



Recommendations for specialty trainee assessment and review

Incorporating lessons learnt from the
workplace-based assessment pilot

Implementation August 2014

Executive summary

In August 2012 the Joint Royal Colleges of Physicians Training Board (JRCPTB) set up a pilot study to introduce and evaluate the use of formative supervised learning events (SLEs) and summative assessments of performance (AoPs).

The lessons learnt from the pilot – together with feedback from trainee and trainer surveys, specialist advisory committees (SACs) and heads of schools of medicine – have contributed to a series of recommendations for the system of assessment and review of training which will be implemented in August 2014.

Key recommendations:

- > AoPs did not function well as summative assessments and will not be part of our assessment strategy.
- > SLEs will continue to use the established set of tools of mini-clinical evaluation exercise (mini-CEX), acute care assessment tool (ACAT) and case-based discussion (CbD) and the forms will focus on constructive feedback and action plans.
- > The educational supervisor's report is pivotal to the annual review of competence progression (ARCP) process. The educational supervisor should report on the trainee's engagement with the curriculum and learning demonstrated through SLEs and other evidence. The report must also include a summary of feedback received via the multiple consultant report (MCR) and multi-source feedback (MSF).
- > The minimum number and type of SLEs will be clearly defined for each specialty by the SACs and will be documented in the ARCP decision aids.
- > The number of links to curriculum competencies for each SLE will be limited.
- > Trainees may link SLEs and other evidence to curriculum competencies in order to demonstrate engagement with and exploration of the curriculum. The trainee has to make a judgement as to the evidence needed.
- > Supervisors should sample the evidence linked to competencies in the ePortfolio. It is not necessary to examine all the competencies to determine a trainee's engagement with the curriculum and to make a judgement on the trainee's progress.
- > A number of medical specialty curricula have large numbers of competencies (in some cases more than 100). We are developing checklists for core medical training (CMT) and acute internal medicine (AIM) to guide trainees and supervisors during specialty placements on the potential for group sign off of competencies.
- > Ten of the common competencies will not require linked evidence in the ePortfolio.
- > Detailed guidance on the assessment and review requirements will be provided for trainees, supervisors and ARCP panels via the ePortfolio and JRCPTB website.

Background

The case for change

The Academy of Medical Royal Colleges, Conference of Postgraduate Medical Deans and the General Medical Council held a joint forum in November 2010 which debated whether WPBA was fit for purpose and queried how effectively and consistently current systems were being applied.

In 2011 the GMC published a discussion paper *Learning and assessment in the clinical environment – the way forward*, which proposed the introduction of new terminology to distinguish between two purposes of assessment: formative assessment for learning through SLEs, and summative assessment used to determine progress referred to as AoPs.

In 2012, a JRCPTB survey of over 500 trainees found that 67% said WPBAs were too time-consuming, with a large proportion concerned that their supervisors did not have time to complete the assessments, often leaving the trainees to complete them – including feedback. A survey of supervisors showed that two-thirds did not find WPBAs effective in identifying under-performing trainees.

It was never intended that WPBAs should be used to confirm every competence in the curriculum, but the advent of the ePortfolio allowed detailed recording and linkage of assessments and other evidence to multiple competencies, creating what many felt to be an unproductive 'tick box' culture.

A pilot study of formative and summative WPBA

A JRCPTB working group was set up to review the above concerns. The group began with the premise that assessments should be performed better, with emphasis on feedback and trainee reflection, and carried out at appropriate intervals through the training year. The group also wanted to promote the crucial role of clinical and educational supervisors and their reports in the overall assessment and review process.

A study was set up to evaluate the revised assessment system's feasibility and acceptability by piloting SLEs and AoPs with trainees and their supervisors in core medical training and nine specialties within three deaneries (Northern, East Midlands North and Wales) starting in August 2012.

