THE MCR FOR CESR – Documents 2022

Contents

Multiple Consultant Report (MCR) pro-forma for CESR Applications

Please read the guidance on the JCST website about completion of the MCR before doing this. There is
MCR-Guidance for Consultants
MCR-Guidance for Applicants
Example completed Multiple Consultant (MCR) report for CESR

Only one MCR is required which will cover all the Capabilities in Practice (CiPs) and Generic Professional Capabilities (GPCs), however there must be contributions from two or more consultants who regularly work with the applicant.

The MCR for CESR would be like the final MCR for a trainee and should be a summative assessment. The MCR should cover a period of at least 6 months prior to making the CESR application. It should be prospective ie should be completed at the end of the assessment period. The Guidance for Consultants and Applicants give details.

You should be aware that the MCR Consultant Raters' opinions form one part of the evidence presented and are insufficient in themselves to warrant recommendation for certification. The decision on whether to recommend an applicant for certification will be based on an evaluation of all evidence presented.

Applicant	
Name:	
Position:	
Consultants	
Consultant name: Your specialty, qualifications, current position and place of work;	

Consultant position and place of work where the applicant was working with you.	
Relationship to applicant (including place of work and dates when they worked with you).	
Environments in which applicant was observed on a frequent basis. By frequent we mean at least 1 session per fortnight over 6 months.	In patient care □ Theatre □ Out patients □ Multi-disciplinary meetings □ Emergency Take □ Critical care □
Have you been able to make regular and direct observation of the applicant's work? If so, can you explain why you have been able to come to an accurate holistic judgment about all aspects of their performance?	
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Consultant Report **The utmost integrity and probity is expected of you in completing this form. Inaccurate or misleading completion could result in danger to patient safety.** In completing this form we accept full responsibility for our comments in this report and confirm they are based on direct knowledge of this applicant.	

We can confirm that we made this decision together after discussion (Please state your names and indicate who the lead consultant is). **Lead Consultant Name:** **Collaborating Consultants' Names :**		
Date of assessment:		
Period covered:	From:	To:
Hospital(s):		
Generic Professional Capabilities Generic Professional Capabilities Framework		
GPCs **Reasons for your support** Give brief descriptions of examples of how you have seen the applicant demonstrate each capability as expected of a consultant, and indicate any concerns you have. You should state the evidence on which you base this judgment. Please review the descriptors for each GPC domain before completing this form.		
Descriptors for Domain 1:Professional values and behaviours		
Comments:		
Appropriate for independent practice: Yes / No		
Descriptors for Domain 2:Professional skills		
Comments:		
Appropriate for independent practice:		

Yes / No
Descriptors for Domain 3: Professional Knowledge Professional Knowledge-please note that this includes national legislative requirements and the health service and healthcare systems in the four countries(UK)
Comments:
Appropriate for independent practice: Yes / No
Descriptors for Domain 4: Capabilities in health promotion and illness prevention
Comments:
Appropriate for independent practice: Yes / No
Descriptors for Domain 5: Capabilities in leadership and team working
Comments:
Appropriate for independent practice: Yes / No
Descriptors for Domain 6: Capabilities in Patient safety and quality improvement
Comments:
Appropriate for independent practice: Yes / No
Descriptors for Domain 7:Capabilities in safeguarding vulnerable groups
Comments:
Appropriate for independent practice: Yes / No
Descriptors for Domain 8: Capabilities in education and training.
Comments:
Appropriate for independent practice: Yes / No
Descriptors for Domain 9: Capabilities in research
Comments:
Appropriate for independent practice: Yes / No

Capabilities in Practice (Please only complete the areas in which you have directly observed the applicant)
CiPs- Capabilities in Practice https://www.iscp.ac.uk/media/1139/all-cips-including-specialties-specific-2021.pdf **Reasons for your support-** Give brief descriptions of examples of how you have seen the applicant demonstrate each capability as expected of a consultant, and indicate any concerns you have. You should state the evidence on which you base this judgment. Please review the descriptors for each Capability in Practice before completing this form.
CiP 1 Manages an outpatient clinic
Comments:
Supervision Level : I / II / III / IV / V
CiP 2 Manages the unselected emergency take
Comments:
Supervision Level : I / II / III / IV / V
CiP3 Manages ward rounds and the on-going care of in-patient cares
Comments:
Supervision Level : I / II / III / IV / V
CiP 4 Manages an operating list
Comments:
Supervision Level : I / II / III / IV / V
CiP 5 Manages multi-disciplinary working
Comments:

Supervision Level : I / II / III / IV / V
CiP 6 Specialty specific CiP (Otolaryngology, Cardiothoracic Surgery, Plastic Surgery only)
Comments:
Supervision Level : I / II / III / IV / V
CiP 7 Specialty specific CiP (Cardiothoracic Surgery only)
Comments:
Supervision Level : I / II / III / IV / V
Overall statement Is the applicant is capable of performing at the level of a consultant in the UK health services and on what do you base this.
Overall statement
I understand that I am responsible and accountable for my recommendation that the applicant has reached the level of a day-one consultant as described by the specialty syllabus in each of the CiPs. **I confirm that all completed parts have been honestly written.**

Signature:	**GMC Number or Name and Number of your Medical Registration Body if not in the UK:**	**Date:**

The Multiple Consultant Report (MCR) for CESR Applicants

Guidance for applicants

The MCR should be produced prospectively.

