Getting ready for the RCA….a guide to the Guidance, November 2020

Please note: because of the emergency nature of the RCA, this guidance is likely to change in the light of the developing experience with the exam. All Trainees and Educationalists are advised to revisit the RCGP website and review the requirements and guidance listed in the third section (*Guide to the Guidance*) regularly.

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1. Background to the RCA - the challenges

The proposal to use recorded consultations of trainees' actual work looked easy enough to do when first proposed by the major stakeholders at a forum including AiTs, BMA, COGPED, the Statutory Educational Bodies and the RCGP themselves. Just get trainees to send in a few videos and let someone external look at them - but as always there were hidden challenges, some of them massive:

- The need for GMC approval. They stated straight away that a proper exam was a legal requirement, so just sending in a few videos for a superficial glance using a COT template would not be approved
- Urgency of the situation, with the need to create a serviceable examination with just 6 weeks' notice before go-live. Usually new systems of examination take years and multiple pilots to develop and perfect
- Reverting to the old system of assessment by video was not appropriate for two reasons:
    - General Practice had changed since the old video assessment days
    - In a COVID environment most consultations had become remote, with the F2F elements being reserved for the examination section of an ongoing remote consultation
- The nature of the proposed exam. In any such assessment, the candidate rather than the examiner choses the cases, which results in:
    - Lack of standardised cases
    - Lack of ability to ensure that the whole curriculum is covered
    - Huge variety of case material that trainees have access to

The last three should not be underestimated: they make assessing the same areas of the curriculum in the same way that the CSA does impossible.

Lack of standardised cases.

In essence, the problems are:

1) What should the exam do with the candidate who submits 13 perfectly conducted consultations about earwax with a series of articulate patients, who explain their ideas concerns and expectations before the candidate needs to ask them; and should such a submission really score

higher than one with 13 well enough conducted consultations with patients with complex clinical and/or communication needs where identifying their ICE has been a struggle?

2) Whilst recorded consultations have the advantage of being real-life examples, they have the disadvantage of having been cherry picked by the candidate. As one trainee put it: "What do lay people think of the RCA? If I was getting on a plane and I knew that the pilot had been passed as competent because they had been assessed on their own favourite 13 landings, I wouldn't be very confident". Similarly, whilst the RCA demonstrates that a trainee can consult with their favourite patient type over their favourite clinical problem, it does not make a realistic estimate of the *range* of an individual candidate's clinical skills. On the other hand, the CSA, where the tasks that all candidates will have to perform are defined, might cover anything within the desired range, and so provides a comparable measure of the range of each candidate's skills.

Related to this there is the issue of the medium used: can you demonstrate your skill satisfactorily on the telephone?

The mitigation for the first is the guidance to candidates on cases to submit which has now been refined into mandatory criteria and recommendations; and the concept that candidates start with a zero score and gain marks by demonstrating that *they* have done something rather than the patient having done all the hard work. Low challenge cases (defined as cases where neither the clinical focus nor any complexity of communication / consultation skills specifically required a doctor to conduct the consultation) simply do not afford the opportunity for candidates to show their readiness for safe, independent practice. Overly complex ones simply take too long.

Secondly the marking schedule was specifically adapted to suit telephone as well as video consultations. So far, the overall rate of phonecall consultations has been 74% and there is insufficient information to indicate that a particular recording medium gives a trainee a significant advantage or a disadvantage, despite over 40,000 having already been assessed.

Ensuring sufficient evidence of curriculum capability.

This is achieved in the CSA through the simple fact that the case material might be chosen from any area of the curriculum, whereas in the RCA the candidate choses the case material. There are also some de facto areas of potential difficulty for the RCA in providing sufficient evidence of curriculum capability:

- Clinical examination
- Urgent and Unscheduled Care
- Working with colleagues
- Organisational management and leadership
- Community orientation
- Less common but important clinical topics such as genomics, learning disability, malaria

Whilst the MRCGP is not currently asking for any extra evidence in those areas from extra WPBAs, the mitigation is to ask ARCP panels and the training community to pay especial attention to those aspects of the trainee's evidence at ESR and ARCP.

Variety of case material available to trainees.