The JRCPTB commissioned RCP London's education department to carry out an evaluation process, which included obtaining feedback from trainees and trainers using focus groups and online questionnaires. In addition, anonymised data were derived from analysis of WPBAs recorded on the ePortfolio. Further information on the WPBA pilot and the evaluation report is available via the JRCPTB website (www.jrcptb.org.uk). The key findings are as follows:

- > WPBAs were often performed retrospectively without direct observation and there was some confusion regarding the purposes of SLEs and AoPs which reduced the validity of the tools.

- > Trainees and trainers did perceive SLEs as teaching tools during the pilot, but the timing and quality of feedback was variable. More guidance was needed on the importance of effective feedback and development of action plans following SLEs.

- > AoPs were less feasible than SLEs in the clinical environment. AoPs were unsuccessful as either learning tools or summative assessments.

- > ARCP decision aids were not felt to be consistent or sufficiently clear. ARCP requirements should be well-defined and readily accessible to trainees and trainers.

The JRCPTB also implemented the following in August 2012 as a part of the review process:

- > Assessments should take place throughout the training year; clustering of assessments prior to an ARCP panel was not acceptable.
- > Introduction of specific assessment forms for core medical training and higher specialty trainees (HST) using different anchor statements in the rating scales.
- > 'Radio buttons' for scoring sections on WPBA forms removed and replaced with free-text boxes (HST only).
- > CbDs, mini-CEX, ACATs categorised as SLEs in the ePortfolio.
- > Directly-observed procedural skills (DOPS) separated into two categories of routine and life-threatening procedures, with a clear differentiation of formative and summative sign off.

Summary

This document outlines the JRCPTB recommendations for specialty trainee assessment and review to be implemented for the academic training year commencing in August 2014.

There are no wholesale changes of the current assessment framework; the focus is on SLEs as tools for learning and demonstrating trainees' engagement with the learning process and with the curriculum. The burden of assessment and the time spent linking and reviewing evidence against competencies has been reduced to allow time for more productive educational activity and appraisal.

Changes will be made to the ePortfolio to facilitate the recommendations and we will also explore an improved format for how evidence of educational activity is presented to ARCP panels. The JRCPTB will provide detailed guidance and communications to support trainees, trainers and training programme directors.

Recommendations for specialty trainee assessment and review

Supervised learning events

- > We have embraced the recommendations of the GMC and have designated mini-CEX, ACAT and CbD as SLEs.
- > SLEs are formative and require high-quality trainer feedback, trainee reflection and action plans. The SLE form focuses on capturing constructive feedback on what was done well and areas for improvement. Trainer feedback will include giving the trainee information about their level of knowledge and performance, using anchor statements.
- > SLEs may be linked to curriculum competencies in the ePortfolio as evidence of engagement with, and exploration of, the curriculum. However, it is not appropriate for an SLE to be linked to large numbers of competencies and for this reason the number of links should be limited to eight for an ACAT, while the CbD and mini-CEX may each be linked to two competencies in the curriculum.
- > Each specialty will provide indicative guidance as to the numbers of SLEs and the types of other evidence which a trainee should record in the ePortfolio. It is important that educational supervisors, training programme directors and trainees have clear guidance, and that the same standards apply throughout the UK.
- > The results of SLEs will not feed directly into the ARCP process but the educational supervisor report will include evidence of engagement and progression demonstrated through SLEs and other evidence in the ePortfolio. ARCP panels should not explore the SLEs to determine trainee progression but will be expected to review feedback and action plans for underperforming trainees.

Assessments of performance

- > Assessments of performance did not function well as summative tests and will not be part of our strategy.

Direct observation of procedural skills

- > DOPS have not been altered for 2014 and will continue to be used as tools to assess the performance of trainees in undertaking practical procedures, against a structured checklist. It is essential that trainees receive immediate feedback to identify strengths and areas for development.
- > DOPS will continue to be separated into two categories of routine and life-threatening procedures with a clear differentiation of formative and summative sign off. Formative DOPS for routine and potentially life-threatening procedures should be undertaken before doing a summative DOPS and can be undertaken as many times as the trainee and their supervisor feel is necessary.

