Assessments

Information for Specialist Training Committees and Specialist Trainees in Palliative Medicine on Curriculum 2007 - 2010

This replaces the paper issued in October 2007, and is effective from August 1st 2010

SAC for Palliative Medicine

Assessments - Information for STCs and Specialist Trainees in Palliative Medicine, Spring 2010

Background

Under the direction of PMETB, all specialties reviewed their assessments for higher specialist trainees in 2007, producing a comprehensive assessment strategy. PMETB/GMC has published rigorous standards against which assessment strategies and methods are measured and for those that would like more detailed information, these can be found at www.GMC.co.uk. The assessment methods have been phased in, with the first set (Mini-CEX, DOPS and MSF) introduced in October 2007. Guidance was issued in October 2007 which included the anticipated new workplace based assessments from 2010. The last set of new workplace-based assessments, Case-based Discussion (CbD), Teaching Observation (TO) and Audit Assessment (AA), have now been piloted, and will be formally introduced **from 01/08/2010.**

In our assessment strategy, we have attempted to strike a balance between assessing the breadth of the curriculum and ensuring that specialist trainees and supervisors are not overwhelmed by the number of assessments required.
A detailed blueprint of assessment methods against all aspects of the curriculum is available on www.jrcptb.ac.uk.

SpRs who are following the 2004 curriculum are not required to undertake these assessments but are encouraged to do so, as they provide the best opportunity to demonstrate that the competencies in the curriculum have been achieved.

Transition Phase:

The introduction of the new assessment methods will be mandatory for trainees in StR posts following the 2007 curriculum. **The new assessments will be introduced prospectively pro-rata from 01/08/2010.** We anticipate that Specialty Training Committees and educational supervisors will take a pragmatic approach when deciding the minimum number of assessments needed for each trainee, taking into account the time available before the next ARCP/RITA, less than full time training, anticipated maternity leave, and so on. This will need to be decided as soon as possible to allow the assessments to be completed and to ensure that competence has been demonstrated before progression to the next year of training in 2011. However, it remains the responsibility of the trainee to ensure that at least the minimum number of assessments agreed has been successfully completed.

Out of Programme Training or Research (OOPT/OOPR):

Trainees who are considering taking out of programme training (OOPT), by applying prospectively to have this counted as part of their training programme, (ie those planning to train in other units or conduct research) will need to take particular note of the assessment requirements. It is expected that by the end of training, all StRs will have completed the total minimum number of assessments to a satisfactory standard described in the attached tables. Thus, in each of the three years in programme, they will need to complete more assessments than those stipulated in each of the years in the table. If this is not the case, credit will not be given for up to 12 months OOPT/R and they will receive a RITA E until assessments are complete. This will be applied pro rata as described above for those StRs currently in training and a pragmatic approach will be taken for those currently in OOPT. For example, a current StR counting a year of research as their third year of training would not be required to undertake the new assessments for years one and two that they have already completed, but would need to complete the minimum number of assessments for years three and four during their research period and the fourth year of training.

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Current requirements

The attached table outlines the requirements for assessments for each year of training from 2010 - 11. Trainees working less than full time will be assessed on a pro rata basis and will therefore undertake the same number of assessments as full time trainees over the course of their training.

It is very important that all major aspects of the curriculum are "sampled" during assessment to ensure that trainees are competent across the full range of subjects. We have therefore specified the areas that must be covered by Mini-CEX, Case-based Discussion (CbD) and DOPS listed below. The number of assessments specified is the *minimum* required and if a trainee scores low marks in any area this must be repeated to ensure that a satisfactory standard has been achieved. It will be expected that all assessments are placed in the trainee's portfolio and are reviewed at their ARCP.

Assessments may be done either by the educational supervisor or a nominee who the supervisor knows to be in a position to undertake assessments safely. This does not necessarily need to be a consultant colleague and could include SAS colleagues, more senior SpRs/StRs or consultants from another relevant specialty. Senior nurse colleagues may provide assessments for appropriate items in the curriculum such as communication skills and some DOPS. Each year, there must be *at least 2 different assessors* for Mini-CEX to ensure validity.

At present, there are no formal assessment methods for research or management and these will rely on the portfolio and educational/research supervisor's report.

