Trainer Guide to Entrustable Professional Activities

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Table of Contents

EPAs and Why They Matter

Entrustable professional activities (EPAs) describe the discrete activities which can be entrusted to trainees, are essential to the profession, and encapsulate one or more core competencies (Ten Cate & Scheele, 2007). EPAs allow trainers to make competency-based decisions on the level of supervision needed by a trainee (Ten Cate, 2013). The Irish College of GPs has developed a framework of 18 EPAs for postgraduate GP training. To be nominated for the Certificate of Satisfactory Completion of Specialist Training (CSCST), trainees are required to demonstrate competency progression in each clinical post as evidenced by EPA entries, and by the end training have achieved a level of entrustment of being ready for independent practice in at least one domain within each EPA.

Detailed guidance on the knowledge and professional conduct that GP trainees must acquire by the end of their training is available in the form of EPA descriptors.

Key document: EPA descriptors

Descriptors of progressive levels of trainee abilities in EPAs are used throughout competency based medical education programmes. In Irish GP training we use the term "supervision levels" to describe the progress of the trainee and to help make the entrustment decisions arising from the learning event.

There are 6 domains common to all EPAs. The 6 domains are:

1. Primary Care Management
2. Person Centred Care
3. Specific Problem-Solving Skills
4. Comprehensive Approach
5. Community Orientation
6. Holistic Approach.

Each domain functions like a lens through which trainers can give feedback on EPAs. These domains come from the WONCA European Definition of General Practice, and the current GP Training curriculum is arranged according to these domains. Guidance on EPA supervision levels for each of the EPAs and their respective domains is available.

Key document: Guideline on EPA supervision levels

Understanding the distinction between *ad hoc* (situational, real-time) and *summative* entrustment decisions enables trainers to guide trainees effectively while maintaining patient safety and educational rigour (Ten Cate, 2005; Ten Cate & Scheele, 2007). Decisions on the level of supervision for individual patient interactions are based on many factors - including the trainee's experience to date - and are not reflective of their year in training. Supervision level

decisions do not tell the whole story, and Training Programmes must use good judgement to fill in the gaps in determining the competence of a doctor. In addition to demonstrating competency progression as evidenced by EPA records, trainees on the Irish College of GPs Specialist Training Programme in General Practice must satisfy other mandatory criteria to be awarded the Certificate of Satisfactory Completion of Specialist Training (CSCST).

Key document: Criteria for Satisfactory Completion of Specialist Training

Your role as a trainer is critical in supporting trainee development. Feedback conversations are a cornerstone of clinical learning, helping trainees reflect on their performance, understand expectations, and identify specific areas for improvement. High-quality feedback, especially when embedded in the workplace, enhances learning and provides valuable insights into a trainee's readiness for increased clinical responsibility. Facilitating effective and timely feedback conversations and being thorough, fair, and objective in your assessment is important (Medical Council Guide to Professional Conduct & Ethics for Registered Medical Practitioners, 9th Edition 2024).

Ad Hoc Entrustment: A Developmental Opportunity

Most EPA supervision levels reflect ad hoc entrustment decisions - these are real-time decisions made by clinical supervisors based on a "gut-feeling" to allow a trainee to perform a clinical task. Ad hoc entrustment happens every day in healthcare settings, largely as part of the flow of ordinary work-based teaching practices. Ad hoc entrustment refers to situational, real-time decisions made by you as a trainer to allow a trainee to perform a clinical task.

Ad hoc decisions are usually based on:

- Trainee features (Ten Cate, O., & Chen, H. C., 2020) including:
  - Agency (proactive toward work, team, safety, personal development)
  - Reliability (conscientious, predictable, accountable, responsible)
  - Integrity (truthful, benevolent, patient-centred)
  - Capability (task-specific knowledge, skills, experience, situational awareness)
  - Humility (recognizes limits, asks for help, receptive to feedback)
- Estimated risk of the situation
- Urgency of the job to be done
- Suitability of this task at this moment for the trainee

Ad hoc entrustment decisions **do not necessarily constitute a precedent** for similar decisions in the future (Ten Cate et al., 2016) and they **do not imply a general judgement** of the trainee's

overall competence in that clinical area. Ad hoc entrustment decisions are **small but meaningful data points in a broader, longitudinal picture of development**.