Multiple consultant report

- > The MCR was introduced in October 2013 as a tool to obtain structured feedback on trainees' clinical abilities from a range of supervisors. For most specialties, trainees will be expected to obtain reports from four to six consultants. The requirement has been reduced or removed for some specialties with fewer supervisors at the request of the SAC.
- > MCR forms are automatically collated in the ePortfolio and should be reviewed during appraisal meetings with the educational supervisor. The feedback will provide important information to help the educational supervisor to form an opinion on the trainee's progress and will be included in the educational supervisor report to the ARCP panel, along with details of any action taken to address concerns raised.
- > MCR results are shared in full with the trainee, unlike the confidential MSF reports which are only shown in anonymised form. Unsatisfactory comments in the MCR must be supported by evidence.
- > Guidance on the use of the MCR, including specialty requirements, is provided on the JRCPTB website.

Multi-source feedback

- > MSF will remain unchanged and will continue in its current format.

Audit assessment and Quality improvement project assessment tool

- > The audit assessment tool was designed to provide structured, formative feedback and will continue in its current format.
- > The quality improvement project assessment tool (QIPAT) is used in core medical training, general internal medicine (GIM) and acute internal medicine (AIM) to assess a trainee's competence in completing a quality improvement project. It is a formative tool and will continue to be used in these specialties as an alternative to audit assessment.

Teaching observation

- > The teaching observation tool was designed to provide structured, formative feedback and will continue in its current format.

Patient survey

- > The patient survey (PS) will remain unchanged and will continue to be used in its current capacity.

Information on these assessment tools is available on the JRCPTB website.

Linking of evidence and signing off curriculum competencies

- > The competencies to be explored in each placement should be agreed by the trainee and the educational supervisor, and recorded at the first appraisal meeting. The level of competency expected and the number/percentage of competencies to be explored by the trainee at each stage of training are described in the curriculum and the ARCP decision aid for each specialty.
- > The trainee will provide evidence of exploration of the agreed competencies by linking evidence in the ePortfolio (such as SLEs, DOPS, reflection, eLearning programme or tutorial (note that linkage of SLEs to individual competencies should be limited as described above)). It is acceptable for competencies to have only one piece of linked evidence if the trainee feels this shows engagement and the supervisor agrees.
- > Some specialties have divided the knowledge, skills and behaviours in the curriculum into a large number of individual competencies (119 in CMT and GIM, 116 in AIM). We are developing checklists for CMT and AIM to indicate the likely competencies to be encountered during specialty placements. This will allow group sign off of relevant competencies, based on the supervisor's deep knowledge of the trainee's performance.
- > Ten of the common competencies in the curriculum describe fundamental aspects of a doctor's knowledge, skills and behaviours which are best addressed by the MSF, MCR and/or PACES element of the MRCP(UK) and feedback on these areas will be received and documented in appraisal and educational supervisors' reports. It will therefore not be necessary for trainees to link additional evidence to these competencies in the ePortfolio. Please see appendix 1.
- > The trainee should assign a rating from the prescribed drop down list for each competency or group of competencies explored to indicate that they have met the level expected for the stage of training (eg 'satisfactory' or 'level 1 competent'). The trainee may wish to indicate that they require further development in an area of the curriculum if appropriate and discuss this with their educational / clinical supervisor. Comments supporting the self-rating should be recorded in the box provided.
- > Educational and clinical supervisors should determine the engagement of the trainee with learning and the curriculum at regular intervals during placements, beginning after 2–3 months. This should be done by reviewing the ePortfolio and sampling the evidence linked by the trainee to the competencies. The supervisor should discuss with the trainee the linked evidence and trainee's self-rating in addition to any feedback received from clinical supervisors and others in the multi-disciplinary team.
- > The supervisor should determine whether the trainee's self-rating of curriculum coverage is appropriate and record their own rating against the competencies, with feedback. This process should take place at the mid-point and end of placement reviews as a minimum and the outcome should be recorded in the appraisal documentation.
- > For a supervisor to examine every competence in a curriculum with large numbers of competencies is likely to be unproductive for both trainee and trainer. The process of sampling the trainee's evidence in the ePortfolio forms the basis on which the educational supervisor can confirm that the trainee has engaged with learning and explored the curriculum.
- > JRCPTB recommends that a total of 10–12 competencies are explored by sampling during the course of the training year (unless there are concerns about an individual trainee in which case more may be required). For CMT, GIM and AIM, this will mean around 10% of competencies should be sampled in trainees who are making satisfactory progress.