This Guidance should be read in conjunction with the Example Multiple Consultant Report (MCR) for CESR.

The standard for CESR is equivalence to the specialty training curriculum in place at the time that you apply for CESR. The surgical curricula are changing. This is why:

The GMC designed its new standards for postgraduate medical curricula *Excellence by Design* and its framework for *Generic Professional Capabilities*, published in May 2017, to help postgraduate medical training programmes re-focus trainee assessment away from an exhaustive list of individual competencies, towards fewer broad capabilities required to practice safely as a day-one consultant. Trainees finish training when they are judged to have reached the level required of a day-one consultant in all areas of practice, as well as providing evidence that they have met other certification requirements. CESR applicants will have to demonstrate they have reached an equivalent standard.

As a result, the surgical curricula will become outcomes-based, meaning that trainees will be assessed against the fundamental capabilities required of consultants in the working week. These include the general skills which all doctors need to have (the Generic Professional Capabilities – GPCs) as well as those needed to carry out all the specific day to day tasks undertaken by a consultant surgeon (Capabilities in Practice – CiPs).

CESR applicants will have to demonstrate that they have met these requirements.

Generic Professional Capabilities (GPCs)

The GPC Framework was developed by the GMC and the Academy of Medical Royal Colleges with the aim of providing a consistent approach to ensuring that all doctors demonstrate appropriate and mature professional capabilities. The framework is divided into nine domains.

- professional values and behaviours
- professional skills
- professional knowledge

- capabilities in health promotion and illness prevention
- capabilities in leadership and team working
- capabilities in patient safety and quality improvement
- capabilities in safeguarding vulnerable groups
- capabilities in education and training
- capabilities in research and scholarship

Each of these domains contains a list of descriptors which illustrate the capabilities and behaviours required.

The GPCs describe the interdependent essential capabilities that underpin professional medical practice in the UK. They also serve as educational outcomes, carrying equal weight to the Capabilities in Practice (see below), and are an integral part of the surgical curriculum through every phase of training.

Satisfactory achievement of the GPCs by trainees will demonstrate that they have the necessary generic professional capabilities needed to provide safe, effective and high quality medical care in the UK.

Capabilities in Practice

The new curriculum also describes high-level outcomes of training which all consultant surgeons are required to deliver called Capabilities in Practice (CiPs)

The CiPs operationalise and contextualise the syllabus under the main activities needed for independent practice at the level of a day-one consultant. The end of training (i.e. equivalence to a CCT) will be reached when supervisors agree that a trainee is performing at the level of a day-one consultant.

The CiPs which apply to all surgical specialties are:

- Manages an Out-Patient Clinic
- Manages the Unselected Emergency Take

- Manages Ward Rounds and In-Patients
- Manages the Operating List
- Manages the Multi-Disciplinary Meeting

In addition to this Cardiothoracic Surgery, Paediatric Surgery and Plastic Surgery have additional specialty specific CiPs as follows

Cardiothoracic Surgery

- Manages patients within the critical care area
- Assesses surgical outcomes both at a personal and unit level

Paediatric Surgery

- Assesses and manages an infant or child in a NICU/PICU environment

Plastic Surgery

- Safely assimilates new technologies and advancing techniques in the field of Plastic Surgery into practice

More detail is given in the relevant Specialty Specific Guidance (SSG) and curricula.

In keeping with the GPCs, each of the CiPs also contains a list of descriptors summarising what is expected in each.

At the heart of these changes is the principle that the knowledge and skills essential for everyday practice should be reflected authentically in the curriculum.

In order to be recommended to the GMC for CESR and entry on to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all the CiPs and GPCs.

The Multiple Consultant Report

A new assessment tool is required for outcomes based assessment. The Multiple Consultant Report (MCR) allows assessment of performance relative to the level required of a Day 1 consultant in each CiP and the GPCs. The MCR is an assessment based in

the workplace using observations gathered over an extended period of time. For trainees, this is the entire duration of a placement. For CESR applicants we would expect observations to be over a similar time frame. The MCR for CESR would be like the final MCR for a trainee and should be a summative assessment. The MCR should cover a period of at least 6 months prior to making the CESR application. Applicants should bear this in mind when they first begin to gather their evidence for CESR.

For trainees the MCR will involve the professional judgement of the Clinical Supervisors who work with trainees on a day-to-day basis, assessing them against the high-level outcomes of the curriculum; the GPCs and CiPs. For CESR applicants this means substantive consultants who are of equivalent standing to a Clinical Supervisor. These will be the consultants (or those in an equivalent role outside the UK) with whom the applicant has worked for a period of time. They will have been able to closely observe the applicant's practice across all the CiPs and many of the GPCs.

