	An experienced and qualified person who delivers education to the registrar; normally a GP but can also be a suitably qualified and experienced non-GP.
Portfolio	A collection of evidence of learning progress and completion of assessments. Can include data that is quantitative (eg test scores) and qualitative (eg supervisor reports, self-reflections, practice visit reports).
Profession-led training	The operational model for RACGP's vocational training program as distinct from AGPT, delivered under the control of the Department of Health until 2022.
Progress	Demonstrated improvement in competency.

Progressive assessment	The assessment of registrars throughout training for the purpose of directing their education and for determining progress decisions based on the achievement of competency milestones.
ReCEnT	The Registrars Clinical Encounters in Training research project measures the types of patients and conditions they are seeing during their training. It involves the registrar completing encounter forms for 60 consecutive consultations.
Registrar	A medical practitioner enrolled in the Australian General Practice Training (AGPT) program or Fellowship Support Program (FSP).
Remediation	The process by which a registrar receives additional support in order to address performance concerns.
Summative assessment	Generally a high-stakes assessment, this is an activity in which a judgement is made against refined standards about a registrar's competency. These judgements inform decisions such as progression, supervision needs and final sign-off of completion of training.
Supervisor	An accredited GP who works in an accredited training practice and takes responsibility for the education and training needs of the registrar while in the practice.
Training program	Either the: i. Australian General Practice Training Program (AGPT), or ii. Fellowship Support Program (FSP).
Training region	An area in which the RACGP delivers general practice training as defined by the relevant training program.
Workplace-based assessment	Observation and assessment of a registrar's practice to track progression through training.

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