Assessment Methods in the New Curriculum

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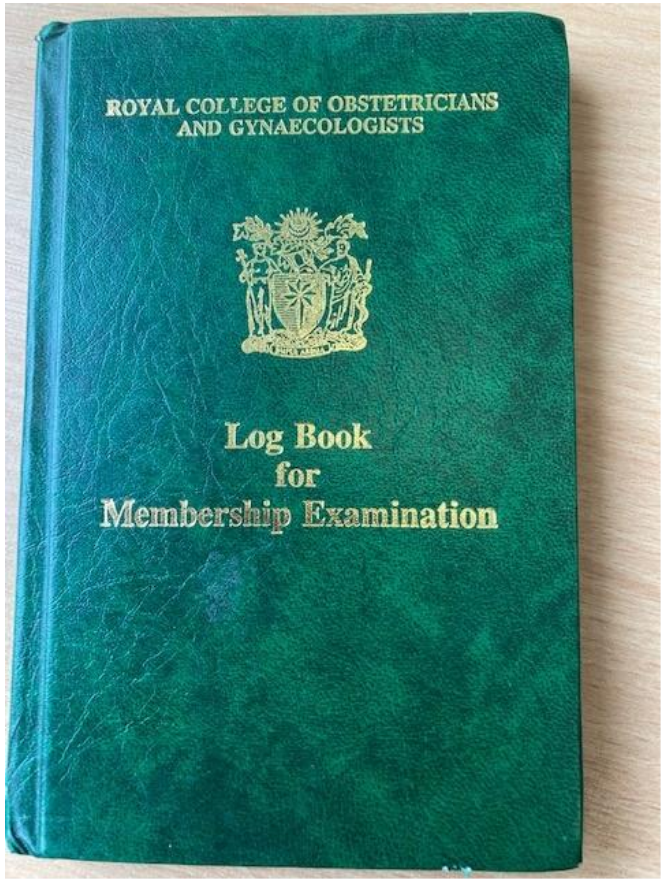
My Reflection Pre Calman



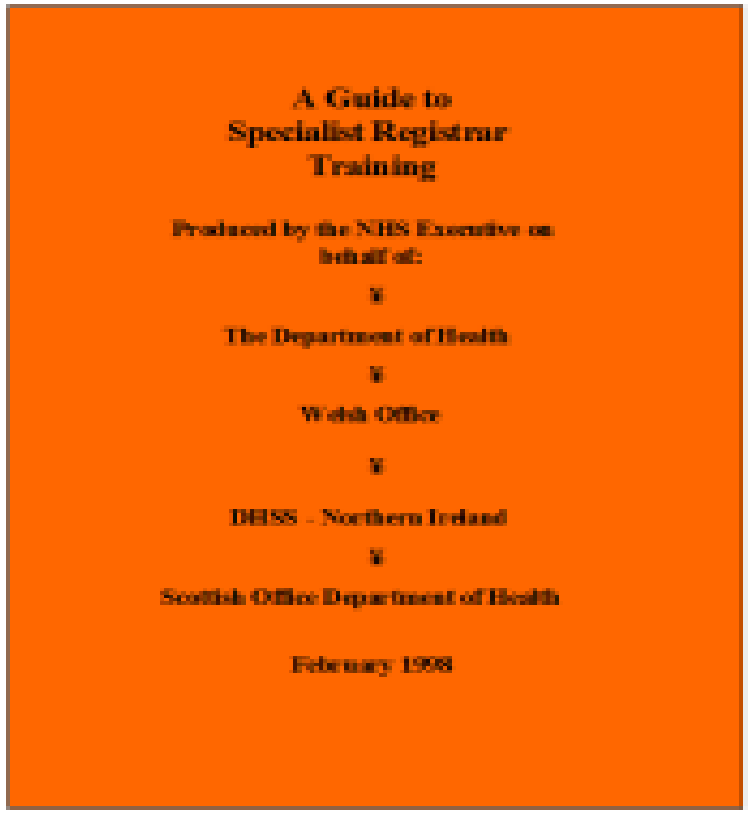
Calman Report 1993

“produce a shorter, more structured and organised training pathway so that independent clinical competence as a consultant can be achieved much earlier than in the past in many disciplines”.

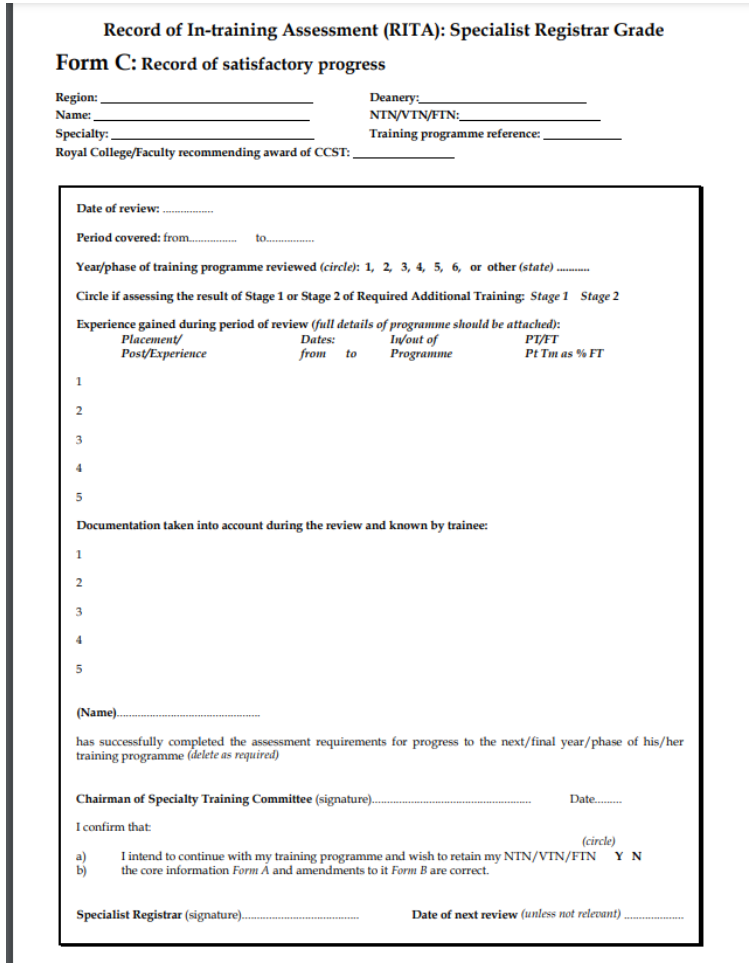
The key features of the new grade may be summarised as:

- Explicit educational and service entry requirements for admission to training programmes.
- Competitive entry.
- A shorter duration of training for most specialties.
- More intensive, managed training.
- **Progress dependent on educational attainment.**
- Graded service responsibility as the trainee progresses.

