An informative guide to formative and summative assessment for Paediatric Trainees and Trainers

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1. Introduction

‘Training is patient safety for the next 30 years’
Professor Sir John Temple, Time for Training 2010

I am delighted to endorse this College guide to workplace based assessment which will help to demystify some of the recent changes made to assessment including the new terminology being used. The innovations and improvements in our assessments enhance their educational value and ensure that our trainees are getting the best training and educational support. Ultimately and even more importantly, I believe this will support patient safety and drive higher quality of care.

The RCPCH is determined to provide a comprehensive assessment system that seeks to test a trainee’s skills, knowledge and behaviours against those identified in the curriculum. Undertaken in the right way, workplace based assessment provides opportunities for trainees to focus on their learning and to receive constructive feedback on their progress. It is also a chance for them to reflect on this feedback and jointly with their educational supervisor to identify areas for development.

I would like to thank my Paediatric colleagues listed in this document for their input into producing this guide and allowing the College to make it available for all to use and I hope it helps to support all stakeholders in creating a positive and valuable learning experience.

Dr Simon Newell MD FRCP FRCPCH
Vice President of Training and Assessment
2. Workplace based Assessments: Supervised Learning Events (SLE’s) and Assessments of Performance (AoP’s)

Workplace-based assessments are part of the assessment strategy of all specialties and are strongly promoted by the GMC. They are an excellent opportunity for the trainee to receive feedback, reflect and develop. They give trainers the opportunity to see how the trainee functions in “real life” and enables the trainee to demonstrate skills such as professionalism and decision making.

In September 2013 the RCPCH made a number of changes to these assessments aiming to improve their educational impact. The main change is that the scoring aspect of assessments has been removed. The essential feature is that feedback is recorded and suggestions for development are made.

Virtually all of the assessments are now conducted as a formative Supervised Learning Events (SLEs), an assessment for learning. The primary outcome is the learning that follows on from the assessment. If an assessment is summative in nature, then it should be conducted as an Assessment of Performance (AoP). An AoP makes a judgement about whether a specific competency has been achieved and should be viewed as an assessment of learning.

It should be expected that early on in training, a less than perfect performance by a trainee undertaking an assessment should be seen as the norm, although it goes without saying that patient safety and quality of care must be maintained at all times.

Guidance around numbers of assessments to be completed should be seen as just that - a guide. Between them, trainees and trainers should prospectively identify and plan learning opportunities according to the individual needs of the trainee and should update development plans accordingly. Additionally unplanned learning events should also be taken as when these arise as these too present valid opportunities for learning.

Prior to the Annual Review of Competence Progression (ARCP) meeting the Educational Supervisors Report or Trainers Report as it is more commonly known is completed, and while numbers and distribution of assessments will be documented, it is an opportunity for the Educational Supervisor to document trainee engagement with SLE’s and that they have sufficiently demonstrated their progression through reflection, learning and development.

The aim of this guide is to provide trainees and trainers with the basic information needed to undertake assessments and progress through their training, including some ideas of how to complete SLEs/AoP’s in a busy unit.
3. Types of Assessment

Case Based Discussion (CbD)

Supervised Learning Event

Purpose?

- CbD is designed to assess clinical reasoning and decision making and the application or use of medical knowledge in relation to patient care. The focus of discussion is around an actual entry that is made in the patient’s notes and exploring the thought processes that underpinned that entry. The purpose of the assessment is to learn and cases should be chosen that have created challenge, doubt or difficulty.

How many?

- A minimum of 4 (level 1 trainees), 6 (level 2 trainees) and 8 (level 3 trainees) each year must be achieved, with the trainee aiming to complete more than the minimum. At all levels, one of these should be a Safeguarding CbD where the focus is on the management of a Safeguarding related case.

Who can assess them?

- You should aim to have the majority of CbD assessments completed by a Consultant. In cases where this is not possible SASGs, Senior SpRs and St 7-8 trainees are acceptable as assessors.

Comment from trainees:

“I have worked in a Trust where there is a dedicated CbD “clinic” one afternoon a week for which trainees can sign up and perform CbDs during dedicated time”

“I have got into the habit of photocopying interesting cases I see in A&E to use for CbDs”

“We used my management of a newborn that required intubation and transfer out as an interesting CbD. I learnt a lot from the whole process”

“After a complex case has been presented, discussed and trainee’s plan debriefed the consultant can ask the trainee to write some brief written reflection, their learning and what they will take forward. This, along with learning points from consultant, can form the written feedback for a WPBA”
Mini Clinical Evaluation Exercise (Mini CeX)

Supervised Learning Event

**Purpose?**

- Mini-CeX is designed to provide feedback on skills essential to the provision of good clinical care in a paediatric setting.
- The purpose of the assessment is to learn and cases should be chosen that have created challenge, doubt or difficulty.