The MCR is a meaningful assessment based on the holistic professional opinion of those who are working with the applicant. The MCR is summarised through the award of a supervision level which shows how much supervision is needed in each of the CiPs and whether any continued development is required in the GPCs. The supervision levels are:

I. Able to observe only
II. Able and trusted to act with direct supervision
    a) Supervisor present throughout
    b) Supervisor present for part
III. Able and trusted to act with indirect supervision
IV. Able and trusted to act at the level of a day-one consultant
V. Able and trusted to act at a level beyond that expected of a day-one consultant

Level IV in each CiP shows the standard of a day-one consultant which is the standard that would show equivalence to the CCT curriculum. Level V is to provide for someone who demonstrates exceptional performance in that CiP.

The MCR form

The MCR for trainees is available via ISCP and you may be familiar with this. However we have developed an equivalent version for CESR and you should use this version which is available from the JCST website – link to MCR form for CESR.

The MCR is designed for more than one consultant to complete at the same time. Consultants will meet (this can be virtual) to discuss the person they are rating and complete the form. The form allows several consultants to provide their details. If one

consultant is unable to comment on certain aspects of practice, for example, because they had not worked with the applicant in that area, then another consultant can complete this. The consultants should make it clear about who has contributed to which part of the MCR.

If it is not possible for the consultants to meet, even virtually, they can provide separate forms.

The minimum number of consultants completing the MCR is two, but ideally all consultants who regularly work with the applicant should contribute. The more input there is, the more meaningful the MCR will be.

When completing the form the consultants need to take into account the descriptors for the GPCs and the CiPs. There are links to these descriptors on the form itself. To support an application for CESR, when supervision level IV or V is awarded, consultants should refer to the descriptors to make an overall free text statement giving reasons for the supervision level they are awarding. They should state the evidence on which they base their judgement. Consultants are responsible and accountable for their supervision recommendations.

Where no consultant is able to complete the MCR or certain aspects of it then they should state this on the form and give reasons. The applicant will need to provide additional documentary evidence to show that they meet the CiP or GPC. The consultants and the applicant should discuss any gaps in the CiP or GPC assessment. The onus is on the applicant to find alternative evidence if necessary.

You (the applicant) should provide reflection on your practice for any GPC or CiP where you feel this would support your application. This will be particularly important if an MCR is not offered as part of the evidence.

Providing the MCR

As with all the evidence for CESR, the onus is on the applicant (you) to provide the MCR. **The MCR must be prospective** and advice about this is given below. Because the MCR should reflect at least a 6 month period prior to your application you should begin this process when you begin to gather your evidence for CESR.

- Approach the consultants you are asking to assess you (Consultant Raters) as part of your evidence collection for CESR.
- You should do this at least 6 months in advance of when you are going to submit your application.
- You should provide them with the documentation and advice about the MCR for CESR.
- You should then arrange a meeting with them to discuss the MCR for CESR and your objectives.

- The onus is on you to ensure that the Consultant Raters are fully aware of the report that they need to produce at the end of the ‘placement’ so they can keep the Capabilities in Practice (CiPs) and General Professional Competences (GPCs) in mind while working with you.
- You should provide a record of this meeting with your CESR application. This should be a document signed and dated at the time of the meeting by the Consultant Raters and state that they:
  - are aware of the report to be provided;
  - understand the (CiPs),(GPCs) and supervision levels for the MCR; and
  - will be observing your practice over this period.
- The meeting record should also set out your objectives.

You may find the Example Multiple Consultant Report (MCR) for CESR and MCR-Guidance for Consultants helpful in aiding the discussion.

If you are unable to provide an MCR or aspects of the MCR

If you are unable to provide an MCR or aspects of the MCR, you will need to provide alternative evidence. A list of items that could demonstrate equivalence to the MCR or aspects of the MCR is provided at Annex A of the 2021 version of the Specialty Specific Guidance (SSG). This list is not exhaustive and you may have other items to include. You will need to map the evidence to the CiPs and GPC headings using the descriptors to do this, and also provide reflection.

Mapping the evidence means you should state which items show equivalence to each of the CiPs and GPC headings and describe why.

This document should be read in conjunction with the SSG.

The Multiple Consultant Report (MCR) for CESR Consultants

Guidance for consultants completing the form

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VI. Able to observe only
VII. Able and trusted to act with direct supervision
    c) Supervisor present throughout
    d) Supervisor present for part
VIII. Able and trusted to act with indirect supervision
IX. Able and trusted to act at the level of a day-one consultant
X. Able and trusted to act at a level beyond that expected of a day-one consultant

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You may be familiar with how the MCR works for trainees. We have developed an equivalent version for CESR applicants and you should use this version which is available from the JCST website MCR form for CESR link.