Mini-Clinical Evaluation Exercise (Mini-CEX):

Mini-CEXs allow direct observation of doctor-patient interactions by different healthcare professionals (including the educational supervisor), where developmental feedback is provided immediately after the encounter. The observed process should take no longer than 15 minutes. Some will involve evaluation of clinical problems for symptom management but others will have an emphasis on aspects of communication, including breaking bad news, and managing family expectations. A minimum of six mini-CEXs will be completed in each of years ST3 and ST4 of training, four in ST5 and two in ST6.

The assessment programme (see Table 2) provides a list of the top 10 subject areas to be covered. Emphasis will be placed on the first seven of these during ST3 and ST4 and these will usually have a greater number of competency statements than for the other presentations i.e. increased sampling is required to ensure competence. By the end of ST3 the trainee will have to have demonstrated satisfactory competence in at least 50% of areas 1-7 of the top 10 topics, and by the end of ST4 the trainee must have demonstrated satisfactory competence in 100% of Topics 1-7. In the event of unsatisfactory performance in Mini-CEX, further assessments will be required and this information will be reflected in the trainee's portfolio at their ARCP/end-of-year RITA. Presentation areas 7-10 reflect the progression of the trainee's learning, and competence in these areas will be sampled more frequently in ST5 and 6. By the end of ST5 the trainee will have to have demonstrated satisfactory competence in at least 80% of the top 10 topics, and by the end of ST6 the trainee must have demonstrated satisfactory competence in 100% of the top 10 topics.

Direct Observation of Procedural Skills (DOPS):

DOPS is a structured checklist for the assessment of practical procedures. It is another doctor-patient observed encounter, using a different observer for each procedure where

possible. The observed process should take no longer than 15 minutes. The specific procedural skills required in the specialist curriculum usually reflect an emphasis on prompt relief of patients' symptoms. A minimum of four DOPS will be performed in each year of training. There is a list of 10 DOPS (see Table 2), all of which have to be satisfactorily achieved, and in two of which (syringe driver set up, paracentesis) competency has to be shown at all stages of training. In the event of unsatisfactory performance in DOPS, further assessments will be required and this information will be reflected in the trainee's portfolio at their ARCP/end-of-year RITA.

Multi-source Feedback (MSF):

MSF provides feedback from a range of co-workers across the domains of Good Medical Practice. Personal behaviours and attitudes can affect clinical practice and team dynamics, but it can be very difficult to obtain evidence that such behaviour is sufficiently disruptive to require addressing formally. MSF will be performed within 6 months of starting each placement (ie normally four in the four years of training), with each feedback form being returned directly to the educational supervisor. In addition, all trainees are expected to complete a self-assessment. If any aspect of feedback is unsatisfactory the Training Programme Director will be informed and specific interventions will be agreed between the trainee and educational supervisor, linked to their Personal Development Plan. Assessment of progress will be by repeating the MSF within 2 months of the end of the placement, and this information will be reflected in the trainee's portfolio at their end-of-year RITA. Repeated unsatisfactory MSF will result in targeted or repeat training and if MSF does not become satisfactory will result in the trainee being removed from the programme and not receiving a CCT.

Newly introduced assessments

Case-based Discussion (CbD):

CbD is a structured discussion of real clinical cases managed by the trainee. Its particular strength is evaluation of their clinical reasoning and decision-making. The trainee prepares two cases and the educational supervisor (or appointed nominee) chooses one as a basis for a structured discussion involving feedback, which should take no longer than 30 minutes. A minimum of four CbDs will be completed in each year ST3, 4, 5, 6.
There is a list of the top 20 presentation subject areas (see Table 2), and 70% of these will normally have been sampled by the end of specialist training. Emphasis will be placed on the first 11 of these during ST3 and ST4 which may have a greater number of competency statements than for the other presentations i.e. increased sampling is required to ensure competence. By the end of ST3 the trainee will have to have demonstrated satisfactory competence in four (36%) of areas 1-11 of the top 20 topics, and by the end of ST4 the trainee must have demonstrated satisfactory competence in eight (72%) of Topics 1-11. In the event of unsatisfactory performance in CbD, further assessments will be required and this information will be reflected in the trainee's portfolio at their ARCP/end-of-year RITA.

Presentation areas 12-20 reflect the progression of the trainee's learning and skills, and competence in these areas will be sampled more frequently in ST5 and 6. By the end of ST5 the trainee will have to have demonstrated satisfactory competence in twelve (60%) of the top 20 topics, and by the end of ST6 the trainee must have demonstrated satisfactory competence in fourteen (70%) of the Top 20 topics.