Trainees who work in cosmopolitan inner-city Birmingham, for instance, have a very different patient demography consulting with them from a trainee working in an isolated, rural village in North Northumberland close to the Scottish Border. The population in such rural areas, such as it exists, is 99% White British, as pretty well all the ethnic minority patients live in our cities. Their patients are also, on average, at least 5 years older than the people living in Birmingham. (For some further stats, see Appendix 1, Diverse but not homogenous)

One of the purposes of a standardised CSA is that it offers the opportunity to test trainees' ability to consult not just *about* any condition listed in the curriculum, but also *with* a wide range of patients from all backgrounds; so one of the 13 cases could involve consulting with a patient whose first language is not English, or who has issues with their sexuality. How do you do that with a trainee working in one of our rural practices?

Just to emphasise this: London: 45% White British, so a trainee has a 55% chance of consulting with someone from an ethnic minority - and even within London there will be great variation between practices. Northeast: 94% White British, so a trainee has a 6% chance of consulting with someone from an ethnic minority. This is even more pronounced in the Black population. And in all areas, people from ethnic minorities are more likely to live in the cities. In short, in the county of Northumberland, ethnic minorities make up less than 3% of the population - and in about a dozen of the training practices there, the rate is pretty well zero.

Break that down to local authority and the differences become starker; down to individual practices even more so.

There is no easily obtainable data about sexual orientation, but this statement does appear on the internet: "LGB identity is most common among London residents (where 27% of gay men and lesbians, as well as 19% of bisexuals, took residence, compared to only 14% of heterosexuals) and those aged under 35". So, a rural community with an ageing population may have very few.

Socio-economic status is a problem everywhere where practices are often defined within geographies with predominantly one socio-economic group.

With a very high IMG rate in our GP trainees, there are cross-variables of the practitioner confounding all of that.

So far, the MRCGP has not really identified any appropriate mitigating action for most of these issues apart from highlighting that treating people who are different from ourselves inappropriately is a Fitness to Practice issue. The RCA does make emphasis on value-added, so submitting consultations with less articulate patients could allow you to demonstrate more skills than a similar consultation with a patient with higher health literacy.

In summary

The RCA Core Group was given the task of inventing a proper exam that gave an objective assessment of a trainee's clinical skills in real life settings across 13 consultations; was undertaken by the candidate from their own current working environment; and that treated all trainees everywhere fairly. A pretty big ask.

It did its best, and so did the candidates for the first two sittings. Within 6 weeks the group had devised a properly structured format, marking schedule and guidance on cases to submit that went

live with just enough time for the trainees to then collect sufficient numbers of consultations to submit that in the main fitted the guidance. The submissions were double marked, with different examiners for every case, so 26 examiners saw each candidate. In the event, there was good concordance between marking pairs. In the main the trainees submitted cases that were challenging enough to demonstrate skill. (Not being challenging enough being defined as a case where neither the clinical focus nor any complexity of communication / consultation skills specifically required a doctor to conduct the consultation)

However, the curriculum coverage in terms of clinical topics was extremely variable.

In response to trainee feedback indicating a need for further guidance on case submission, and learning from the emergency RCA diets, the group has now developed more specific guidance to trainees and some mandatory and recommended selection criteria.

The exam is (like all exams) imperfect. However, it would appear to be good enough in these COVID times. It has certainly "performed" like an exam, and whilst it ideally would have eradicated Differential Attainment, sadly, it has not.

It, and especially the new mandatory criteria, have produced huge concerns and challenges for trainees, and how to prepare yourself for this exam and interpret those criteria is now the subject of a lot of guidance that can be summarised thus:

2. A Mnemonic to help trainees prepare

Get Planting

Read the Guidance

There is so much available now it is difficult to tell which are the important bits, so at the end of this document is an index to it all

Start Early

Start recording as early as possible, so that you get into the swing of it.

Sort the Technology

- webcam
- all necessary tech (particularly if remote working)
- awareness of information governance issues of recording/storing consultations

Sort the Processes in the practice

- Consent (gaining it in a legal way)
- Concerns (of anyone in the team)
- Cases (how are you going to get them?)

With regard to the latter, discuss with your trainer how you are going maximise your chances of getting useable consultations of an appropriate level of challenge sufficient to demonstrate safe and independent practice.

Reception, admin staff and triage clinicians need to be 'on board' and know what is happening and only book appropriate cases / allow you to pick appropriate cases from the lists of other clinicians.

Simple triage consultations are unlikely to cover all three domains of the examination.

Problems that are new to you are more likely to be suitable for submission.

If possible, only book willing/consenting patients to maximise opportunity.

Be creative in how cases are identified – ask nurses for any newly diagnosed hypertensives and diabetics.

Do some Little things

Make sure that everyone in the practice knows not to interrupt you. Use do not disturb signs on the door.