**How many?**

- A minimum of 8 (level 1 trainees), 6 (level 2 trainees) and 4 (level 3 trainees) each year must be achieved, with the trainee aiming to complete more than the minimum.

**Who can assess them?**

- Consultants are usually well placed to provide feedback but trainees may learn from others and wish to record some CeXs with staff such as SAS and more senior trainees.

**Comments from trainees:**

“*My consultant leaves dedicated time at the end of the ward round for recording the assessments that have been carried out during the ward round*”

“My best example was on a routine morning ward round when my consultant suggested we do a Mini-CeX. She observed me examine the patient and explain the management plan to the parents. I received immediate feedback and it took no time at all!”

“My consultant watched me counsel a parent who was due to deliver a 32 weeker. We used this as a Mini CeX”

Discussion of Correspondence (DOC)

Supervised Learning Event

Replaces SAIL (Sheffield Assessment Instrument for Letters)

**Purpose?**

- An assessment of correspondence using a structured approach in order to form an objective view of its quality.
- Assessment should be carried out with both the correspondence and the clinical notes available.
- Aims to allow structured assessment and learning development across all written communication.
How many?
- 5 per training level (level 2 and 3 assessment).

Who can assess them?
- At least one of these to be assessed by a consultant.
- Additional assessments may be carried out by others such as SAS.

Comments from trainees:
“Following completion of my clinic letters my consultant suggested we use one as a DOC. I found the process really useful”

“I was quite surprised that a transfer letter that I had written could be used as a DOC! Was really useful feedback”

Directly Observed Procedural Skills

Assessment of Performance (AoP)
- List of compulsory DOPS (see below)
- Aim to complete by the end of level 1
- DOPS repeated until satisfactory level is reached

Purpose?
- Designed specifically to assess practical skills. Trainee is judged to be competent to perform the procedure without supervision or to still need supervised practice.

How many?
- Aim to complete 1 satisfactory AoP for each compulsory DOPS during level 1 training.

Who can assess them?
- These should be assessed by consultants, more senior trainees, nurse practitioners, SAS and others who are proficient in the procedure and have read and understood the guidance on DOPS.

Compulsory DOPS
- Bag, valve and mask ventilation
- Capillary blood sampling
- Venesection
- Peripheral venous cannulation
- Lumbar puncture
• Non-invasive blood pressure measurement by oscillometric and auscultation methods
• Tracheal intubation of term newborn and preterm (28-34 weeks) babies
• Umbilical venous cannulation

Other DOPS

• When other procedures are performed that are not part of the list of compulsory DOPS these should be recorded in the skills log section of your ePortfolio which is used to demonstrate development continued competence. Trainees can also do optional DOPS on a range of other procedures, as this may be a way of showing particular interest or aptitude in an area of practice or a specialty. For those in GRID training please consult with your CSAC for more details regarding compulsory DOPS.

Comments from Trainees:

“The ANNP I work with watched me perform a cannulation – she gave timely and useful feedback”

Pilot assessments

The Handover Assessment Tool (HAT), Acute Care Assessment Tool (ACAT) and LEADER CbD are pilot Supervised Learning Events.

As these are pilot assessments the aim should be to complete a minimum of:

• 1 HAT and LEADER for level 1
• 1 HAT, ACAT and LEADER for levels 2 and 3

Trainees should aim to complete more than the minimum number required.

These assessments can count towards the overall number of SLEs.

Purpose?

HAT: Assessment of Handover

This assessment aims to evaluate the effectiveness of handover and is not dependant on a single model. It is intended to be used flexibly to allow different styles of handover to be assessed. Headings in “area to be covered” column are suggestions to prompt discussion. Looks at structure/organisation and safety issues.

ACAT: Assessment of Acute Care

The ACAT provides an opportunity for the trainee to receive formative feedback on their ability to integrate multiple skills in a complex and challenging environment such as a ward round or A&E “take”.
**LEADER: Clinical Leadership skills assessment**

The LEADER CbD is based around a clinical case with the discussion focusing less on the clinical elements of the case but instead on leadership issues highlighted.

**Who can assess them?**

HAT and ACAT: At least one of each of these to be done by a consultant. Additional assessments may be carried out by others such as SAS.

