RCA at a glance:

FAQs, Myth debunker and quick reference guide

Health warning – this is not an official College guide but has been put together by a group of Severn educators who happen to be examiners

What is the RCA?

The Recorded Consultation Assessment (RCA) is the temporary substitute for the CSA exam whilst the latter is not able to be conducted due to Covid -19 restrictions

How temporary?
This is uncertain but likely to continue until well into 2021. Whether it overlaps with the CSA to accommodate shielding trainees is not yet clear.

But what is it?
It is an assessment of 13 consultations – video, audio or face to face, recorded and submitted by ST3 trainees and assessed by RCA examiners.

So much cheaper than the CSA then?
Unfortunately only a little cheaper as 26 different examiners are needed (2 mark each case independently)

Who are the examiners?
CSA examiners (all GPs) who have been trained in assessing the consultations using an online platform.

So, it's just like the old video assessment for summative assessment?
No, this assessment uses the same domain marking criteria as the CSA, (unlike the 'old' video exam which some felt was a 'tick box 'exercise)

Domain Marking?
Three domains of 'Data Gathering ', 'Clinical Management 'and 'Interpersonal Skills ', with 3 marks available for each domain (Clear Pass 3 marks, Pass 2 marks, Fail 1 mark ,Clear Fail 0)- see grid below

What's the pass mark?
Unlike the CSA each case is marked (completely independently) by two different examiners to ensure reliability in what was, at first, a new and untested assessment. Each candidate is assessed by 26 assessors with a total possible mark of 234 (2x117). The mark required to pass varies daily (see below) but will be likely to be between 135 and 145 (a pass in all domains in all cases gets 156)

It sounds much easier than the CSA …
It may sound easier but in fact the standard seems very consistent and so far the percentage passing ,using the borderline method which calculates the passing grade needed on each day, is very similar to that of the CSA .

How are the marks awarded if there is no written case to mark against?
Each domain is assessed using a template readily available on the college website (and attached here for easy reference) .The candidates need to *demonstrate* that they have achieved the expected standard in each domain .In other words if it isn't seen/ heard in the recording by the end of 10 minutes ,it will be assumed not to have happened.

What is that standard?
The standard required is that of a GP fit for independent practice. Just like the CSA. Each case will be assessed against what is current normal practice for managing whatever presenting complaint is being shown in each case.

Isn't it much easier since the trainees can choose which consultations to submit, and 'cherry pick'?
The aim is still the same – to demonstrate good safe consulting fit for independent practice. There is a skill in selecting the correct consultations to submit (see below) but cherry picking may result in selection of low challenge cases that simply do not demonstrate competence.

is it easier to score IP marks on video or F2F rather than telephone?
Analysis so far is that marks are consistent whichever format submitted

What if the patient suddenly brings up a second problem?
Part of the skill of a GP would be to manage this situation. Being able to say something like - that is very interesting and we do need to deal with that as well. Could we complete todays issue and then we can deal with the second problem at a later date. (or words to that effect)

What are 'Low challenge cases'?:
Below are examples of some consultations that have not presented an opportunity for the candidates to demonstrate their competences:

A previously diagnosed condition, recurred, with the same clinical management as before

Review of meds, no significant change needed

Triage call, needs TCI for exam, management depends on exam findings

The diagnosis & clinical management are reasonably within the scope expected of a **non-medically** qualified person. i.e. if an HCA would have been able to deal with the same problem as effectively don't submit!

An ‘expert patient’ who does not allow the doctor to demonstrate competence

How can/should I help as a trainer?

You may well be asked to check every case that your trainee is considering submitting. As they can upload many before making the final submission it is better to help them use the marking grid (below) to ensure that they can be self-critical of their own consultations and avoid the common pitfalls , possibly using the SoX RAG © rating also attached below – if mostly green , submit, if amber or red reconsider…. (see also the ‘top tips to help trainees’ guide).

Please do NOT suggest whether a case will pass ,but facilitate and guide your trainee to make a critical appraisal of their own consultations and let them decide.