Get a stop clock to help you know how long you've been consulting for. Don't be rigidly bound to it – the patient needs what they need.

Consider crib sheets. These should not be scripts to follow but a few keywords representing whatever reminders you find helpful, placed in a way where you can easily see them between cases – e.g. next to the phone or computer. Things such as identity check, consent, introduction, impact, and ideas, concerns and expectations (ICE) etc., to help you remember to cover key points.

However, do **not** follow them as a rigid script, because following them rigidly will lead to an overly structured consultation that doesn't flow, that tends to override the patients cues, and which will lose you marks. So, once consulting, ignore the cribsheet and focus on the patient.

Beware Artificiality

While follow up from letters might work, beware artificially 'Creating' a consultation by simply recapping the history and suggested treatment options when these are already in the letter or previous referral. You need to consider what you have actually 'added' to the patient care by their contact with you. If a patient has considered the guidance already offered and has made a clear decision, then recapping does not add anything, and such a consultation would not provide evidence of *your* skills. The RCA does make emphasis on value-added, so submitting consultations with less articulate patients could allow you to demonstrate more skills than a similar consultation with a patient with higher health literacy.

To this end, never, ever, slavishly follow your cribsheets. That slows the consultation and makes it cumbersome and unnatural; and the examiner will spot you gazing at the wall instead of making eye contact with the patient.

Make Notes, provided it doesn't impact on the flow of the consultation or rapport building, jot some key words and cues down while the patient is giving their opening statement. This is perhaps more suitable during telephone consultations.

Avoid Typing and overuse of the computer because this can distract from the flow of the conversation.

ICE

Really important, but never, ever actually use the phrase "Ideas Concerns and Expectations." For a start, it's three questions anyway, and most people have difficulty focusing on one at a time let alone three. Secondly, the language is not natural. Thirdly, they often relate to different parts of a consultation. Yes, they (ICE) must be explored, *but not all three at once.* Unnatural? - Just think. When your best friend comes round in distress and starts telling you about some horrible experience they have just had, is it a phrase you use with them? No, firstly you listen and empathise, and then you use say things like: "Goodness, why on earth do you think they did that?" [Ideas] "Goodness, that sounds terrible. Are you worried about what they are going to do next?" [Concerns] and "How can I help?" [Expectations]. So, do that with your patients, adapted to what they have just said and in language that flows naturally from you.

The examiner doesn't kNow the patient.

They can't see medical records and so are unaware of past medical history, medication, and allergies. So, if relevant, verbalise them.

Get the balance right when making the final choice

Finally, when it comes to choosing which cases to submit, look for balance and especially those complicating factors which make a superficially simple consultation into a complex one. For example, patient expectations, beliefs, psychological issues, social situation, hidden agendas.

Many of your best consultations will be in one of the red boxes in the table below, and therefore unsuitable for submission. The examiners know that. As a result, they are not looking for your best, most complex consultation. They are looking to ensure baseline competence.

	Multiple factors present	**Some factors present**	**Complicating factors absent**
High Clinical Challenge	**Extremely challenging consultation - excellent opportunity to display capabilities but case likely to be hard to complete in 10 minutes.**	Very challenging consultation - excellent opportunity to display capabilities.	Challenging consultation- good opportunity to display capabilities.
Moderate Clinical Challenge	Very challenging consultation - excellent opportunity to display capabilities.	Challenging consultation - good opportunity to display capabilities.	Moderate level of challenge in consultation - some opportunity to display capabilities.

Low Clinical Challenge	Challenging consultation - good opportunities to display capabilities.	Moderate level of challenge in consultation - some opportunity to display capabilities.	**Low level of challenge in consultation - very limited opportunity to display capabilities (insufficient evidence).**

3. A Guide to the Guidance

There is extensive guidance available at https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx. An index appears below. ***However, the best way to prepare is to learn how to consult well remotely***

Essential Reading (*= and for your Educational Advisers):