**LEADER: Consultant**

**Comments from trainees:**

“My consultant runs a “carousel” ward round when appropriate so that trainees can take on different roles, such as leading part of the ward round with consultant supervision. I had to deal with nursing queries/bed management issues and all the things my consultant usually deals with. I performed my first ACAT during one of these”

“We have consultants present in ED in the evenings and my consultant watched me “manage the show” as an ACAT. I learnt a lot from the whole experience and the feedback I was given”

“My consultant watched me handover to the team during morning handover. Although the experience was quite daunting at first I learnt a lot about how to structure handovers and the type of thing that I am expected to handover. I have found that my handovers are so much quicker now”

“During a resuscitation of a shocked child in ED one day my consultant let me lead the team. She then fed back to me. It was a really useful experience and I learnt a lot about myself. We then recorded this as a LEADER CbD”

“My consultant assessed me handover to the evening team”

“Following a successful resuscitation my consultant watched me handover to the retrieval team. We then spent 10 minutes discussing the case. Along with my reflection on the handover, we recorded this as a HAT”

“I did an audit on admissions for patients in DKA and suggested several ways on which admission rates could be reduced and the service improved. We recorded the discussions we had, and my reflection, as a LEADER CbD”

**Other Assessments**

**ePaedMSF**

ePaedMSF is an online workplace based assessment tool for paediatric trainees, providing multi-source feedback (MSF).

It is important to get a good range of people to complete the feedback. Please see guidance below for completion:
Level 1 (ST1-3)

You must have a minimum of one satisfactory ePaedMSF per year, and one of the ePaedMSF Reports within Level 1 must cover neonatal and general paediatric practice.

Level 2 (ST4-5)

You must have a minimum of one satisfactory ePaedMSF per year, and one of the ePaedMSF Reports within Level 2 must cover neonatal, community and general paediatric practice.

Level 3 (ST6-8)

You must have a minimum of one satisfactory ePaedMSF per year, and one of the ePaedMSF Reports within Level 3 must cover all aspects of subspecialty.

ePaed CCF

Carers for Children Feedback. Feedback sought from parents/carers. Used as an additional tool when required.

An important tool used for Consultant revalidation.

Specialty Trainee Assessment of Readiness for Tenure (START)

This assessment aims to look at whether a trainee has the skills required to perform at the level of a newly-appointed consultant. It is completed in Level 3 training (ST7), the aim being that trainees can then use the feedback they receive to develop themselves in their final year of training.

All trainees who have entered Level 3 training on or after 1 August 2011 will be required to undertake START before applying for their CCT.
4. Feedback and Reflection

To maximise the educational impact of a SLE it is imperative that feedback is provided to the trainee. Ideally this feedback should be delivered immediately but more importantly it should lead to an action plan which encourages the trainee to self-evaluate and self-reflect, and in addition it should lead to specific and SMART learning objectives which are recorded in the trainee’s Personal Development Plan in ePortfolio and thereby allowing the educational supervisor to follow this up with the trainee.

Formative feedback provides the opportunity to share educational objectives, chart progress but also enhance learning and there are a number of different considerations and guidelines to think about when delivering feedback, some of which are listed below.

Feedback should be:

- Specific
- Concise
- Relevant
- Timely
- Private
- Focused
- Objective

It should also:

- Offer corrective advice
- Praise effort and strategic behaviours
- Take a holistic approach
- Be a two way discussion

As part of the feedback process it is important to document what was discussed and taking a narrative approach is often the best way to achieve this. The trainee and trainer work together on this in a chronological way to recall and reflect on what happened in a step-by-step approach, thus ensuring that the learning points are captured.

Further guidance on giving effective feedback can be found on the college website

Reflection ¹

Reflection is a key component to delivering a successful SLE. It is an opportunity for the trainee and trainer to analyse the event and examine what could be done differently to reach improved outcomes. Reflection can be done in isolation or it can be done through discussion with peers, mentors or supervisors and very much depends on the individual. It is however important that the trainee records their reflection in ASSET and agrees a development plan with their educational supervisor.
Tips for reflection

- Jot down (on your phone, notepad) 1 or 2 bullet points on the SLE to reflect on at a later time
- What learning/skill development is visible?
- What learning needs are revealed?
- How might these learning needs be addressed and met?
- What actions might you take, beyond looking at your own learning needs?
- Discuss your reflection and evidence with a peer, appraiser, supervisor or mentor