The MCR is designed for more than one consultant to complete at the same time. Consultants will meet (this can be virtual) to discuss the person they are rating and complete the form. The form allows several consultants to provide their details. If one consultant is unable to comment on certain aspects of practice, for example, because they had not worked with the applicant in that area, then another consultant can complete this. The consultants should make it clear about who has contributed to which part of the MCR.

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- You should provide a record of this meeting with your CESR application. This should be a document signed and dated at the time of the meeting by the Consultant Raters and state that they:

  - are aware of the report to be provided;
  - understand the CiPs,GPCs and supervision levels for the MCR; and
  - will be observing your practice over this period.

- The meeting record should also set out your objectives.

There is an Example completed Multiple Consultant Report (MCR) for CESR which can help.

If an applicant is unable to provide an MCR or aspects of the MCR

Where an applicant is unable to provide an MCR or aspects of the MCR, they will need to provide alternative evidence. A list of items that could be used to provide this evidence is provided with Annex A of the 2021 version of the Specialty Specific Guidance (SSG). This list is not exhaustive and the applicant may be have other items to include. They will need to map the evidence to the CiPs and GPC headings using the descriptors to do this, and also provide reflection.

This document should be read in conjunction with the SSG.

Example Multiple Consultant Report (MCR) for CESR

This has been completed as an example, is fictional and written to describe a female applicant who identifies as she/her.

Please read the guidance about completion of the MCR before doing this. There is

- Guidance for Consultant Raters
- Guidance for Applicants
- An example of a completed MCR.

Only one MCR is required which will cover all the Capabilities in Practice (CiPs) and Generic Professional Capabilities (GPCs), however there must be contributions from two or more consultants who regularly work with the applicant.

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Applicant	
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Consultant name: Your specialty, qualifications, current position and place of work;	
Consultant position and place of work where the applicant was working with you.	
Relationship to applicant (including place of work and dates when they worked with you).	
Environments in which applicant was observed on a frequent basis. By frequent we mean at least 1 session per fortnight over 6 months.	In patient care □ Theatre □ Out patients □ Multi-disciplinary meetings □ Emergency Take □ Critical care □
Have you been able to make regular and direct observation of the applicant's work? If so, can you explain why you have been able to come to an accurate holistic judgment about all aspects of their performance?	
Can you confirm that you have read about and understand the • 2021Curriculum • Generic Professional Capabilities (GPCs)	

• Capabilities in Practice (CiPs) More details available from • Capabilities in Practice (CiPs) • https://www.iscp.ac.uk/iscp/curriculum-2021/ • https://www.jcst.org/	
Can you confirm that you have read and understand the guidance about the Multiple Consultant Report (MCR) for CESR on the JCST website.	
Consultant name: Your specialty, qualifications, current position and place of work;	
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Environments in which applicant was observed on a frequent basis. By frequent we mean at least 1 session per fortnight over 6 months.	In patient care □ Theatre □ Out patients □ Multi-disciplinary meetings □ Emergency Take □ Critical care □
Have you been able to make regular and direct observation of the applicant's work? If so, can you explain why you have been able to come to an accurate holistic judgment about all aspects of their performance?	
Can you confirm that you have read about and understand the • 2021Curriculum • Generic Professional Capabilities (GPCs) • Capabilities in Practice (CiPs) More details available from • Capabilities in Practice (CiPs) • https://www.iscp.ac.uk/iscp/curriculum-2021/ • https://www.jcst.org/	
Can you confirm that you have read and understand about the Multiple Consultant Report (MCR) for CESR which are on the JCST website.	
Consultant Report	

The utmost integrity and probity is expected of you in completing this form. Inaccurate or misleading completion could result in danger to patient safety.

In completing this form we accept full responsibility for our comments in this report and confirm they are based on direct knowledge of this applicant.

We can confirm that we made this decision together after discussion (Please state your names and indicate who the lead consultant is).

Lead Consultant Name:

Collaborating Consultants' Names :

Date of assessment:	30 September 2020	
Period covered:	From: 01 April 2020	To:30 September 2020
Hospital(s):	Milton Keynes General Hospital	

Generic Professional Capabilities

Generic Professional Capabilities (GPCs)

GPCs

Reasons for your support

Give brief descriptions of examples of how you have seen the applicant demonstrate each capability as expected of a consultant, and indicate any concerns you have. You should state the evidence on which you they base their judgement. Please review the descriptors for each GPC domain before completing this form.