Area	What it covers	Where it currently sits
What is the RCA? *	Essential introduction and overview of the RCA	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx#
Use of third-party reviewers *	Who you can and cannot show your videos to	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx# Appears at the end of the attachment
Reusing old assessment videos	Warning re not reusing videos	This currently appears under 'Apply for the RCA'
Clarification of examination of patients *	Which patient examinations cannot be submitted	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx# Appears at the end of the attachment
RCA Policy	The formal regulations	https://www.rcgp.org.uk/-/media/Files/GP-training-and-exams/CSA-page/CSA-RCA/MRCGP-examination-RCA-policy-2020.ashx?la=en
Mandatory Criteria *	What your submission MUST contain	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment/mandatory-case-selection-criteria-for-recorded-consultation-assessment.aspx
Delivery of the RCA	Logistics of what happens	https://www.fourteenfish.com/
Guidance on Consent *	Consent and the implications of the GDPR	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/-/media/F0C813F4063D4496A5231FD723938AB8.ashx
Apply for the RCA	Logistics of applying	Applying for the RCA
Dates	Dates and deadlines	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/~/link.aspx?_id=73EC1B03977A4205B38F3B269AEC7A08&_z=z

RCA results and feedback*	How to interpret feedback	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/~/link.aspx?_id=CB707301A59A475DACA45910A3EEE81C&_z=z
Penalties for breaches in regulations	How your mark is affected if you miss a mandatory criterion etc.	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment/recorded-consultation-assessment-feedback-statements.aspx#data
FAQs	Most of the things you need to know about the regulations and the logistics	https://www.rcgp.org.uk/-/media/Files/GP-training-and-exams/CSA-page/CSA-RCA/FAQs-Recorded-Consultation-Assessment.ashx?la=en

Recommended Reading

Preparing for the RCA	Top Ten Tips for trainers (and trainees) ** An analysis of CSA	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/~/link.aspx?_id=3BFFA3D8C4A34F75BE4E4210775F20D2&_z=z https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/-/media/77B0C1D899584B1C9DCA6AE392CD6EE4.ashx
RCA Consultations	Continues the above	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx#
How to conduct a remote consultation		This is what you should focus on with your trainer
Guidance on cases to submit	Overview Examination of patients Extended guidance Insufficient evidence advice	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/-/media/6C48707ACAB248B2939A4A2AAA15ACC7.ashx https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/~/link.aspx?_id=4E38BE49593B4D778BCDEBEB5284A8AF&_z=z
RCA marking	An explanation of how the exam is marked	Generic Grade Descriptors RCA Domain Marking

Targeted reading for those who need to read it:

Declaring a disability	Everything you need to know if you have one	MRCGP Examination regulations Candidates with a Disability - Recorded Consultation Assessment Recorded Consultation Assessment - Information for Disability Assessors Recorded Consultation Assessment – Reasonable Adjustments Frequently Asked Questions RCA Request for Reasonable Adjustment Form
Complaints, Reviews and Appeals	Policies and procedures for complaints, reviews and appeals	RCA policy document MRCGP regulations, reviews, appeals, complaints and mitigating circumstances.
RCA summary reports	Pass rates	https://www.rcgp.org.uk/training-exams/mrcgp-exam-overview/mrcgp-recorded-consultation-assessment.aspx
DPIA		Data Protection Impact Assessment Procedure

Appendix 1 - Diverse but not homogenous

- Most ethnically diverse region London (44.9% White British) followed by W Midlands (79.2%). Least ethnically diverse: North East (93.6% White British) and Wales (93.2%)
- Highest percentages identifying as Asian London (18.5%) and West Midlands (10.8%). Lowest in the South West (2.0%) and Wales (2.3%)
- Highest percentages of the Black population London (13.3%) and the West Midlands (3.3%). Lowest North East (0.5%) and Wales (0.6%)
- Highest percentage of Mixed ethnicity London (5.0%) and the West Midlands (2.4%) Lowest North East (0.9%) and Wales (1.0)
- % general population living in an urban location: 81.5%,
- % Pakistani, Bangladeshi, and Black African living in an urban location: 99.1%, 98.7%, 98.2%

This disparity is even more obvious the more local the area looked at (England + Wales figures only):

Local authority	% White	Position	Local authority	% White	Position
Newham	29	1	County Durham	98.2	165
Brent	36.3	2	Herefordshire	98.2	166
Harrow	42.2	3	Caerphilly	98.3	167
Redbridge	42.5	4	Northumberland	98.4	168
Tower Hamlets	45.2	5	Powys	98.4	169
Slough	45.7	6	Blaenau Gwent	98.5	170
Ealing	49	7	Cumbria	98.5	171
Leicester	50.5	8	Flintshire	98.5	172
Hounslow	51.4	9	Redcar and Cleveland	98.5	173
Waltham Forest	52.2	10	Isles of Scilly	98.8	174

Source: https://www.ethnicity-facts-figures.service.gov.uk/