The role of the educational supervisor

- > The key role of the educational supervisor in the learning process cannot be over-emphasised. They help to determine the quality of training and assessment and are responsible for identifying trainees who need additional support. The educational supervisor's report is central to the success of the ARCP process.
- > The educational supervisor should ensure induction, midpoint and end of attachment appraisal meetings take place (this may be devolved to the clinical supervisor in core medical training) and that the appropriate competencies to be covered in each placement are discussed and agreed. The appraisal reports should be completed throughout the year and should inform the final educational supervisors' report.
- > In the educational supervisors' report to the ARCP panel, the educational supervisor will make an overall judgement on the progress of the trainee based on all the evidence, including SLEs and the trainee's response to action plans. The educational supervisor has to include reports on the MCR, MSF, and the SLEs. The educational supervisors report will be modified to take into account the recommendations.
- > Detailed guidance on the role of the educational supervisor and completion of appraisal documentation and the educational supervisor report will be provided.

Annual review of competence progression

- > The ePortfolio curriculum record should be used to present evidence that enables the ARCP panel to determine whether satisfactory progress is being made to proceed to the next phase of training.
- > The educational supervisor's report, including the summary of feedback from clinical supervisors and the MSF, is pivotal to the ARCP process. The results of SLEs will not feed directly into the ARCP process but the report will include evidence of engagement and progression demonstrated through SLEs and other evidence in the ePortfolio. ARCP panels should not explore the SLEs within the ePortfolio to determine trainee progression but will be expected to review feedback and actions plans for underperforming trainees.
- > The targets that have to be achieved for a satisfactory ARCP outcome at the end of each training year will be clearly defined for each specialty in the ARCP decision aids.

Summary and key points

- > There are no significant changes to curricula or to assessment tools as set out by the JRCPTB and approved by the GMC.
- > SLEs will utilise the methods of ACATs, CbDs and mini-CEX as trainee-led formative tools for learning. These tools can also show evidence of engagement with the curriculum but the number of ePortfolio links should be limited (eight for ACATs, two for CbDs and mini-CEX).
- > Implementation of the recommendations will achieve a reduction in the burden of assessment while emphasising the positive developmental benefits of supervisor and trainee interaction in the workplace. Guidance will be provided to assist trainees and trainers in understanding the use of SLEs.
- > The ePortfolio will be developed to allow more intuitive grouping of competencies, clearer presentation and summary views of educational activity for both supervisors and ARCP panels. We will work with the specialties to take this forward.

For further information, visit:
www.jrcptb.org.uk/assessment

Appendix 1

Common competencies not requiring linked evidence in the ePortfolio

The common competencies in the curriculum describe fundamental aspects of a doctor's knowledge, skills and behaviours.

The ten common competencies below are repeatedly observed by supervisors and feedback on these skills and behaviours is received through the MSF, MCR and PACES element of the MRCP(UK). This should be recorded in the appraisal and educational supervisors' reports.

Trainees should receive formative feedback on these competencies when undertaking SLEs. However, it has been agreed that it will not be necessary for trainees to link SLEs to these competencies in the ePortfolio.

- > History taking
- > Clinical examination
- > Therapeutics and safe prescribing
- > Time management and decision making
- > Decision making and clinical reasoning
- > Teamworking and patient safety
- > Managing long-term conditions and promoting patient self care
- > Relationships with patients and communication within a consultation
- > Communication with colleagues and cooperation.
- > Personal behaviour.