Because ad hoc entrustment decisions are context-specific further information is needed to determine what a supervision level indicates about the trainee's competence e.g., an entrustment decision of "requires close supervision" may have had more to do with the fact that the clinic was running behind schedule and therefore the trainer needed to be more involved with performing a procedure, than with a trainee's lack of skill.

With many such entrustments collected over time, a clear and detailed record of growing clinical capability can emerge - supported by the structured framework of the EPAs. Ad hoc entrustment is essential for learning, as it provides trainees with opportunities to experience autonomy and develop confidence under safe conditions (Hauer et al., 2014). Following ad hoc entrustment with a feedback conversation helps the trainee understand what informed your decision, what they did well, and what could be improved. These conversations help trainees consolidate learning, address concerns early, and build the reflective habits necessary for accountability and safe, independent care.

Ad hoc decisions, when they are recorded, appear in a retrospective scale, a scale that "looks back" and reports on how much supervision or help was provided or needed when a trainee was entrusted with a task in one particular situation (van Enk A and Ten Cate O., 2020). While such documentation usually occasions important and timely oral feedback for the trainee, the main purpose of filling in and filing away (in, for example, a trainee's portfolio) a retrospective scale is to create data for a future decision about a trainee's formal advancement and their permitted or expected level of autonomy going forward (an Enk A and Ten Cate O., 2020). A common analogy used in EPA literature is that of pixels – the greater the number and range of pixels, the clearer the photograph; the picture is also made clearer by the narrative feedback that accompanies recorded learning events, describing aspects of the trainee's performance.

Summative Entrustment: A Formal Assessment Milestone

Summative entrustment is a formal, high-stakes decision, usually that a trainee can move to the next stage of training or that a trainee is ready to perform a specific EPA independently and safely. Unlike ad hoc decisions, summative entrustment is based on grounded trust i.e., the accumulation of multiple observed experiences, data points, and trainer judgments over time (Ten Cate et al., 2016; Schuwirth & Van der Vleuten, 2011). Summative entrustment decisions reflect a generalised and continuing permission to act at the expected supervision level and are a cornerstone of programmatic assessment, where many low-stakes assessments (including EPA feedback records) contribute to high-stakes decisions (Van der Vleuten et al., 2012). Summative entrustment decisions are decisions that are not made in the moment but on the basis of evidence collected over time and from multiple sources.

In the General Practice Training Programme, summative entrustment decisions are made by scheme Competency Progression Committees (CPCs). The CPC evaluates trainee progress towards becoming an independent GP. Progress is reviewed in partnership with the trainee using multiple sources of feedback including EPA feedback, GP trainer reports (ITERs), and other assessments. The CPC process is designed to support the trainee's learning development plan. There is an expectation that trainee progress will develop in line with ICGP published EPA supervision levels. As many supervision level descriptors are repeated across competency domains and EPAs, trainees are not expected to achieve the level of independent practice in every competency domain within every EPA. Rather, trainees should demonstrate progressive development across all competency domains throughout training, as evidenced by their EPA records. By the completion of training, trainees must also demonstrate readiness for independent practice across all 18 EPAs, evidenced by an entrustment decision of "ready for independent practice" in at least one competency domain within each EPA, to be eligible for nomination for the Certificate of Satisfactory Completion of Specialist Training (CSCST).

To be awarded the CSCST, trainees must demonstrate competency progression in each clinical post as evidenced through EPA records.

Prior to qualifying from GP training the CPC should be satisfied that:

- Sufficient ICGP EPA data is being logged by the trainee;
- Over time, there is evidence of entrustment level progression;
- Prior to qualifying from GP training there are some EPA records for every EPA that shows the trainee has reached the level of entrustment of being ready for independent practice - the entrustment records across all EPAs and across the entire duration of training should be of a distribution with which the CPC is satisfied;
- EPA records demonstrate application to learning by trainees;
- The entrustment levels are credible when compared to EPA supervision level descriptors for the stage of training;
- Intimate examinations which require evidence of performance are at the level of being ready for independent practice prior to completion of training as evidenced by EPA entries.

All trainees who commenced in training in July 2021 or later must **mandatorily** demonstrate their ability to perform the following five mandatory intimate examinations:

1. Breast examination;
2. Bimanual examination of the female pelvis;
3. Vaginal/vulval examination in women, considering also trans men;
4. Scrotal/penile examination in men, considering also trans women;
5. Digital rectal examination.