Descriptors for Domain 1:Professional values and behaviours

Comments:

Dr A works with the utmost honesty and integrity. She is aware of her limitations and recognises when to seek advice. Dr A works within appropriate equality legislation and has recently attended one of the Trusts' E&D Courses. We have observed this across a variety of settings. Dr A's dealings with patients their carers and the wider team are commented on further under the headings of the Capabilities in Practice. We are satisfied that we have no concerns in this area.
Appropriate for independent practice: Yes /~~No~~
Descriptors for Domain 2:Professional skills
Comments: Dr A shows appropriate professional behaviour and judgement in a wide range of clinical and non-clinical contexts and circumstances. Having observed Dr A's clinical skills we are confident that She performs at the level of a day 1 consultant. Further commentary and examples are given under the headings of the Capabilities in Practice. We are satisfied that we have no concerns in this area.
Appropriate for independent practice: Yes / ~~No~~
Descriptors for Domain 3: Professional Knowledge Professional Knowledge-please note that this includes national legislative requirements and the health service and healthcare systems in the four countries(UK)
Comments: Dr A understands and is meticulous about data protection and confidentiality and maintains confidentiality at all times. This is our direct observation from working with her in the outpatient clinic, in the wards and in theatre. Dr A is up to date with the legislation around confirming and completing medical certificates of cause of death. She has demonstrated through her governance activities that she understands and works within the structure and organisation of the health service and system. During our general discussions with Dr A, we are satisfied that she understands how practice is managed within the independent sector and the wider health and social care landscape across the four countries. Dr A has also demonstrated his understanding of how services are commissioned, funded and audited. We are satisfied that we have no concerns in this area.

Appropriate for independent practice: Yes / ~~No~~
Descriptors for Domain 4: Capabilities in health promotion and illness prevention
Comments: Having read and understood the curriculum, including the descriptors for this domain of GPC, we are satisfied that we have no concerns in this area. We have found Dr A to be aware of the factors involved with health promotion and illness prevention. We have observed her giving advice about smoking cessation and obesity in clinic.
Appropriate for independent practice: Yes / ~~No~~
Descriptors for Domain 5: Capabilities in leadership and team working
Comments: We understand that Dr A will have provided evidence of this with her application. We have observed directly Dr A's supervision of junior doctors on the ward, and also her supervision of junior registrars performing surgical procedures in theatre. Dr A worked in a very collegiate manner with those colleagues and she had good interactions with no complaints ever received. Dr A was careful to be supportive to colleagues and helped the more junior trainees both in terms of support when they were overloaded or uncertain, and also gave practical support in letting them perform procedures under her supervision. Dr A is a positive role model who is respected and liked by peers across the multidisciplinary team. We are satisfied that we have no concerns in this area.
Appropriate for independent practice: Yes / ~~No~~

Descriptor for Domain 6: Capabilities in Patient safety and quality improvement
Comments: We understand that Dr A will have provided evidence of quality improvement with his application. In terms of patient safety we had no issues at all. Dr A was very safety conscious and always knew when it was appropriate or necessary to ask for help or supervision. We consider that Dr A meets this capability.
Appropriate for independent practice: Yes / ~~No~~
Descriptors for Domain 7:Capabilities in safeguarding vulnerable groups
Comments: Dr A maintains strict infection control measures, and is very aware of the need to safeguard vulnerable groups of patients. Our direct observation of working with Dr A is her strict observance of infection control protocols, and concern for patient safety on the wards and in the operating theatre. We are satisfied that we have no concerns in this area.
Appropriate for independent practice: Yes / ~~No~~
Descriptors for Domain 8: Capabilities in education and training.
Comments: We understand that Dr A will provide evidence of this with her the application. However, we have observed Dr A directly and have found her to be a keen teacher for medical students and junior doctors and Dr A often goes out of the way to teach on the job. We consider that she understands that the safety of patients must come first and that the needs of education must be considered in this context. We are satisfied that we have no concerns in this area.

Appropriate for independent practice: Yes / ~~No~~
Descriptors for Domain 9: Capabilities in research
Comments: We understand that Dr A will provide evidence of this with the application. However we would like to comment that she was active on the academic front, both in terms of research projects and enhancing her CV by means of publications and presentations. We are aware of the curriculum requirements and those of the GPCs. We are satisfied that we have no concerns in this area.
Appropriate for independent practice: Yes / ~~No~~
Capabilities in Practice **(Please only complete the areas in which you have directly observed the applicant)**
CiPs- Capabilities in Practice (CiPs) **Reasons for your support-** Give brief descriptions of examples of how you have seen the applicant demonstrate each capability as expected of a consultant, and indicate any concerns you have. Please review the descriptors for each Capability in Practice before completing this form.
CiP 1 Manages an outpatient clinic
Comments: CiP 1: Manages an outpatient clinic

We have shared patients in one outpatient clinic session each week over the last 6 months with Dr A. All of the patients have been under our individual names and we have tended to alternate which of us the patients see in order that we can keep an eye on progress and so that Dr A can broaden her experience.

The clinics we share are general clinics; We try to separate out patients presenting with conditions related to our special interest of xxxxx, but there is inevitably some cross over and so some of these patients have also presented as new or follow-up cases to the general clinic.

Through this experience, we have found that there is no need for us to pre-select which patients Dr A sees. It is clear to us that she cares well for all who see them and feedback from nursing staff is uniformly positive.