Pitfalls:

The patient gives most of the DG without being asked and/or tells the doctor the correct diagnosis and management plan ("I googled the management, doctor"). It's very difficult for the candidate to earn marks if they're not having to do some work in the consultation.

Not appearing to be listening to the patient and asking repeated information or inappropriate ICE

Two partial consultations mixed, e.g. one issue DG, another CM

No *evidence* of a NEW management plan
(e.g. medication reviews with no changes in management

Ignoring serious/major symptoms

Not asking an appropriate range of questions to allow an appropriate differential diagnosis to be reached

Consultations where the only real option is to bring the patient in to be seen F2F with no discussion of possible management plans

When significant element of the consultation happens *after* 10 min

Advice to trainees from examiners:

- Examiners need to see evidence of *focused* history taking, making a diagnosis or range of diagnoses, and formulation of a management plan.
- .. need to present new acute undifferentiated cases to demonstrate this eg headache, fatigue, back pain, shoulder pain, sore throat, cough etc, and to **actively** take a focused history - so 'when did this start?', not 'tell me more'. So, no follow ups, no medication reviews, and no cases where there is no diagnosis to make and the management is straightforward .
- A patient with sciatica who says 'I think I have sciatica, I had it two years ago and I would like some physio as that helped before' is going to be difficult to score well compared with a patient who just says they have back pain.

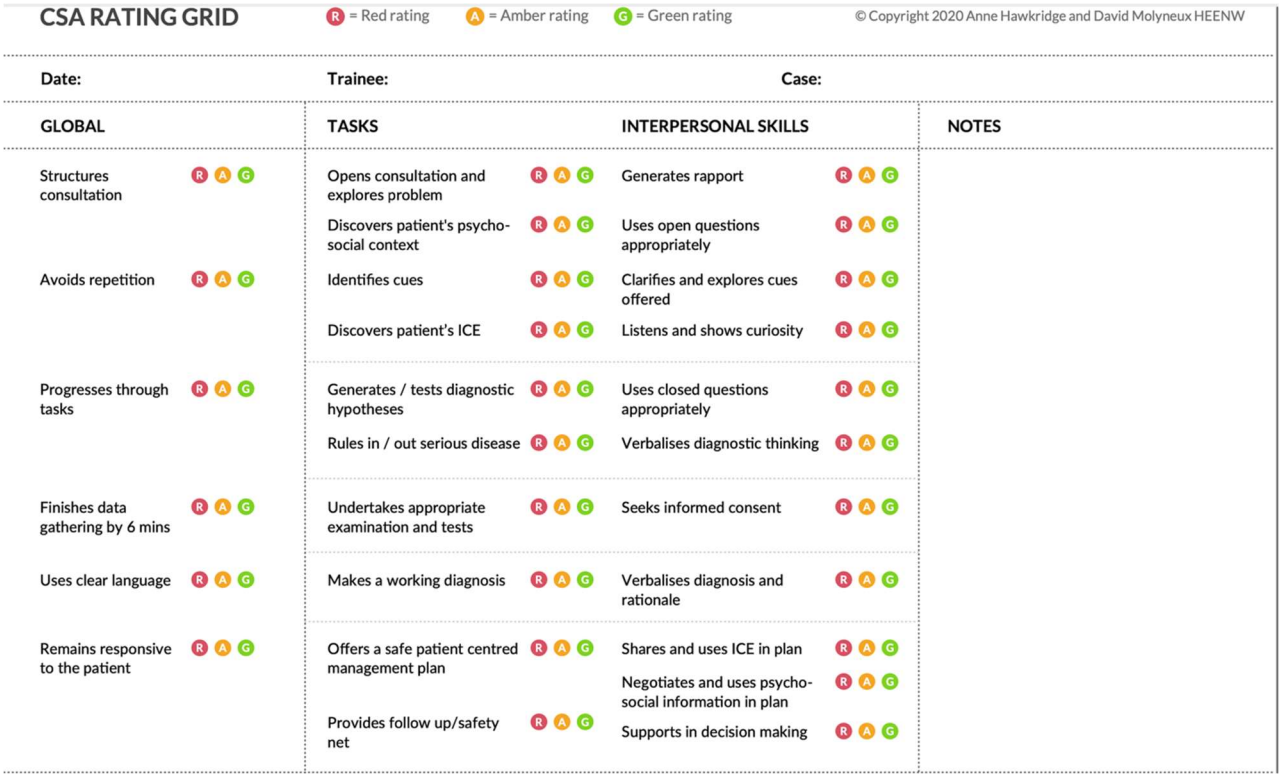
- Make sure there is “A beginning, a middle and an end.” Remember 1/3 of your marks are for clinical management. Don’t video an overly long clinical history which ends with a plan to bring the patient down to the surgery to examine them (unless you can set out your intended management plan clearly beforehand)
- Don’t bring back patients you’ve already seen for a review once you’ve read up on their condition. It’s obvious and it doesn’t score highly.
- Do show new problems with some depth. You might perform brilliantly giving antibiotics for otitis externa, but you won’t earn many marks.
- Do watch yourself consulting, learn what you could improve on and adjust your consulting style accordingly.
- Do show the video to your ES before you submit it