RITA, Orange Guide 1998



The Orange Guide



Record of In-training Assessment (RITA): Specialist Registrar Grade

Form C: Record of satisfactory progress

Region: _____ **Deanery:**_____
Name: _____ **NTN/VTN/FTN:**_____
Specialty: _____ **Training programme reference:** _____
Royal College/Faculty recommending award of CCST: _____

Date of review: .....

Period covered: from..... to.....

Year/phase of training programme reviewed *(circle)*: **1, 2, 3, 4, 5, 6, or other** *(state)* .....

Circle if assessing the result of Stage 1 or Stage 2 of Required Additional Training: *Stage 1 Stage 2*

Experience gained during period of review *(full details of programme should be attached)*:

	Placement/ Post/Experience	*Dates: from to*	*In/out of Programme*	*PT/FT Pt Tm as % FT*
1				
2				
3				
4				
5				

Documentation taken into account during the review and known by trainee:

1
2
3
4
5

(Name).....

has successfully completed the assessment requirements for progress to the next/final year/phase of his/her training programme *(delete as required)*

Chairman of Specialty Training Committee (signature)..... Date.....

I confirm that:

(circle)

a) I intend to continue with my training programme and wish to retain my NTN/VTN/FTN **Y N**
b) the core information *Form A* and amendments to it *Form B* are correct.

Specialist Registrar (signature)..... **Date of next review** *(unless not relevant)* .....

Workplace Based Assessments

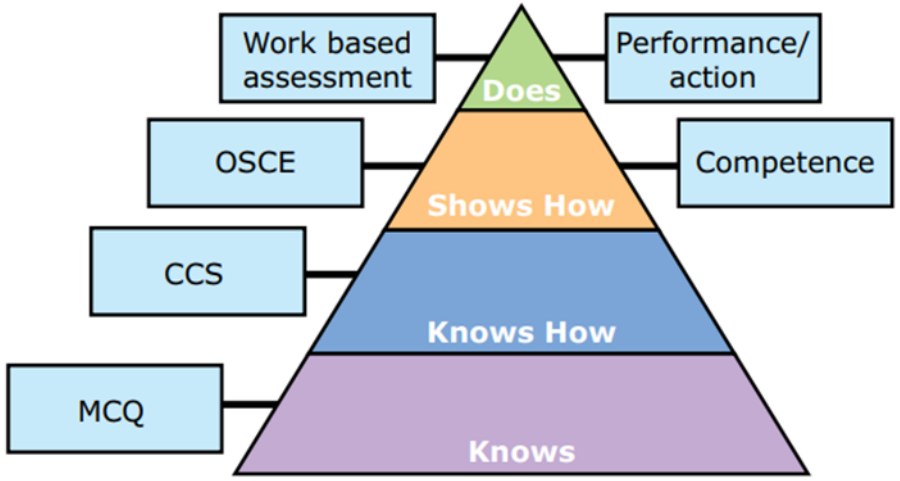


Figure 3: Miller's Pyramid

- Introduced 2005

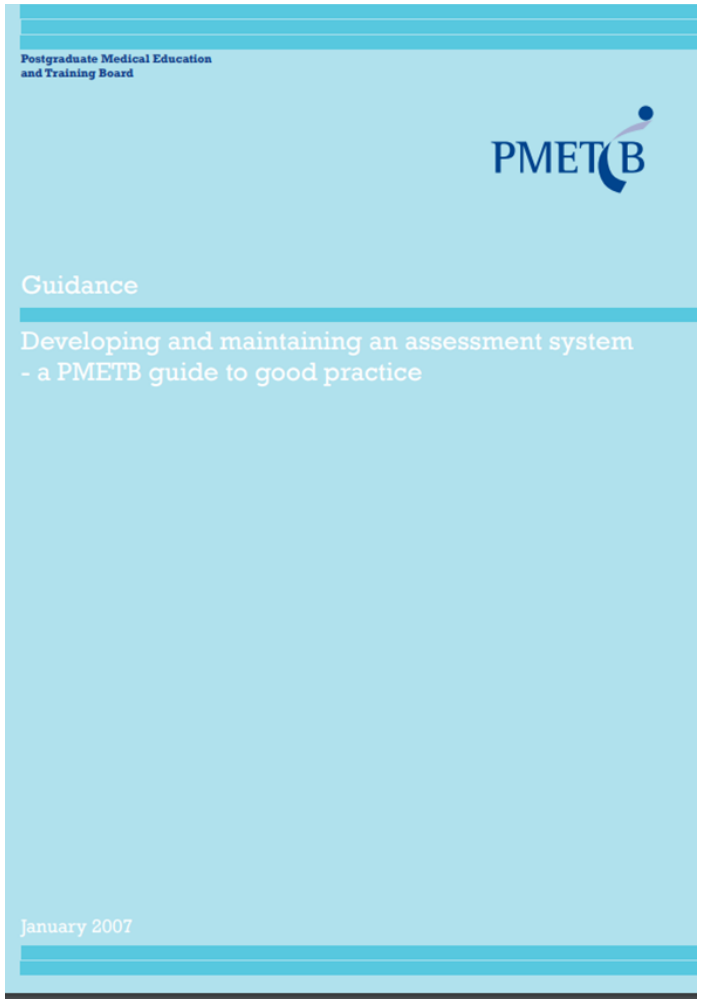
Work based assessment encompasses the true "does" (using judgments about day to day practice, such as multisource feedback) as well as the "shows how" (competence), when an individual knows he or she is being assessed, although it is a routine clinical encounter.