Over the last 6 months, we have shared out the triaging of referrals with Dr A. We have noticed that she has a slight tendency to boost the urgency level compared to what we would have allocated, but this is well within acceptable norms. Dr A carries out this task efficiently and regularly. The admin staff are complimentary about how Dr A approaches the work. On occasion Dr A orders investigations before seeing the patient in clinic. On these occasions she always writes to the patient and GP to keep them informed and the investigations she orders are appropriate and accelerate the care of that patient.

Dr A manages to be thorough and efficient when assessing new patients as shown by the letters she dictates (a proportion of which we have asked the admin staff to show to us) and the number of patients she sees in the clinic. The nursing staff are understandably complimentary about this but they also comment that the patients all like Dr A with some asking particularly to see her again.

In keeping with Dr A's triage practice, we have noticed a slight tendency to investigate patients when we would not, but again we see this as within normal clinical variation. Dr A does show the confidence to discharge newly referred patients when appropriate without requesting investigations.

We practice in area of limited ethnic diversity but we do have some minority ethnic patients who cannot speak English and for whom interpreters are required. Our practice also includes some vulnerable adults with learning difficulties, communication with whom is also challenging. We have tended to observe Dr A during these consultations, particularly the latter, and we are satisfied that she is able to manage these situations as would be expected of a consultant.

We have taken a graduated approach to permitting Dr A to break bad news to patients in clinic. Early during our year together we would directly observe these consultations. After seeing Dr A's abilities in this area, we started leaving her to conduct the consultations on her own but would go in to see the patient ourselves afterwards; on these occasions we were was struck by how many patients commented positively on how the consultation was conducted and on our questioning, it was clear Dr A had indeed managed to explain the important information to them. We now leave these consultations to Dr A and have had no complaints.

Dr A's case selection is good. We cannot recall having to reverse a decision to operate made by Dr A and, through our review of her clinic letters and our sharing of patients in clinic, we have not come across anyone we would have operated on that she decided not to. Dr A does occasionally ask for our opinion on whether we should offer surgery to patients with considerable co-morbidity and what choices of operation would be appropriate in such cases. Dr A brings a detailed review of the patient's background to these discussions and always gives us her recommendation. We generally agree on a final decision, but on occasion we do have differing views; these are no more than we would expect between consultant colleagues and to us it shows Dr A is developing her own approach to practice.

We have monitored Dr A's approach to clinical paperwork in general, including her management of results on out patients. Dr A deals with these in a timely and appropriate manner, either arranging to see patients again or simply writing to them to reassure them as appropriate.

Throughout all Dr A's outpatient work, she demonstrates high professional standards, behaviour and values. We have perused all the domains of the Generic Professional Capabilities and feel Dr A demonstrates all of them in relation to Dr her outpatient work.

We have no hesitation in saying that, in our opinion, Dr A is capable of practicing at the level expected of a day one consultant in the general outpatient work required in XXXXX Surgery.

Supervision Level :

I / II / III / IV / V

IV - Performs at the level of a day 1 consultant

CiP 2 Manages the unselected emergency take

Comments:

We have worked with Dr A over the last 6 months and have been able to closely observe her practice as she has been contributing to the care of our patients in all areas of clinical practice on a daily basis. In writing this report we have paid attention to the requirements of the Generic Professional Capabilities and to the descriptors of the five Capabilities in Practice.

We have had opportunity to both observe and work with Dr A on the unselected emergency take within our specialty and have been able to compare and incorporate our observations with those of our consultant colleagues for both the acute daytime and out of hours components.

The overriding opinion is that Dr A has been an active and integrated participant in the emergency take and that over the year her decision making and overall patient management has developed to a level that is commendable, as is also the case for her communication and team working.

Whilst Dr A had always undertaken a prompt assessment of the acutely unwell and / or deteriorating patient, she has after feedback and self-reflection ensured that a structured history is taken and communicated to the team, of which she has in effect been the leader. Dr A now ensures that a focussed clinical examination is undertaken to support a diagnosis, direct diagnostics or inform on the options for intervention. She does now truly formulate an appropriate overall impression and diagnosis.

Where necessary Dr A will ensure initiation and delivery of resuscitative treatment and initial management. This will include ensuring that sepsis has been considered, recognised and treated in compliance with our local protocols.

We have found that over the year Dr A has developed in assessment of patient's comorbidities and takes this into account when planning the management and will seek specialist advice where appropriate.

Dr A's management decisions are now made appropriately at the level of a day one consultant and irrespective of whether the plans are operative or conservative they are well explained to both the patient and rest of the team. These decisions are made in a timely manner with a situational awareness of the on-call priorities.

We are confident that Dr A has demonstrated knowledge that covers the breadth of the syllabus and so is able to manage the whole range from straight forward to unusual cases. Those cases that require operations are carried out to a level compliant with the objectives of the syllabus and supported within her portfolio by index cases competencies. Dr A is able to deal with unexpected intra operative events in a calm and appropriate manner.

Dr A has demonstrated excellent communication of appropriate peri and post- operative management plans with anaesthetic and recovery colleagues and is thorough in approach to post-operative care inclusive of sensible and planned discharge and follow up plans. She also ensures that these are communicated to primary care.

