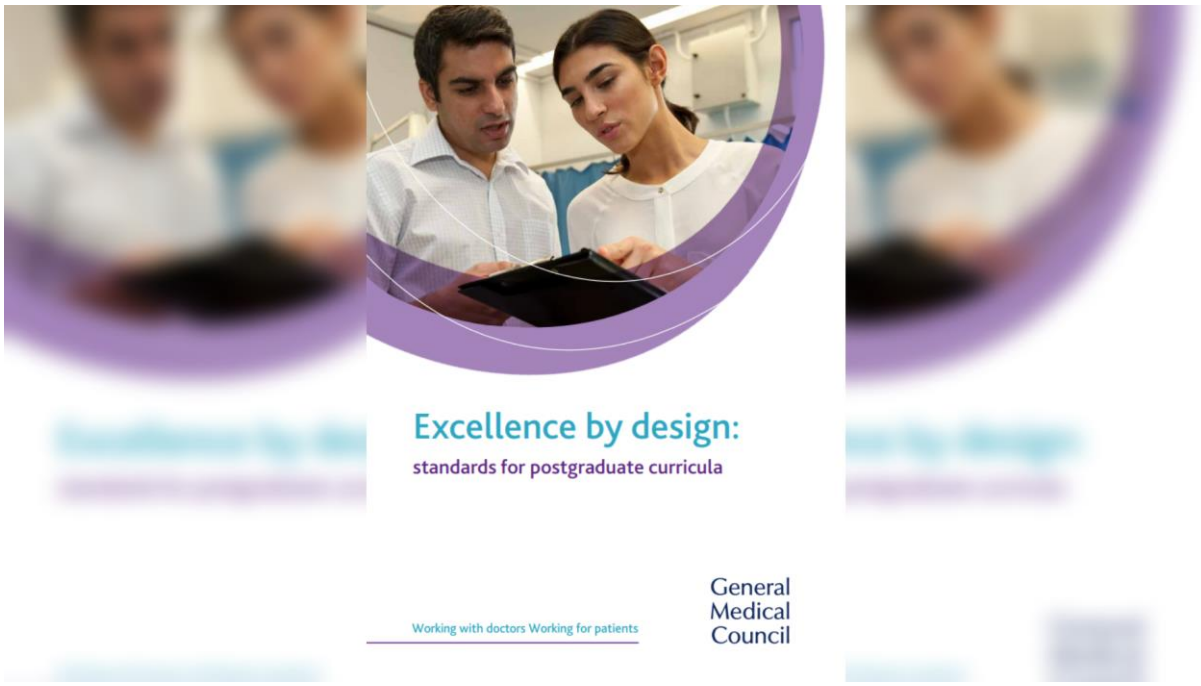
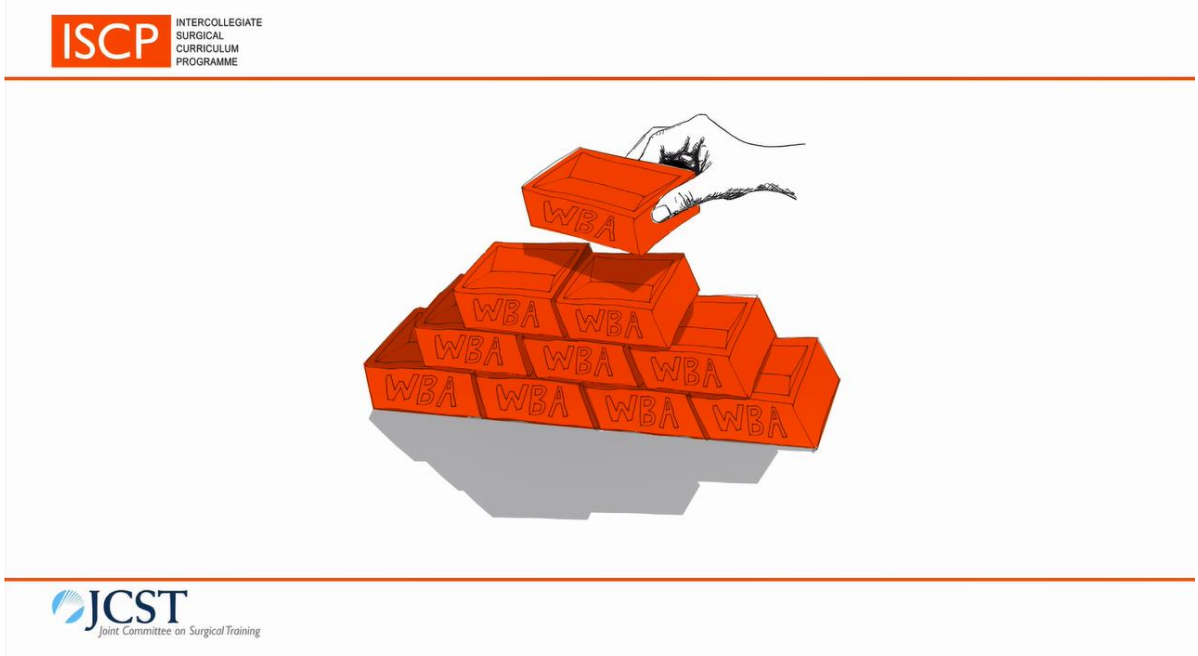
Introduction to Capabilities in practice (CiPs) – Video Transcript

Since 2007 assessment of competence in the workplace has been through workplace based assessments, or WBAs. These will be familiar to you and include the PBA, DOPS and CEX. These assessments are very good at assessing performance in a particular operation or discussing management of a particular condition, but surgery, is of course, more than that, and integrates lots of tasks, often at the same time to perform well in managing the acute take or managing outpatients for example.