Competence is necessary but not always sufficient for adequate day to day performance.

Norcini JJ, Blank LL, Duffy FD, Fortna GS. The mini-CEX: a method for assessing clinical skills. Ann Intern Med2003;138: 476-81.

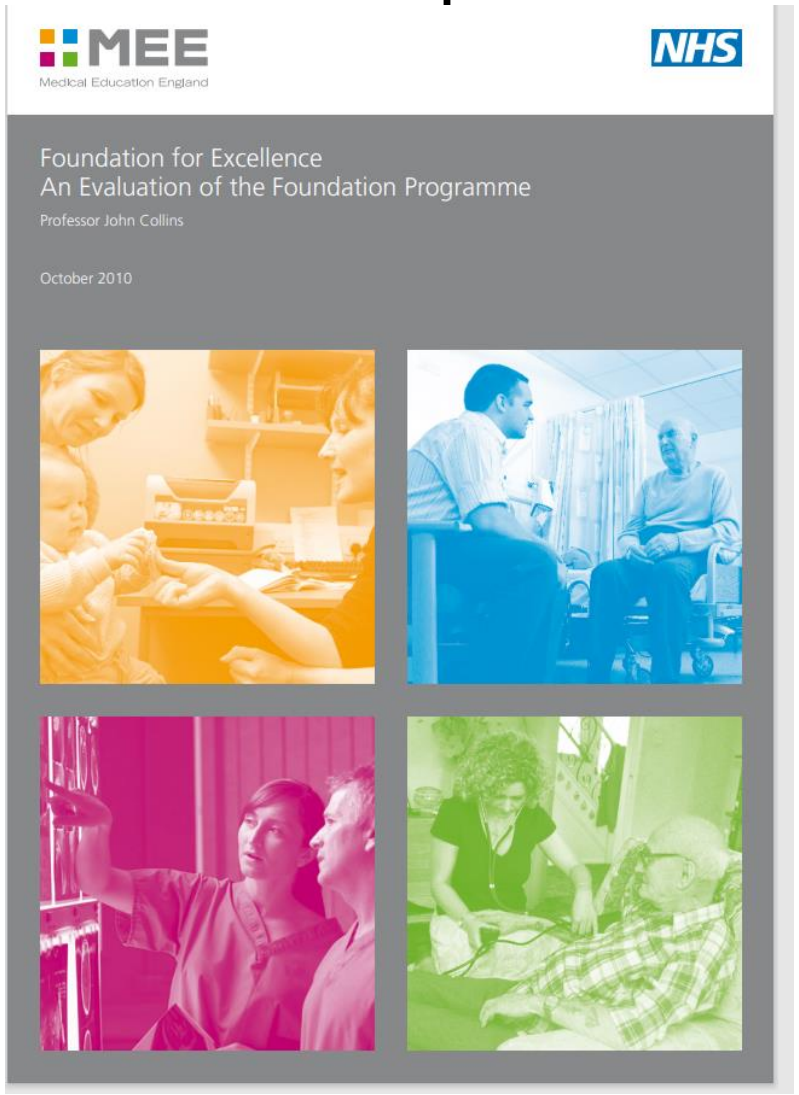
Rethans JJ, Sturmans F, Drop R, van der Vleuten C, Hobus P. Does competence of general practitioners predict their performance? Comparison between examination setting and actual practice. BMJ1991;303: 1377-80

PMETB 2005 Types Of Assessment



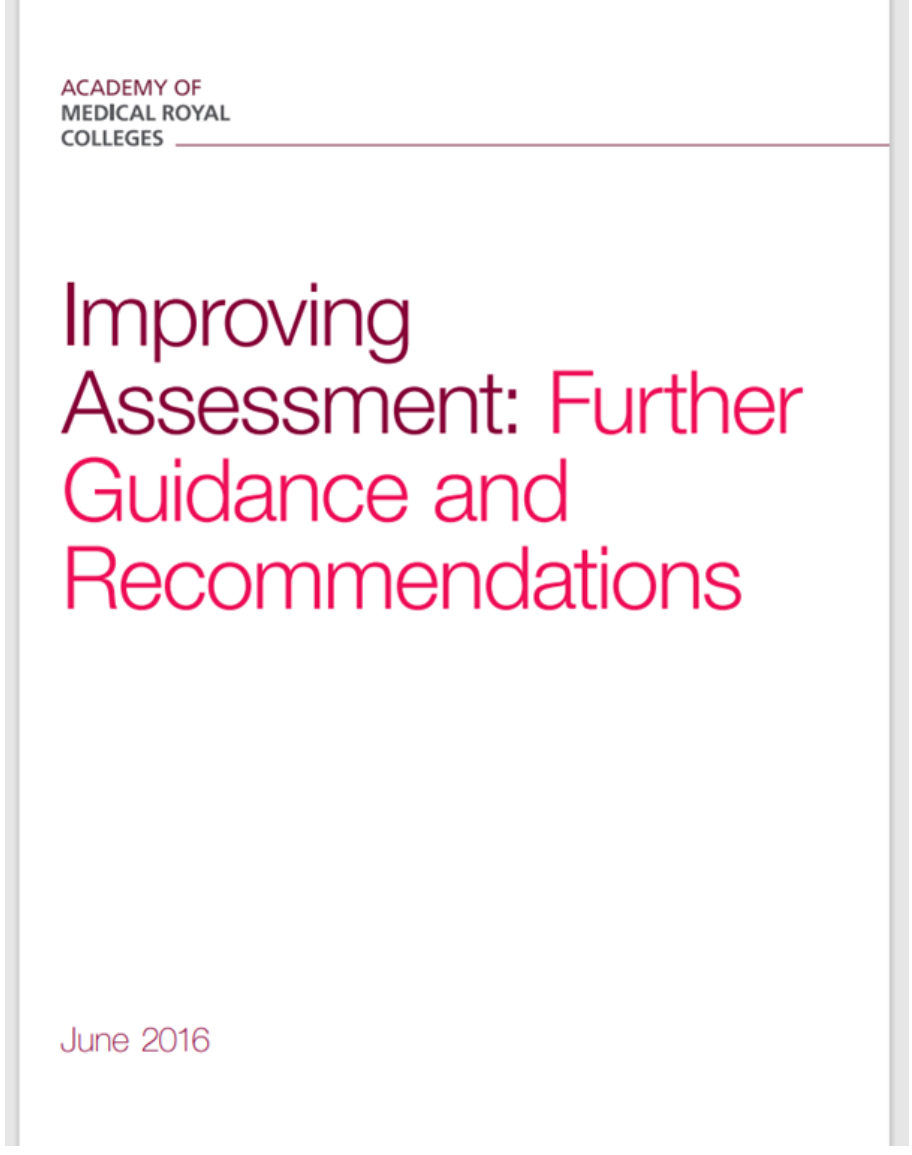
- 1) **A real (medical) patient encounter** • an actual individual patient encounter - e.g. by mini-CEX, mini-ACE;
- 2) **Direct observation of a skill** • direct observation of a skill - The consistent feature is that one or more assessors, who are trained in the assessment of that skill, make a judgment about a real life performance.
- 3) **Behaviour over time** • MSF - e.g. TAB, mini-PAT.
- 4) **Behaviour in a real situation or environment** • observation of teamwork - e.g. in psychiatry; • (simultaneous) multiple actual patient encounter - e.g. in emergency room, labour ward.
- 5) **Discussion of clinical materials** • review of a documented incident or of medical records - e.g. case note review;
- 6) **Simulation** • consultation skills - e.g. with 'standard patient' or other role player;
- 7) **Cognitive assessments** • knowledge - e.g. by invigilated test such as MCQ, EMQ;
- 8) **Reflective practice** • review of outcomes of care, or of processes undertaken; • review of trainee-held materials - e.g. file ('portfolio') of achievements; • reflective practice - e.g. reflective diary, written up case, topic or event.