¹ Taken and adapted from the RCPCH Guide to Reflection for Consultant Paediatricians
5. The role of the trainee and the role of the Educational Supervisor

**The role of the trainee**

- Take ownership of your learning and assessment
- Complete WPBA’s in a timely manner (roughly one every 2 weeks)
- Do not leave all the assessments to the end of post & update ePortfolio regularly
- Send WPBA forms for completion to supervisors & reflect soon after the assessment
- Supply dates of APLS/NLS/Safeguarding courses to ES so that they can update the trainer’s report with this information
- You will be informed approximately 6 weeks before your ARCP of the need to supply the following:
  - Enhanced form R (will be sent to you)
  - 1 or 2 trainer’s reports a year (completed by your educational supervisor)
  - Evidence of completion of WPBA and Multi-source feedback
  - Completed CCT grid

**The role of the Educational Supervisor**

- Review trainee’s WPBA to make sure they are being completed
- Invite trainees using Asset to perform WPBAs
- Offer formative feedback to trainees at all levels throughout the year
- Offer guidance on the areas that trainees need to explore/develop
- Follow up feedback and learning outcomes for trainees generated by WPBAs
- Encourage trainees to complete assessments in a timely manner (roughly one every 2 weeks)
- Respond to alerts (6 week inactivity on Asset & “cause for concern”)
- Complete a training report that informs the trainee’s ARCP following discussion with local faculty on individual trainees
- Complete Clinical Supervisor’s part of training report also unless advised otherwise
- Use trainee’s PDP section/Development Log & Skills log to aid completion
- Encourage trainees to tick off competencies on ePortfolio
6. Annual Review of Competence Progression (ARCP) and Revalidation

The ARCP occurs for EVERY trainee on, at least, a yearly basis. It is a formal process which looks at the evidence gathered by the trainee relating to their progress within a training programme. The aim of the ARCP panel is to consider the evidence provided by the trainee and make a judgement on whether a trainee is suitable to progress to the next stage of training/complete their training. Following discussion and consideration of the evidence the trainee will be issued with an “outcome” that is considered to be either “satisfactory” or “unsatisfactory”.

The ARCP usually occurs “in absentia” (i.e. without the presence of the trainee) except at ST7 level and if there are concerns that the trainee is not likely to get an outcome 1 or 6.

The evidence that is considered by the panel includes:

- Enhanced form R (sent to trainee for completion about 6 weeks before ARCP date)
- Educational Supervision Report (either 1 or 2 per year)
- Clinical Supervisors report (or a dual educational/clinical supervisors report)
- Employer’s return (supplied by Trust)
- Review of trainee’s E-portfolio
- CCT grid (your list of posts with duration of each)

ARCP Outcomes

Outcome 1:
Satisfactory Progress - Achieving progress and the development of competences at the expected rate

Outcome 2:
Development of specific competences required – additional training time not required

Outcome 3:
Inadequate progress – additional training time required

Outcome 4:
Released from training programme with or without specified competences

Outcome 5:
Incomplete evidence presented – additional training time may be required
Outcome 6:
Gained all required competences - will be recommended as having completed the training programme and for award of a CCT

Outcomes for trainees in FTSTAs, LATs, OOP, or undertaking “top-up” training:

Outcome 7:
Fixed-term Specialty Trainee (FTSTAs) or LATs

- **Outcome 7.1:** Satisfactory progress in or completion of the LAT / FTSTA placement
- **Outcome 7.2:** Development of Specific Competences Required additional training time not required
- **Outcome 7.3:** Inadequate Progress by the Trainee
- **Outcome 7.4:** Incomplete Evidence Presented

Outcome 8:
Out of programme for research, approved clinical training or a career break (OOPR/OOPT/OOPC).

Outcome 9:
Doctors undertaking top-up training in a training post.

Revalidation
Revalidation is the General Medical Council's way of regulating licensed doctors to give extra confidence to patients that their doctors are up to date and fit to practice.

All doctors in specialty training will have to revalidate, usually every five years. In addition, doctors in postgraduate training revalidate when they receive their Certificate of Completion of Training (CCT).

Since 2013 the ARCP has formed the basis of revalidation for doctors in specialty training and it is extremely important to get it right.