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Audit Assessment (AA)

Experience of the audit cycle, (including defining criteria, collecting data, identifying and implementing change) are essential for trainees, since as consultants they will be expected to fulfil clinical governance requirements by demonstrating maintenance and improvement of the quality of patient care through audit.

Each trainee will complete a minimum of two audit assessments during their four year training, playing a leading part in the first audit and supervising the second. The assessment tool can be downloaded from the JRCPTB website. In the event of unsatisfactory performance further assessments will be required, and this information will be reflected in the trainee's portfolio at their ARCP.

Teaching Observation (TO)

Teaching in different contexts (eg. large/small groups, undergraduate/postgraduate, to medical/non-medical staff), is an integral part of every specialist's training that continues into their role as a consultant. Trainees will be expected to take a full part in the teaching programme of each placement during their training years. Evidence will include observed assessment (by educational supervisor or appointed nominee) of teaching and presentation skills and participant feedback. The Teaching Observation tool can be downloaded from the JRCPTB website. In the event of unsatisfactory performance, specific interventions (eg. attendance at a Presentation Skills course) will be agreed between trainee and supervisor, linked to their Personal Development Plan. This information will be reflected in the trainee's portfolio at their ARCP.

Specialty Certificate Exam (SCE)

The Specialty Certificate Exam (SCE) is expected to be introduced in 2011/12. It will be run by the MRCP Office in the format of "best of 5" answers. Trainees who begin ST5 around the time that the exam is introduced will be expected to pass it before they are recommended for a CCT. It will be run annually. As the exam is in an early stage of development, we cannot give a clear indication of when it will be introduced. The SAC will write to trainees with more information when it is available, giving due notice of any expectations.

Research

Each trainee will demonstrate knowledge of the research process against the competencies set out in the specialty curriculum. Evidence will include presentation of original research, a thorough literature review (oral or written abstract), development of a clinical guideline or audit based on a thorough literature review, or a published paper. Personal involvement in research will be assessed by the trainee's educational supervisor, or by their research supervisor in the case of original research. In the event of unsatisfactory performance further assessments will be required, and this information will be reflected in the trainee's portfolio at their ARCP.

Management

During ST5/6 the trainee is expected to discuss and arrange with their educational supervisor opportunities to lead MDT meetings, become involved in induction for junior doctors, experience involvement with recruitment, staff development, disciplinary procedures, financial management and running a palliative care unit. Each trainee will be expected to have attended a management programme by the end of ST6. Study leave will be approved by their educational supervisor and related to their agreed learning objectives. Evidence of involvement may include written reflection of the study day/course attended and formal feedback to colleagues. In the event of unsatisfactory

attendance or involvement the Training Programme Director will be informed and specific interventions will be agreed between the trainee and supervisor, linked to their Personal Development Plan. Evidence will be included in the trainee's portfolio at their ARCP.

The Record of Reflective Practice (RRP) is not seen as a formal assessment method as it has not undergone formal validation. However it is a core part of the specialist curriculum, recording particularly challenging or very personal experiences during work-place training. PMETB has acknowledged its place in the assessment programme as a valuable tool to encourage the practice of reflection and inform appraisal. A minimum of two records of reflective practice is expected in each year of specialist training. Whilst there is no requirement for the RRP material to be included in the trainee's portfolio at their ARCP, a summary of the structured feedback given by the Educational Supervisor should be included as evidence that reflection has taken place and is related to the trainee's stated learning objectives.

Training in conducting assessment methods

A further specialty-specific training session will be offered by the Royal College of Physicians to include these new assessments. Training is also being offered by Deaneries. It is expected that ***all*** educational supervisors and appointed nominees should undergo training in conducting assessments. If you would like training or more information, please contact your local Head of Specialty Training who will co-ordinate requests.