Within the complexities and pressures of the unselected take Dr A has developed her ability to now be able to manage the potentially difficult and challenging interpersonal situations that may arrive with patients, relatives and staff. This would include appropriately investigating and responding to any complaints that may arise.

Therefore, we have no hesitation in saying that, in our opinion, Dr A is capable of practicing at the level expected of a day one consultant with respect to the management of the emergency take.

Supervision Level :

I / II / III / IV / V

IV - Performs at the level of a day 1 consultant

CiP3 Manages ward rounds and the on-going care of in-patient cares

Comments:

We have performed ward round with Dr A at least twice a week over the last 6 months and over that time have gradually taken a back seat and let her lead the ward round. We have therefore been able to observe interaction with patients and members of the multidisciplinary ward team.

Dr A's preparation for the ward round is commendable – an active hand over is sought from the overnight team and the nurse in charge on our home ward before the start of the ward round. This handover will dictate the start of the ward round as any patient requiring significant intervention overnight will be seen first. Dr A is good at co-ordinating the team and will ensure all know each other (we have frequent changes of staff due to rota gaps) and will clarify their roles on the ward round. This makes the round efficient and the foundation doctors appreciate being noticed and actively involved.

Dr A displays a systematic approach to each patient and is unhurried yet efficient. Notes and the previous day's plan and progress against it are reviewed. Information from the whole team is actively sought. Any radiological investigations are often reviewed at the start of the round as the optimal viewing screen is static.

Communication with patients is good natured, professional and involves the patient, with clear explanations, always an opportunity for the patient to ask questions. Sometimes patients can be challenging, and Dr A would previously retreat from this on occasion, but confidence and assuredness has grown over the last 6 months and this no longer requires improvement, Dr A having responded well to feedback on this issue.

Occasionally, Dr A will be faced with a complication arising from a case she has performed personally. This can be challenging for all of us, but Dr A demonstrates professional maturity and objectivity, not being afraid to accept that a complication has occurred and will act accordingly. In these cases (as in general), Dr A demonstrates complete candour when explaining what is happening to patients.

Clear plans are made for each patient and communicated clearly to nursing staff. Feedback from the nursing staff on the ward has consequently been complimentary, with special mention being made of professionalism, team working and inclusivity.

Dr A will involve the team throughout the ward round by asking opinions and providing and hoc teaching on points where there are knowledge gaps.

At the end of the ward round, Dr A will review the tasks arising from the round with the team, but does this in a way that includes the whole team in managing and dividing the work load. Dr A will usually take the job of speaking to another specialty team if referral is required, or will go to the radiology department to request a scan with the radiologist in person if required urgently, and it is small touches like this that make a difference to the quality of patient care.

It is our opinion that Dr A performs at least to the level of a day 1 consultant in this capability in practice, and in several areas in this domain she performs at a level of a consultant of several years standing.

Supervision Level :

I / II / III / IV / V

IV - Performs at the level of a day 1 consultant

CiP 4 Manages an operating list

Comments:

CiP 4: Manages an operating list

Dr A has been regularly attached to our main all day operating list on a weekly basis over the last year. For the last six months Dr A has also been attached to our fortnightly day case operating list.

As soon as we started working together, it was clear to me that Dr A already had the technical skills needed for the majority of cases requiring surgery in <specialty>. Dr A approaches operative surgery in a calm and methodical manner, ensuring each step of the operation is completed to her full satisfaction before proceeding to the next. In doing this, Dr A exhibits great attention to detail and achieves good haemostasis at each step. She handles tissues well and makes sure that the correct planes are used for dissection. Although this results in Dr A not being the fastest surgeon, it does mean Dr A is very safe. We rapidly became sufficiently comfortable to allow Dr A to carry out most procedures under our direct supervision and was always amused by her firm and clear directions we acted as the scrubbed assistant. These did permit excellent exposure of the operative site and we have learnt some useful tips from these experiences. Intra-operative decision making is a key feature in our specialty and we found Dr A to be surprisingly rather hesitant in this initially, despite having the technical ability to permit all options to be carried out. With encouragement and guidance, however, Dr A has now become confident in making these decisions. In retrospect, we suspect she wanted to learn how others would

handle the case and, once she had established what the approach was became very comfortable working in the same way. Dr A's operative technical abilities, decision making and direction of assistance have developed now to the extent that in our opinion, she is capable of all operative procedures in <specialty>. We now share cases equally and Dr A has clearly demonstrated that our supervision is not required for her cases. We do occasionally operate together on high risk patients and comment that this is akin to operating with a consultant colleague.

Of course, there is much more to conducting an operating list than the technical aspects. Dr A initially took a little while to get used to our electronic theatre list booking system, having not come across one like ours before. Once Dr A had overcome this uncertainty, however, she has shown herself to be assiduous in ensuring that all our operating lists are filled with appropriate cases.