Bottom Line:
<u>Examiners mark only what they see or hear</u>. Better candidates generally demonstrate good history taking while referring to the PMH, psychosocial aspects , medications and previous management plans. They also narrow down a differential diagnosis or identify a list of problems to manage and do it well whilst incorporating the patient’s views.

Marking schema:

Data Gathering, Technical and Assessment Skills	Clinical Management Skills	Interpersonal Skills
a. Candidate opens consultation where appropriate with Introduction, consent and confidentiality	a. Candidate appears to make a safe and appropriate working diagnosis/es	a. Encourages the patient's contribution, identifying and responding to cues appropriate to the consultation
b. Takes an adequate and focussed history to allow for a safe assessment to take place	b. Offers appropriate and safe management options for the presenting problem	b. Explores where appropriate, patient’s agenda, health beliefs & preferences
c. Rules in/out serious or significant disease	c. Where possible, makes evidence-based decisions re prescribing, referral and co-ordinating care with other health care professionals	c. Offers the opportunity to be involved in significant management decisions.
d. Explores where appropriate the impact and psychosocial context of the presenting problem	d. Makes appropriate use of time and resources whilst attending to risks and health promotion	d. If possible, explains and conducts examinations with sensitivity and obtains valid consent
e. Plans and explains (and if possible performs) appropriate physical/mental examinations and tests	e. Provides safety netting and follow up instructions appropriate to the nature of the consultation	e. Provides explanations that are relevant and understandable to the patient
CP P F CF	CP P F CF	CP P F CF

Another useful tool is the traffic light system used in the **SoX programme** (with grateful thanks to HEENW and Anne Hawkridge /David Molyneux for permission to share this):



CSA RATING GRID (R) = Red rating (A) = Amber rating (G) = Green rating © Copyright 2020 Anne Hawkridge and David Molyneux HEENW

Date: **Trainee:** **Case:**

GLOBAL	TASKS	INTERPERSONAL SKILLS	NOTES
Structures consultation R A G	Opens consultation and explores problem R A G	Generates rapport R A G	
	Discovers patient's psycho-social context R A G	Uses open questions appropriately R A G	
Avoids repetition R A G	Identifies cues R A G	Clarifies and explores cues offered R A G	
	Discovers patient's ICE R A G	Listens and shows curiosity R A G	
Progresses through tasks R A G	Generates / tests diagnostic hypotheses R A G	Uses closed questions appropriately R A G	
	Rules in / out serious disease R A G	Verbalises diagnostic thinking R A G	
Finishes data gathering by 6 mins R A G	Undertakes appropriate examination and tests R A G	Seeks informed consent R A G	
Uses clear language R A G	Makes a working diagnosis R A G	Verbalises diagnosis and rationale R A G	
Remains responsive to the patient R A G	Offers a safe patient centred management plan R A G	Shares and uses ICE in plan R A G	
		Negotiates and uses psycho-social information in plan R A G	
	Provides follow up/safety net R A G	Supports in decision making R A G	