Collins Report Foundation 2010



- Assessment burden too high
- Demand on trainer time, need appropriate training
- Not sure of their validity
- Not discriminating, especially for excellence
- No patient involvement

AoMRC 2009 & 2016



2009

- Role of assessments is to help identify areas for improvement so are formative not summative
- Move from numerical values to standard expected at end of training
- Assessors should be trained

2016

Aim of Assessment

- Enhance and facilitate learning
- Demonstrate regulation and maintenance of standard of practice to the public

AoMRC 2016 Recommendations

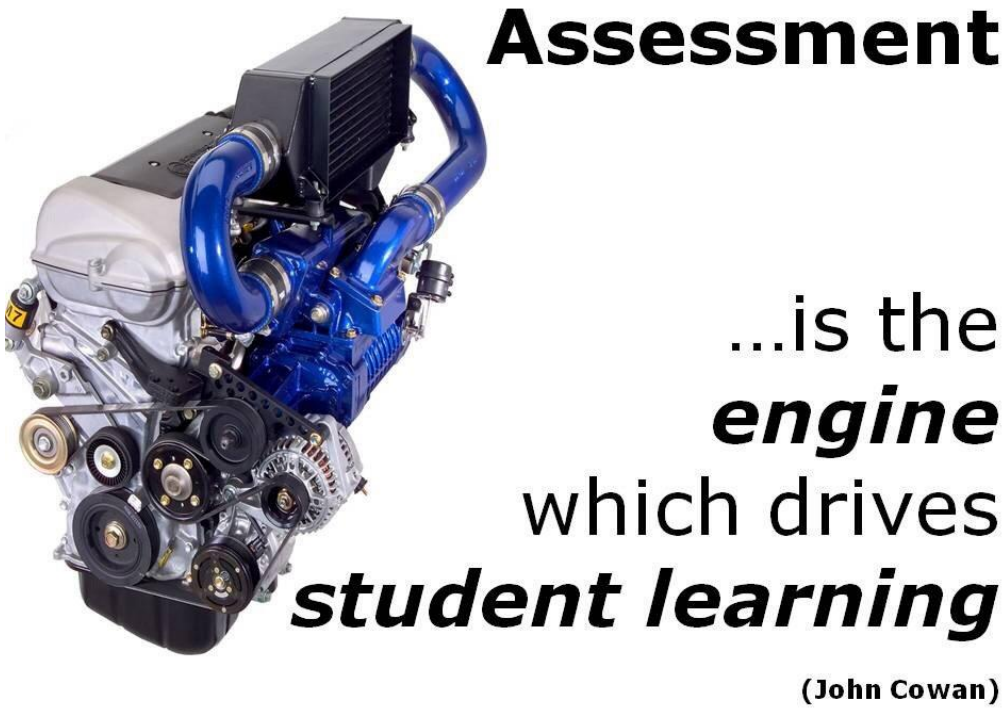
Difficulties with use of WPBAs

- Assessor behaviour- tend to positive
- Poor understanding or purpose and methods of WPBAs
- Engagement of trainers
- Summative Assessments- trainees prefer WPBAs as formative

Recommendations

- Feedback and Learning Development
- Training of Assessors
- Stating a minimum number tends to encourage targeting that number rather than concentrating on development and feedback
- Use of multiple assessors

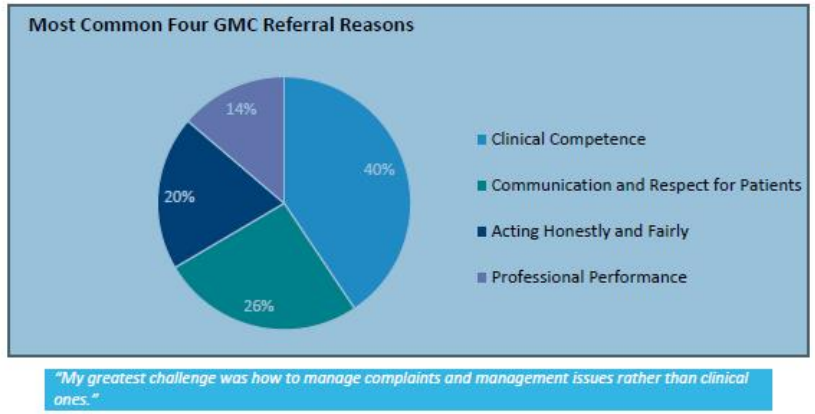
Assessment and Learning



- Assessment of Learning (summative)
- Assessment for Learning (formative)

Patient Safety

GMC Generic Professional Capabilities - Why?