How EPAs Work in the Training Programme

Day to day clinical activity provides multiple opportunities to choose a learning opportunity on which a trainee can seek feedback and record a learning event. Even ordinary, relatively unremarkable clinical presentations can present rich learning opportunities, especially if they are considered according to domains, including primary care management, person centred care, specific problem solving, comprehensive approach, community orientation, and holistic care. Trainees must also demonstrate competency progression in each clinical post as evidenced through EPA records.

EPA feedback is recorded in the trainee e-portfolio. Trainees are expected to record EPA feedback on **1-2 cases per week**. Depending on the case discussed or observed the trainee choses the most appropriate EPA and enters a brief case description making sure - to maintain compliance with confidentiality standards and GDPR requirements - that no identifiable and/or confidential and/or personal and/or sensitive information relating to any person(s) (patients/parents/guardians/carers etc.) is entered.

There are 3 EPA feedback tools:

1. CBD (case-based discussion) for feedback on a clinical experience where the feedback giver has not directly observed the trainee performance.
2. PIP-P (performance in practice - procedure or physical examination) for feedback on a procedure or physical examination that has been directly observed or partially observed by the feedback giver.
3. PIP-C (performance in practice - consultation) for feedback on a consultation has been directly observed or partially observed by the feedback giver.

The relevant tool is chosen. Following a feedback conversation between the trainee and trainer, EPA domain supervision levels are agreed, and narrative feedback is documented.

It is important that the process of recording learning events is quick and efficient and not slowed up by attempting absolute precision in choosing the supervision level. The multiplicity of learning records will even out any small variance in individual entrustment decisions. The supervision levels have been designed to repeat similar themes and descriptions throughout all 18 EPAs. The format for each of the age-linked EPAs (1-12) is almost identical, with some minor changes to language to suit the circumstances. The general abilities addressed in each of the domains is consistent.

Throughout the process of training, both trainees and trainers are expected to uphold clear professional standards. While a doctor is in training, they must have an identified and available trainer**.** Trainees should be respectful of their trainer's time and other responsibilities, seeking

feedback only when it is appropriate to do so. Trainees should not send electronic feedback requests without having first discussed the case with their trainer. Trainees must deliver care that is safe, evidence-based, and patient-centred, while trainers must remain active, available, and engaged in their supervisory responsibilities**.** Trainers are expected to exercise reasonable, informed clinical judgment and supervision**.** The nature of EPAs supports both learners and teachers by providing a structured and traceable record of learning and supervisory decisions.

Trainer responsibilities (Medical Council Guide to Professional Conduct & Ethics for Registered Medical Practitioners, 9th Edition 2024) include:

- Ensuring trainees act within the limits of their competence.
- Providing constructive and timely feedback.
- Being thorough, fair, and objective in trainee assessment.
- Offering support to trainees who have problems with their performance.

While trainers are expected to provide active support, trainees must also respect their trainers time and take responsibility for their own learning objectives, engaging with feedback, seeking opportunities, and reflecting on performance.

Flagging EPA feedback

A trainer may flag an EPA feedback entry if a critical skill or knowledge gap is identified that could pose a future risk to patient safety if not addressed. Flagging indicates the need for targeted follow-up in the workplace, including the accumulation of EPA evidence demonstrating safe performance in this area. A flag is not necessarily an indication that the trainee is struggling; high-performing trainees may have a feedback entry flagged if an important but readily correctable issue is identified. The primary purpose of flagging an EPA is to highlight and support essential learning.

When an EPA entry is flagged, an automatic alert is emailed to the trainee's scheme mentor to notify them of the flagged entry in GPEP. Mentors will need to acknowledge this entry on GPEP. In addition to the automatic GPEP alert, trainers should ensure that any high-level concerns are communicated directly to the scheme directing team (e.g., by email or telephone). For lower-level flagged concerns, further direct notification may be undertaken at the discretion of the trainer. This approach seeks to preserve the openness and educational value of the feedback process by recognising that flagged entries can be appropriately addressed and resolved within the educational relationship between the trainee and trainer, without the need for immediate direct notification of the scheme directing team in every instance.

All flagged EPA entries are addressed in the workplace, and it is the trainee's responsibility to demonstrate that the flagged issue has been satisfactorily addressed, by providing further documented workplace-based EPA feedback as evidence. Flagged entries may be carried forward to subsequent clinical placements, both hospital and General Practice, until sufficient

workplace-based evidence is obtained to support their resolution. It is preferable for flagged entries to be formally marked as resolved in GPEP by the clinical supervisor who addressed the issue, rather than by the scheme directing team or the Competency Progression Committee. However, this may not always be feasible for hospital-based supervisors.