Dr A's case selection is good, if a little on the conservative side of practice particularly in patients with significant co-morbidities requiring complex surgery. We would, however, describe this as being well within the range exhibited in normal consultant practice. Dr A always has detailed discussions with patients about surgery, covering all other treatment options and potential complications, which start in the outpatient clinic and which are continued and completed on the day of admission for the operation. Our admin staff tell us that Dr A is excellent at answering any questions patients have while waiting for their operation. We are lucky to have an excellent anaesthetic assessment team and she uses this to best advantage.

Dr A always speaks to every patient on the operating list on the day of surgery and still manages to be on time for the pre-operative briefing. Dr A gives this clearly, concisely and obviously has a good grasp of all the pertinent facts for each case. Dr A is ready with alternative operative plans for the various eventualities which may present.

During the list, Dr A shows good awareness of the patient's condition and what is happening within theatre. We occasionally receive calls from the ward or recovery areas or questions from our Foundation Doctors. Dr A approaches these calmly and gives good, clear advice while not permitting the disturbance to adversely impact the conduct of the operation. If a delay is required before answering, Dr A is always polite in explaining this. This politeness extends to all of Dr A's interactions in theatre, in her communications with all team members and elsewhere. Staff have commented to me how much part of the whole team they feel when Dr A is the operating surgeon.

Post-operative care extends into Dr A's work on ward rounds and general patient review. Dr A routinely does a post-operative round on the day of surgery and keeps a close eye on patients after that. We have seen Dr A identify and manage surgical complications to a high standard, be they early or late.

Throughout all Dr A's operating theatre work, she demonstrates high professional standards, behaviour and values. We have perused all the domains of the Generic Professional Capabilities and I feel Dr A demonstrates all of them in relation to her operating theatre work.

We have no hesitation in saying that, in our, Dr A is capable of practicing at the level expected of a day one consultant in the operating theatre work required in XXXXX Surgery.
Supervision Level : I / II / III / IV / V IV - Performs at the level of a day 1 consultant
CiP 5 Manages multi-disciplinary working
Comments: We have had opportunity to both observe and work with Dr A and see that she has developed their case understanding and now does appropriately select cases that require, or would benefit from, discussion with the multidisciplinary team. Very importantly for the recording of the case Dr A has learnt to follow the pathways and administrative process that supports both the multi-disciplinary meeting and team working. Subsequently they now have the understanding to be able to deal with and / or avoid inappropriate case discussion by postponing or rearranging these if not all the required information is in place. We feel that Dr A now demonstrates a knowledge level that matches the breadth of the syllabus when dealing with both straight forward and complex cases. As a consequence Dr A has developed the ability to identify those serious, unusual or important cases that require multi-disciplinary input. Over the last year Dr A has demonstrated fully the ability to present the appropriate case histories, inclusive of important clinical features, co morbidities and investigations. More importantly Dr A has achieved this whilst engaging constructively with all members of the MDT in order to reach an agreed management plan. That now also includes recognising uncertainty and being able to manage this, which was not the case a year ago.

As a consequence Dr A is able to lead and direct the Multi-disciplinary interactions to ensure that the case list is discussed in the time available and that all outcomes are appropriately recorded and communicated by appropriate means to the patient, GP and administrative staff. In doing so she also always ensures that the outcomes are acted upon and the management plan or further investigations are instigated. As a group we certainly feel that Dr A can work collaboratively with multi- disciplinary colleagues, inclusive of undertaking joint procedures as have shown that they can deal appropriately with conflicting opinions and effectively manage challenging situations in the best interests of patient outcome. We have therefore no hesitation in saying that, in our opinion, Dr A is capable of practicing at the level expected of a day one consultant with respect to multi-disciplinary team working.
Supervision Level : I / II / III / IV / V IV - Performs at the level of a day 1 consultant
CiP 6 Specialty specific CiP (Otolaryngology, Cardiothoracic Surgery, Plastic Surgery only)
Areas for development:
Areas of excellence:
Comments:
Supervision Level : I / II / III / IV / V
CiP 7 Specialty specific CiP (Cardiothoracic Surgery only)
Areas for development:
Areas of excellence:

Comments:		
Supervision Level : I / II / III / IV / V		
Overall statement Is the applicant is capable of performing at the level of a consultant in the UK health services and on what do you base this.		
Overall statement We have worked with Dr A over the last 6 months and have been able to closely observe her practice as she has been contributing to the care of our patients in all areas of clinical practice on a daily basis. In writing this report we have paid attention to the requirements of the Generic Professional Capabilities and to the descriptors of the five Capabilities in Practice. We would support Dr A's entry onto the Specialist Register, and would employ her as a fellow consultant colleague without reservation.		
I understand that I am responsible and accountable for our recommendation that the applicant has reached the level of a day-one consultant as described by the specialty syllabus in each of the CiPs. **I confirm that all completed parts have been honestly written.**		
Signature:	**GMC Number or Name and Number of your Medical Registration Body if not in the UK:**	**Date:**