GMC fitness to practise data -most concerns about doctors' performance fall into one or more of the nine domains identified in this Generic professional capabilities framework.

Reports from patient safety inquiries recommend the importance of and need for specific training to address individual, team and organisational deficiencies, as well as addressing wider systemic failures.

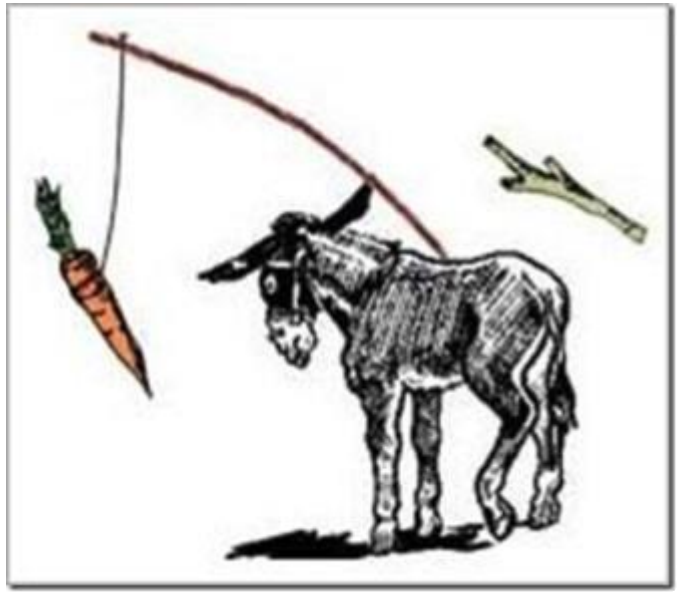
Shape of Training review 2013 recommended the development of a generic professional capabilities framework based on Good Medical Practice.

GMC Generic Professional Capabilities

- All curricula had to include GPCs by 2020

- Methods of Assessment via a programme of assessments
- Recognising GPCs are context dependent, not a one time sign off,
  - Evidence can include
  - E portfolio
  - Direct observation
  - Feedback from colleagues
  - Formative and summative assessments
- Minimum requirement
  - CS/ ES reports through the year
  - ES end of year report
  - One MSF per year

Designing and Maintaining Postgraduate Assessment Programmes GMC 2017



- All activity aimed at judging a learner's attainment of curriculum outcomes, whether for summative (determining satisfactory progression in or completion of training), or formative (developmental) purposes.

Assessments need to

- identify learners who have not demonstrated the expected level of performance, attainment or achievement needed to progress in or complete training give learners appropriate opportunities to
  - receive timely feedback that provides a basis for action, so that they can understand what is expected at their level of practice and
  - provide them with evidence and guidance as to how they can act to improve their performance and continue to develop.
- As well as reaching minimum standards for safe competent practice, learners should be encouraged and have the opportunities to excel at all stages and levels of training.

- Validity -interpretations and uses of tests that make sense and are supported by appropriate evidence'

Designing and Maintaining Postgraduate assessment programmes GMC 2017

Assessment strategy based on the validity model

Table 1. Putting assessment methods into six categories

The GMC produced a table that categorises assessments used according to a common purpose. Many of the assessments may be similar and the table does not list all assessments identified within the curricula.

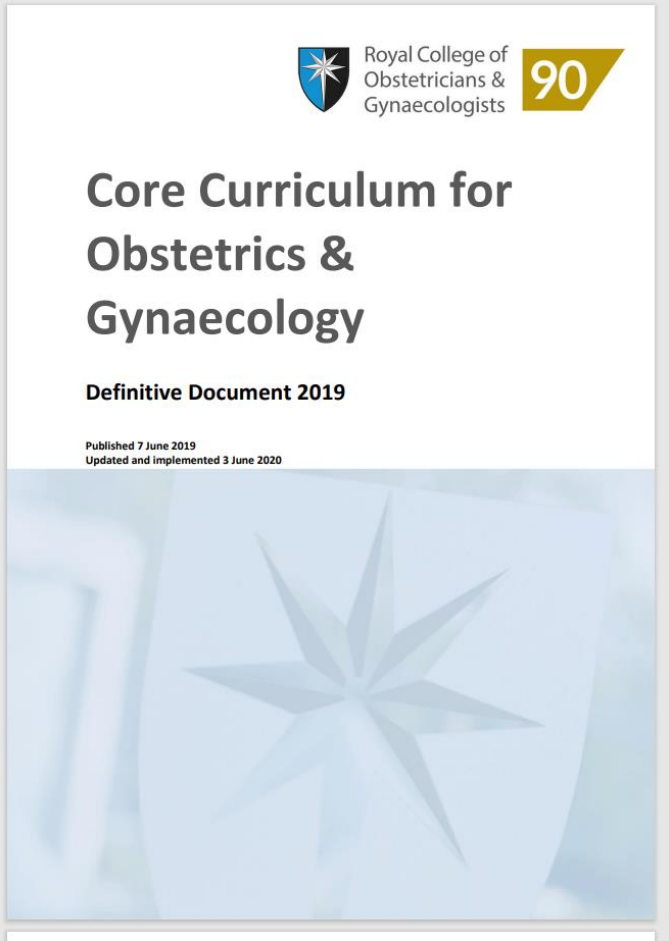
Category	Focus	Assessments
Clinical interaction	Assessment of clinical skills, including specialty-specific variations – consultation, history-taking and clinical reasoning	Mini-CEX, ACE, ECE, Mini-ACE, A-CEX, I-CEX, ICM-CEX, CSA, ACAT, AKT, COT
Procedures	Am assessment that focuses upon a trainee's procedural competence	DOPS; Rad-DOPS, Mini-IPX, DOST, DORPS, Direct Observation of Clinic, PPS, OSATs, NLS, ALMAT
Multisource feedback	Individual assessment involving feedback from colleagues or patients/lay persons with whom the doctor works	MSF, TAB, PS, Mini-PAT, Team Observation, SPRAT, SHEFFPAT/PAED CCF
Professional non-clinical	Other professional non-clinical skills	SAIL, AUDIT, AA, PMAT
Discussion-based	An assessment that uses discussion to perform an assessment of a trainee's decision-making skills	CbD, PBD, PBA, CP, CBDGA
Examination	A formal test usually under timed conditions	AKT, MCQ, EMQ, SCE, SOE, OSCE, KBA, CRP