Recommended timeframe for recording EPA feedback

Timely feedback following a clinical encounter enhances its specificity, relevance, and educational impact, making it more actionable for the trainee. Accordingly, EPA feedback entries should be completed as soon as possible after the encounter. As a general guide, entries should be initiated within two weeks of the clinical event and finalised within four weeks of commencement, with these timeframes representing upper limits to support quality and effectiveness. **Trainers may decline a request to provide feedback when feedback is not requested in a timely manner.**

Ensuring Effective Trainer Feedback

Effective feedback should be grounded in evidence about a trainee's performance of professional work. The purpose of EPA feedback is not simply to judge performance, but to support the trainee's progression towards safe, effective, and independent practice. High-quality feedback provides evidence about current performance, relates it to the expectations of the EPA, and identifies practical steps that will support further development.

Feedback should describe aspects of performance rather than assigning broad labels or making global judgements. For example, statements such as "Excellent communicator" or "Poor decision-maker" provide limited guidance for improvement. More useful feedback identifies the specific performance that contributed to that judgement i.e., "I observed that you explored the patient's ideas, concerns and expectations before agreeing a management plan, supporting patient-centred decision-making." or " When we discussed the case, you identified the need for anticoagulation but were less certain when balancing stroke and bleeding risk."

Using evidence-based language

The language used in feedback can influence how it is received and how useful it is to the trainee. Using evidence-based language helps trainers anchor feedback in observed performance rather than broad judgements. It also makes feedback more credible, easier for trainees to understand, and more likely to result in meaningful action.

Trainers may find the following phrases useful when structuring concise, evidence-based feedback relating to performance of an EPA:

- "I observed..."
- "I noticed..."
- "When we discussed the case..."
- "The impact of this was..."
- "This suggests that..."
- "Next time, consider..."

EPA narrative feedback framework

Box 1 outlines a practical approach to completing each component of the narrative feedback framework following an EPA observation or case-based discussion.

Areas of Strength
Describe specific aspects of performance demonstrated during the encounter.

Areas for Development
Identify one or two aspects of performance that could be strengthened in future similar situations.

Action Plan
Agree practical steps the trainee can take before the next similar clinical encounter.

Timeline
Specify when the trainee should revisit or practise the action plan.

Box 1. Narrative feedback framework

Box 2 shows an example of EPA narrative feedback relating to a directly observed consultation i.e., a PiP-C.

Brief case description
Rectal bleeding in an adult

Areas of Strength
I observed that you explored relevant red-flag symptoms and clearly explained the rationale for urgent referral. The patient appeared to understand and agree with the plan.

Areas for Development
To progress towards greater independence in this EPA, explore the patient's ideas, concerns, and expectations earlier in consultations involving potentially serious symptoms.

Action Plan

Next time, consider asking about patient concerns earlier in the consultation.

Timeline
Reflect on at least two similar consultations over the next two weeks and discuss at the next tutorial.

Box 2. Example of PiP-C narrative feedback.

Box 3 shows an example of EPA narrative feedback relating to a case-based discussion i.e., a CBD.

Brief case description
Acute Cough in an Adult

Areas of Strength
You identified clinical findings that reduced the likelihood of bacterial infection and used these to support a decision not to prescribe antibiotics.

Areas for Development
Continue developing strategies for discussing non-antibiotic management when patients may expect antibiotics.

Action Plan
Next time, consider how you would explain this decision and provide safety-netting advice.

Timeline
Review at next tutorial.

Box 3. Example of CBD narrative feedback.

Specific and actionable feedback helps trainees understand what they are doing well and where they can continue to develop. By using evidence-based language to describe observed performance and identify clear next steps, trainers can maximise the educational value of each EPA observation.

Conclusion

Your day-to-day supervisory interactions as a GP trainer are central to the entrustment process, allowing trainees to:

- Develop clinical skills and confidence
- Generate evidence for summative entrustment
- Support safe progression toward independent practice

Constructive, timely feedback is essential as it supports learning, clarifies expectations, and ensures entrustment decisions are informed and appropriate. Effective feedback should be specific, timely and linked to EPAs. By remaining actively engaged, making informed ad hoc entrustment decisions, and facilitating meaningful feedback conversations, you contribute to the development of confident, competent General Practitioners prepared for independent clinical practice.

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