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TABLE 1: ARCP Decision Aid for Palliative Medicine for 2011 and beyond for trainees on the 2007 curriculum

Minimum standards for satisfactory progress at ARCP/

Curriculum Topic(s)	ARCP/RITA Year 1 (ST3)	ARCP/RITA year 2 (ST4)	ARCP/RITA year 3 (ST5)	ARCP/RITA year 4 (ST6)	ARCP/RITA year 5 (only post RITA E)
Specialty Certificate Exam			Passed *RITA D if not passed	RITA E if not passed	
Mini-CEX [1]	6 satisfactorily completed	6 satisfactorily completed	4 satisfactorily completed	2 satisfactorily completed	
DOPS	4 satisfactorily completed	4 satisfactorily completed	4 satisfactorily completed	4 satisfactorily completed	
MSF	1 satisfactorily completed	1 satisfactorily completed	1 satisfactorily completed	1 satisfactorily completed	
CBD[2]	4 satisfactorily completed	4 satisfactorily completed	4 satisfactorily completed	4 satisfactorily completed	
Teaching observation	1 satisfactorily completed	1 satisfactorily completed	1 satisfactorily completed	1 satisfactorily completed	
Audit Assessment		1 audit assessment		1 audit assessment to include supervision of the audit	
Evidence of experience of Research process		Evidence of satisfactory preparation for project/audit or guideline development based on sound research competencies		Research project /evidence-based audit or guidelines satisfactorily completed with evidence of competencies	
Management		Evidence of leading MDT	Evidence of leading MDT, involvement in induction of junior doctors	Evidence of contribution to senior management meetings, recruitment process	
Attendance	Satisfactory educational supervisor report	Satisfactory educational supervisor report	Satisfactory educational supervisor report	Satisfactory educational supervisor report	
Minimum number of work place assessments	17	17	15	13	

Mini-CEX[1] By the end of ARCP Year 1 the trainee must have demonstrated competence in at least 50% of areas 1-7 of the top 10 topics. By the end of ARCP Year 2 the trainee must have demonstrated competence in 100% of Topics 1-7. By the end of ARCP Year 3 the trainee must have demonstrated competence in at least 80% of the top 10 topics. By the end of ARCP Year 4 the trainee must have demonstrated competence in 100% of the Top 10 topics.

CBD[2] By the end of ARCP Year 1 the trainee must have demonstrated competence in four (36%) of areas 1-11 of the top 20 topics. By the end of ARCP Year 2 the trainee must have demonstrated competence in eight (72%) of Topics 1-11. By the end of ARCP Year 3 the trainee must have demonstrated competence in twelve (60%) of the top 20 topics. By the end of ARCP Year 4 the trainee must have demonstrated competence in fourteen (70%) of the top 20 topics.

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Table 2:

10 top subjects for Mini-CEX [reference(s) to curriculum indexed in red]

1. Communication (eg. of prognosis, of therapeutic goals, with relatives, with team, family conflict) [1.3, 2.3.1, 2.4, 3.2]

2. Clinical evaluation of concurrent clinical problems [2.1.3] eg.
   - respiratory disorder (eg. COPD, chest infection)
   - cardiovascular disorder (eg. IHD, heart failure, arrhythmia, hypotension)
   - peripheral vascular disease
   - peripheral neuropathy
   - anxiety, depression, psychoses
   - pre-existing chronic pain

3. Clinical evaluation/examination for symptom management [2.2.1 & 2.2.2 & 2.2.3] eg.
   - history taking and physical examination for pain assessment/investigation
   - history taking and appropriate examination for other symptom control assessment or clinical problem (eg. SOB, dysphagia, ascites, obstruction, wound breakdown)

4. Clinical evaluation of emergencies [2.2.4] eg.
   - spinal cord compression
   - SVCO

5. Managing family conflict in relation to unrealistic goals [2.4]

6. Assessing the dying patient [2.5]

7. Clinical evaluation of ongoing care of dying patient eg. symptom review, medications, spiritual needs, care pathway [2.5]

8. Critical evaluation of own consultation skills [3.2]

9. Evaluation of psychological response of patient & relatives and to illness (eg. dealing with anger, denial, patient with previous psychiatric illness) [3.3]

10. Evaluating spiritual and religious needs [4.2]

List of required DOPS [2.2.2, 2.2.5, 6.1, 6.2, 10.4]

1. TENS application
2. Paracentesis**
3. Pleural aspiration
4. Urethral catheterization (male and female)
5. Syringe driver set up**
6. Nebuliser set up
7. Passing a nasogastric tube
8. Controlled drug storage
9. Death certification & cremation form procedures
10. Collection and use of service data including NCPC Minimum Data Set