Designing and Maintaining Postgraduate assessment programmes GMC 2017

A programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training.

- The importance and centrality of *professional judgment..*
- Assessors must use their *professional expertise and experience*……
  - A coherent and integrated programme of assessment will include how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

Implementing New Curriculum - RCOG experience



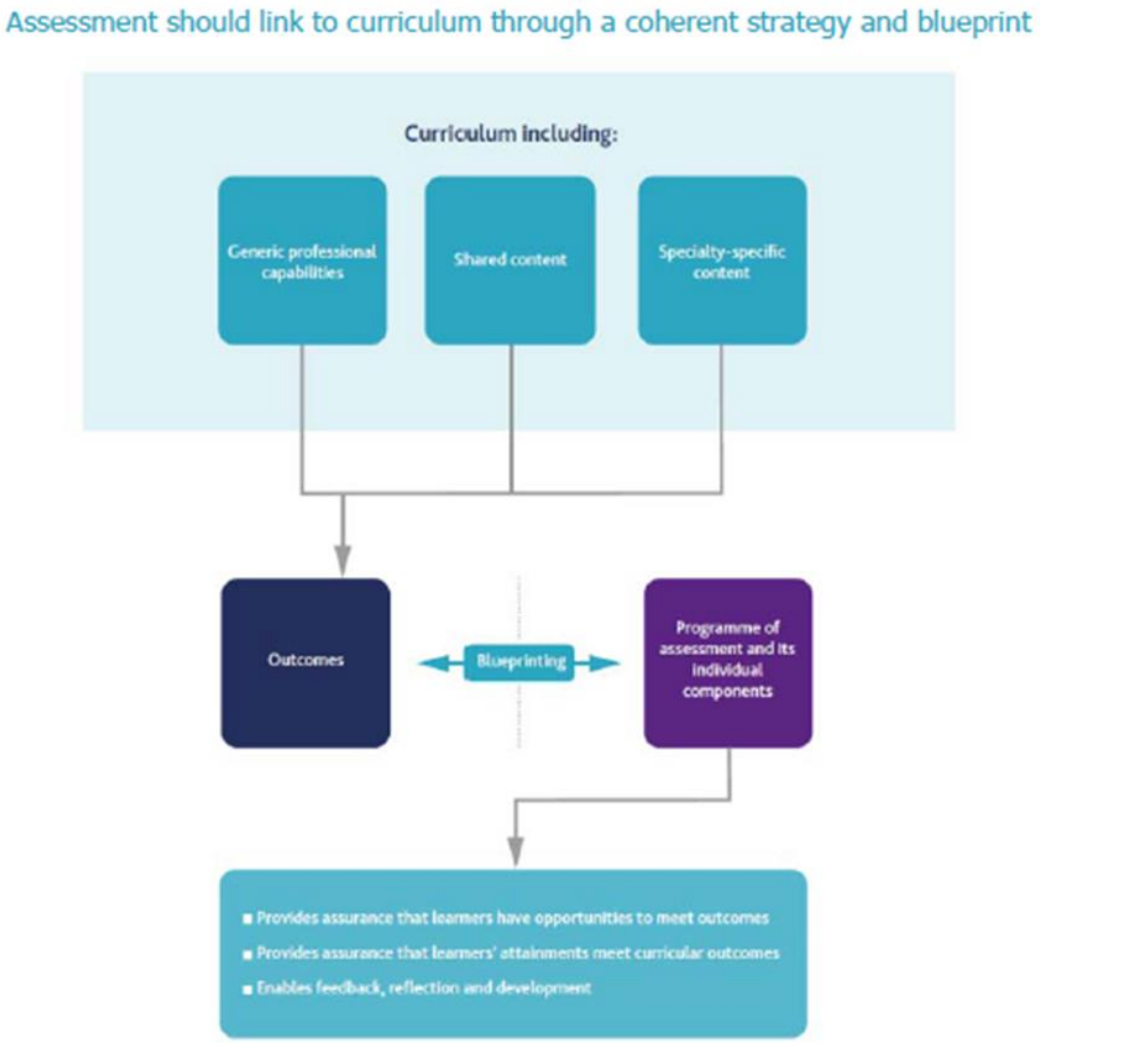
- *A highly skilled Obstetrician and Gynaecologist with the appropriate knowledge and attitudes to lead and deliver high quality care; taking account of patient's needs and advocating for women's healthcare.*
- *This will involve a questioning approach to research and quality improvement.*
- *Working well in teams is essential for safe, effective patient care; obstetricians and gynaecologists must be good communicators, supportive of staff and happy to share their expertise and experience as well as being open to the views of others.*
- *On completing training the individual will be prepared for lifelong learning, which will allow them to be adaptable and flexible for a modern NHS.*