The GMC recognised that assessments are often too detailed and centred on tasks too small to make an overall judgement about how a trainee is performing in the workplace.



If you think of what we do now, and to borrow the construction analogy for learning, the unit of assessment is the WBA. What we do through training is repeat WBAs and placing one on top of the other, to build up to being a competent new consultant. However, as we go along we find it difficult to check how the building is progressing. Most of the time everything goes according to plan, but sometimes we end up with something like this:

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It is undoubtedly a house, it has walls, a roof of sorts, windows, a door, but it is certainly not safe.

Rather than getting involved in each small brick, we need to be able to stand back and see the end-product of training during training, and aim towards that:

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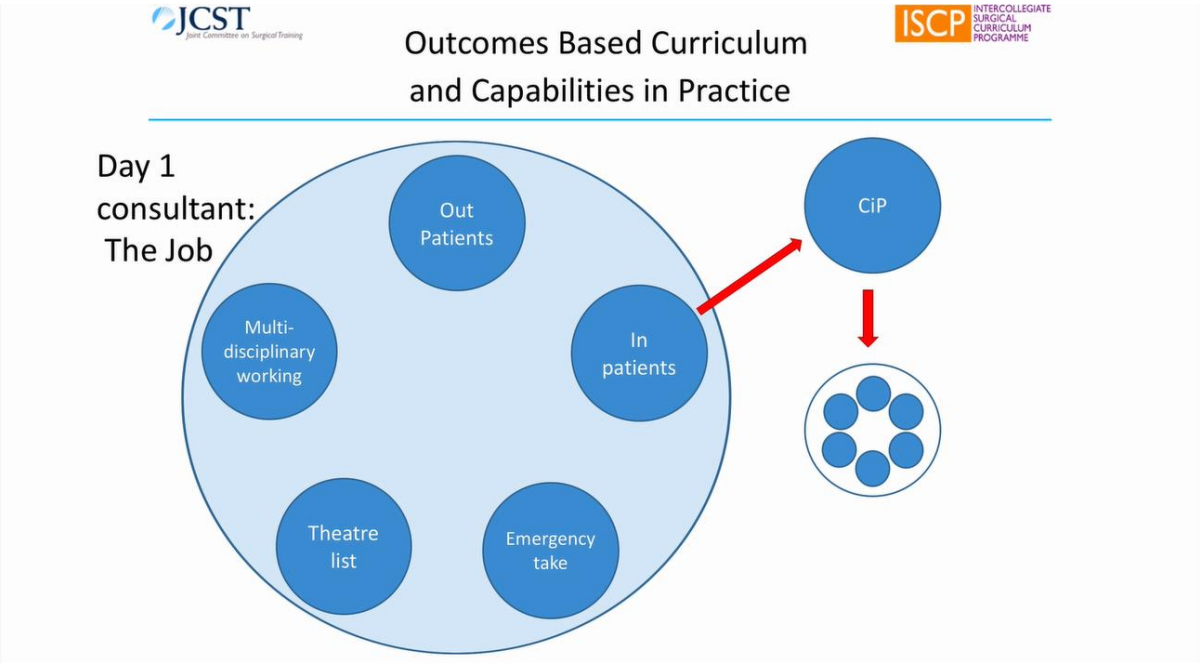
In Excellence by design, published in 2017, the GMC described a set of standards for curricula, and recognised that assessment at present is too 'granular'. To address this they required that new curricula become outcomes based (you finish training when you have acquired the competence to become a day 1 consultant in the speciality) and that they describe fewer, high-level generic, shared and specialty-specific outcomes. These high-level outcomes are known as Capabilities in Practice, or CiPs.

If training is outcomes based, what is the outcome? It is whatever is needed to be a safe day 1 consultant.



With reference to the syllabus and from your professional experience, you know what is required to be a day 1 consultant in your specialty. It is hard to describe without breaking it down a bit first. So, what makes up the essential large tasks of a consultant surgeon through the week? We can break down what we all do into 5 main areas:

- Managing an outpatient clinic
- Managing in patients and ward rounds
- Managing a theatre list
- Managing the acute take
- And multidisciplinary working in a formal MDT or outside of one

Each of these discrete areas of the working week combine to make the overall job, so if you can do these to the level of a day 1 consultant, and have met the generic professional capabilities, then you are ready to complete training. Each of these areas is a high-level outcome of training and is known as a Capability in Practice. These 5 CiPs are common to all surgical specialities. Cardiothoracic Surgery and Paediatric Surgery have also described some extra areas for CiPs that are central to the safe practice of their specialty.

Each CiP integrates many different tasks and requires combinations of knowledge, clinical, professional and technical skills to produce a functioning completely in each CiP. For instance, to manage the acute take a surgeon needs to be able to

Communicate effectively with primary care, patients, the multidisciplinary team in surgery and colleagues from other specialties,

To have the ability to take a history and examine the patient, the knowledge to formulate a differential diagnosis and decide on what tests to perform

To Use clinical judgement and draw on knowledge and experience to develop a plan for treatment and have the technical skills to operate safely on that patient if surgery is required.

In summary then, we are moving to an outcomes based curriculum – the end of training comes when a trainee can safely act as a day 1 consultant. We have to describe some shared outcomes and these are the large areas of the job that we each do each week and are known as capabilities in practice. Using holistic professional opinion about performance in each of these areas relative to what is required to be a safe day 1 consultant will allow us to move away from a granular, tick-box assessment process. To one where we can keep the end point of training in view at all times and always to be able to see the big picture clearly.