** Competency has to be demonstrated four times in the four years of training

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20 top subjects for CbD: [Reference(s) to curriculum indexed in red]

1. Communication eg. between services, prognosis, with relatives, team, family conflict [1.3, 2.3.1, 2.4, 3.2]
2. Recognition, assessment and management of critical change in patient pathway (eg from symptom control to terminal care) [2.1.1, 2.5]
3. Shared care (including services available in different settings) [2.1.1, 2.1.4]
4. Management of concurrent clinical problems (eg. respiratory, CVD, depression) [2.1.3]
5. Management of symptoms/clinical problems (including intractable symptoms) [2.2.1, 2.2.3]
6. Symptoms as sensory, psychological and social experience for patients and impact on carers [2.2.1]
7. Therapeutic options & appropriate choice of treatment/non-treatment [2.2.1]
8. Opioid use (including opioid switching) [2.2.2]
9. Other interventions in pain management (eg. non-drug, nerve blocks, psychological) [2.2.2]
10. Management of emergencies (eg. total pain, SCC, acute confusional states) [2.2.4]
11. Pharmacology/therapeutics (eg. drug dose in altered metabolism, use of drugs outside licence, polypharmacy, syringe drivers, refusal of treatment, resuscitation guidelines) [2.3.2, 6.2]
12. Psychosocial care (eg. impact of illness, family meetings, family dynamics) [3.1]
13. Psychological responses of patients and carers to life-threatening illness and loss [3.3]
14. Self-awareness and insight (eg. personal values, belief systems, skills, limitations, conflict between doctor-pt) [3.4]
15. Grief and bereavement (eg. preparing carer/children for bereavement, supporting acutely bereaved, knowledge of services) [3.5]
16. Patient and family finances (only mentioned because not really covered by any other assessment in curriculum [3.6]
17. Culture, ethnicity, religion, spirituality (eg. awareness/conflict of personal beliefs/attitudes, distinguishing between spiritual and religious needs, need for hope [4.1, 4.2]
18. Ethics (eg. consent, confidentiality, conflicts of interest, withholding and withdrawing treatments) [5.2]
19. Doctor/patient relationship (eg. capacity, wills, autonomous/non-autonomous patients) [6.3]
20. Teamwork & leadership (eg. skill mix, roles, conflict, motivating & leading a team) [7, 10.2]

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Appendix

Worked examples of assessment requirements

These examples are designed to illustrate what is required in different circumstances for the new assessment methods; CbD, Audit Assessment and Teaching Observation.

Trainee in ST5 on maternity leave 01/08/2010 - 01/02/2011, ARCP July 2011
This is a complete 6 month gap in training. Assessments will be expected on return to work - representing only 6 months of training time, ie. Mini-CEX (2), DOPS (2), CbD (2) etc.pro rata for less than full time training. There is no expectation that additional assessments will be needed to be "banked" before going on maternity leave.
If however, the trainee elects to count 3 months maternity leave towards their CCT, the assessments that would have been done in those 3 months must be completed in the time available over the rest of their training. They should be completed at the earliest opportunity and this should be decided on discussion with the educational supervisor +/- the Head of Specialty Training.

Trainee in ST4 hoping to undertake 12 months Out of Programme Research during training
The complete number of assessments will be required over the 4 years. It is therefore very strongly advised to undertake more than the minimum number of assessments for each year of training - both before and after the research period. Some research projects allow for assessments during the project but this cannot be assumed. If the trainee is organised early, they can do 1/3 extra assessments in each year. If they start later, the number will need to be increased. The number of additional assessments (CbD, teaching and audit) will be counted from 01/08/2010.
For example, a trainee returning from a period of research into the beginning of ST5 on or after August 1st 2010, will need to have done all the first 2 years assessments ie MSF (2), Mini-CEX (12), DOPS (8) for a satisfactory ARCP - unless the educational supervisor and Head of Specialty Training agree to spread these assessments over a longer period of time. They will then need to do the final 2 years assessments as outlined in Table 1.

Trainees with part-year training
Trainees who start their training or who have breaks at different times of the year, will need to demonstrate a pro rata number of assessments, using 01/08/2010 as the date of introduction of the new assessments.

Trainees who were employed before October 2007

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Trainees are not expected to do assessments for the years (or part years) of training they completed before the assessments were introduced in October 2007.