Capabilities in Practice

Table 1 – Professional Identities and Capabilities in Practice

Developing the doctor (generic)	
PROFESSIONAL IDENTITY: HEALTHCARE PROFESSIONAL	
CiP 1	The doctor is able to apply medical knowledge, clinical skills and professional values for the provision of high-quality and safe patient-centred care
CiP 2	The doctor is able to successfully work within health organisations
CiP 3	The doctor is a leader who has vision, engages and delivers results
CiP 4	The doctor is able to design and implement quality improvement projects or interventions
CiP 5	The doctor understands and applies basic Human Factors principles and practice at individual, team, organisational and system levels
PROFESSIONAL IDENTITY: RESEARCHER, SCHOLAR AND EDUCATOR	
CiP6	The doctor takes an active role in helping self and others to develop
CiP7	The doctor is able to engage with research and promote innovation
CiP8	The doctor is effective as a teacher and supervisor of healthcare professionals
Developing the Obstetrician & Gynaecologist (specialty-specific)	
PROFESSIONAL IDENTITY: CLINICAL EXPERT	
CiP9	The doctor is competent in recognising, assessing and managing emergencies in gynaecology and early pregnancy
CiP10	The doctor is competent in recognising, assessing and managing emergencies in obstetrics
CiP11	The doctor is competent in recognising, assessing and managing non-emergency gynaecology and early pregnancy care
CiP12	The doctor is competent in recognising, assessing and managing non-emergency obstetrics care
PROFESSIONAL IDENTITY: CHAMPION FOR WOMEN'S HEALTH	
CiP13	The doctor is able to champion the healthcare needs of people from all groups within society.
CiP14	The doctor takes an active role in implementing public health priorities for women and works within local, national and international structures to promote health and prevent disease.

GMC Linking Curriculum and Assessment



Programme of Assessment

Table 9 - Blueprint of Assessments mapped to CiPs

CiPs (short title)	OSATS	Mini-CEX	CbD	NOTSS	TO1/ TO2	Reflective practice	MRCOG		
							Part 1	Part 2	Part 3
Developing the doctor - Generic CiPs									
1. Clinical skills and patient care		X	X	X	X	X			X
2. Working in health organisations		X			X			X	
3. Leadership				X	X	X			
4. Quality improvement									
5. Human factors				X	X	X			
6. Developing self and others				X	X	X	X		
7. Innovation and research									
8. Educator					X	X			X
Developing the obstetrician and gynaecologist- Specialty CiPs									
9. Emergency gynaecology and early pregnancy	X	X	X	X	X	X		X	
10. Emergency obstetrics	X	X	X	X	X	X		X	
11. Non-emergency gynaecology and early pregnancy	X	X	X	X	X	X		X	
12. Non-emergency obstetrics	X	X	X	X	X	X		X	
13. Non-discrimination and inclusion					X	X			X
14. Health promotion		X	X			X			X

5.8 Blueprint of assessments mapped to CiPs

Table 8 – Matrix of Progression

	Basic		Intermediate			Advanced	
	ST1	ST2	ST3	ST4	ST5	ST6 and ST7	
Formative workplace-based assessments							
These are encouraged as a method to provide evidence for CiPs. The aim is for quality over quantity. Useful WBAs will challenge, act as a stimulus and mechanism for reflection, uncover learning needs and provide an opportunity for developmental feedback							
Mini-CEX	✓	✓	✓	✓	✓	✓	✓
CBD	✓	✓	✓	✓	✓	✓	✓
NOTSS	✓	✓	✓	✓	✓	✓	✓
Reflective practice	✓	✓	✓	✓	✓	✓	✓
Formative OSATS	Optional but encouraged						
Summative workplace-based assessments							
Competent Summative OSATS*	✓	✓	✓	✓	✓	✓	✓
TO2	2	2	2	2	2	2	2
Other evidence required for ARCP (to be specified in guidance for each CiP)							
MRCOG examinations							
Part 1	desirable	essential					
Part 2			desirable	desirable	essential		
Part 3				desirable	essential		
Educational Supervisor's Report							
Supervisor's report	1	1	1	1	1	1	1
Trainee feedback							
Training evaluation form (TEF)	✓	✓	✓	✓	✓	✓	✓

*Each procedural skill requires 3 summative OSATS assessed as being competent prior to being able to perform the practical procedure independently with support.

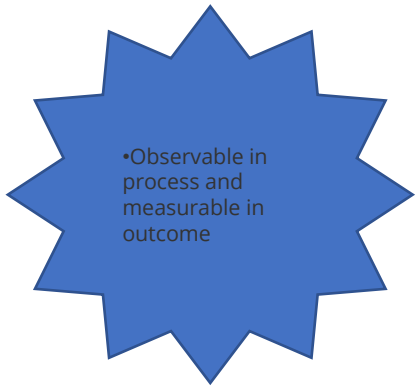
Entrustable Professional Activities (EPA)

'A clinical activity which a trainee can be trusted to complete with indirect supervision once they have demonstrated the necessary competence' (Olle ten Cate, 2005)

AoMRC-2016

- EPAs are units of professional practice defined as tasks or responsibilities that trainees are entrusted to perform unsupervised once they have attained sufficient specific competence.
- An EPA is a description of a clinical task that frames competencies within the context of clinical practice. The implementation of EPAs in a training programme requires the identification of appropriate professional activities as EPAs.

Features of entrustable professional activities (AMEE Guide 140)



Royal College of Anaesthetics

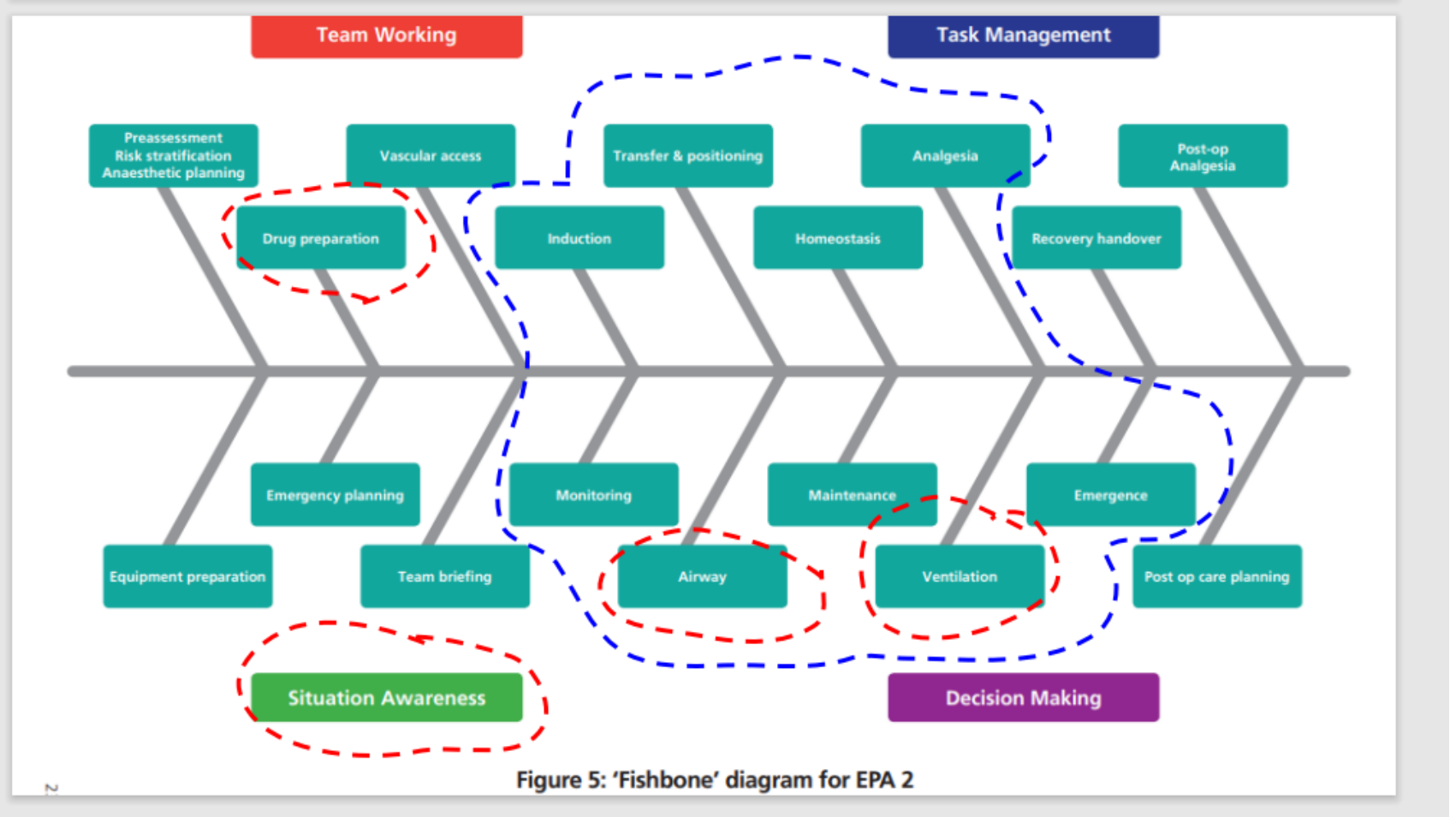


Figure 5: 'Fishbone' diagram for EPA 2

What to use to Assess EPAs

Table 2 of 2

Table 2. Assessment tools suitable as sources of information in the workplace to inform EPA entrustment decisions.

Approaches	Methods	Tools
Watching	Brief and focused observation	Mini Clinical Examination exercise (mini-CEX); Direct observation of procedural skills (DOPS) (with or without video recording); in some cases *insitu* simulation (Patterson et al. 2013) or audio-based evaluation (Sanatani et al. 2020)
	Longitudinal observation	Multisource feedback (MSF) or 360^0 Evaluation
Talking	Brief conversations	Case-based discussions, Chart-Stimulated Recall, One-minute Preceptor, SNAPPS, Entrustment-based discussions
Reviewing results	Product evaluation	Entries in Electronic Health Record; Discharge letters; QI reports; Resident-Sensitive Quality Measures (RSQM)(Schumacher et al. 2018)

CSV

RCOG Entrustability Scale

Table 3 shows the five supervision levels that are based on an entrustability scale which is a behaviourally anchored ordinal scale based on progression to competence and reflects judgments that have clinical meaning for assessors[1] .

Table 3 – Levels of supervision

Level	Descriptor
Level 1	Entrusted to observe
Level 2	Entrusted to act under direct supervision: (within sight of the supervisor).
Level 3	Entrusted to act under indirect supervision: (supervisor immediately available on site if needed to provide direct supervision)
Level 4	Entrusted to act independently with support (supervisor not required to be immediately available on site, but there is provision for advice or to attend if required)
Level 5	Entrusted to act independently

Entrustability Scales - Questions for Trainers

Table 1

The Ottawa Surgical Competency Operating Room (O-SCORE) Scale[a]: An Entrustability-Aligned Anchor Scale

Level	Descriptor
1	"I had to do" (i.e., requires complete hands on guidance, did not do, or was not given the opportunity to do)
2	"I had to talk them through" (i.e., able to perform tasks but requires constant direction)
3	"I had to prompt them from time to time" (i.e., demonstrates some independence, but requires intermittent direction)
4	"I needed to be there in the room just in case" (i.e., independence but unaware of risks and still requires supervision for safe practice)
5	"I did not need to be there" (i.e., complete independence, understands risks and performs safely, practice ready)

[a]The authors adapted the scale from Gofton W, Dudek N, Wood T, Balaa F, Hamstra S. The Ottawa surgical competency operating room evaluation (O-SCORE): A tool to assess surgical competence. Acad Med. 2012;87:1401–407.

Promoting Excellence

Figure 4. Level descriptors for excellence

Things that we do – needs to be observed (OSATs)	
Levels	**Descriptor**
10 does and creates	Develops new technique
9 does and inspires	Skills widely (regionally/internationally) recognised
8 does and teaches	Teaches, rescues (does not need to take over)
7 does and teaches	Teaches, rescues (able to get someone out of trouble but takes over)
6 does and teaches	Teaches
5 does	Independently (unsupervised)
4 does	Independently (indirect supervision)
3 does	Supervised
2 does	Simulation
1 sees	Real, simulation, video and text

My Final Reflection