Supervised Learning Events & Assessments of Performance contribute to the evidence needed for the ARCP panel to make an informed decision, without them the trainee cannot receive a satisfactory outcome and progress on to the next stage of training or receive their CCT.
### 7. Table of Assessments

#### Table 1. Supervised Learning Events and Assessments of Performance (SLEs and AoP)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Purpose</th>
<th>Who can assess?</th>
<th>Examples and tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>MiniCeX (Mini clinical</td>
<td>Designed to provide feedback on skills essential to the provision of</td>
<td>Consultants, SAS and more</td>
<td>Observing an ST1 examining a patient and explaining the management plan to the</td>
</tr>
<tr>
<td>evaluation exercise)</td>
<td>good clinical care. Cases should be chosen that have created challenge,</td>
<td>senior trainees.</td>
<td>parents. Observing an ST4 counselling a parent due to deliver a 32 weeker.</td>
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<td></td>
<td>doubt or difficulty.</td>
<td></td>
<td>Leave time at the end of the ward round for recording such assessments with</td>
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<td></td>
<td></td>
<td></td>
<td>trainees</td>
</tr>
<tr>
<td>CbD (Case based discussion)</td>
<td>Designed to assess clinical reasoning, decision making and the</td>
<td>Majority by a Consultant, SASG,</td>
<td>Set up a dedicated CbD “clinic” one afternoon a week for trainees to perform</td>
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<tr>
<td></td>
<td>application of medical knowledge in relation to patient care. The</td>
<td>Senior SpRs and St 7-8 trainees</td>
<td>CbDs during dedicated time. Trainees should get into the habit of</td>
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<tr>
<td></td>
<td>discussion should focus on an actual entry made in the patient’s notes,</td>
<td>also acceptable.</td>
<td>photocopying the notes of interesting cases to use as later CbDs.</td>
</tr>
<tr>
<td></td>
<td>and should explore the thought processes that underpinned that entry.</td>
<td></td>
<td>After complex cases have been presented and discussed, ask trainees to write</td>
</tr>
<tr>
<td></td>
<td>Cases should be chosen that have created challenge, doubt or difficulty.</td>
<td></td>
<td>written reflection. This, along with learning points from the discussion, can</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>form the written feedback for a WPBA.</td>
</tr>
</tbody>
</table>
| **DOPS (Directly observed procedural skills – this is an AoP)** | Designed to assess practical skills. Aim to complete by the end of level 1 training. Must be repeated until a satisfactory level is reached. Compulsory AoP’s  
- Bag, valve mask ventilation  
- Capillary blood sampling  
- Venesection  
- Peripheral cannulation  
- Lumbar puncture  
- Measuring non-invasive BP  
- Intubation (term/preterm)  
- UVC insertion | Consultants, senior trainees, nurse practitioners and SAS. Must be proficient in the procedure, and have read and understood the guidance. | Other practical skills should be recorded in the skills log of E-portfolio to demonstrate development and continued competence.  
Level 3 GRID trainees have additional compulsory DOPS defined by their CSAC. |
| **LEADER (Clinical Leadership skills assessment)** | A CbD based around a clinical case or problem, with the discussion focusing on leadership issues. | Consultant | Observing a trainee lead a resuscitation. Discussing the implementation of a trainee’s quality improvement project |
| **HAT (Handover assessment tool)** | Designed to evaluate the effectiveness of handover. Not dependant on a single model. Intended to be used flexibly to allow different styles of handover to be assessed. Looks at structure/organisation and safety. | At least one by a consultant. | Observing a trainee’s morning handover.  
Observing a trainee handover to the retrieval team after a successful resuscitation. |
| **ACAT (Acute care assessment tool)** | An opportunity for trainees to receive formative feedback on their ability to integrate multiple skills in a complex and challenging environment such as a ward round or A&E “take”. | At least one by a consultant. | Observing trainees lead the ward round.  
Observing trainees manage A+E for an afternoon, or a busy NNU shift. |
| **DOC (Discussion of correspondence)** | Aims to provide structured assessment and learning for written communication. Assessment should be carried out with both the correspondence and the clinical notes available. | At least one by a consultant. | Reviewing a trainee’s clinic letters  
Reviewing a trainee’s transfer letters or referrals |
| **ePaed CCF (Carers for Children Feedback)** | Feedback from parents/carers. Important for Consultant revalidation | Parents/carers/young people | To be used as and when required. Please contact RCPCH in the first instance. |
| **ePaedMSF (multi-source feedback)** | Provides multi-source feedback (MSF) | Important to get a wide range of professionals. |  |
Table 2. RCPCH based assessments (MRCPH and START)

<table>
<thead>
<tr>
<th>Name</th>
<th>Aim</th>
<th>Structure/Format</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRCPCH *written</td>
<td>To assess knowledge, understanding and clinical decision making abilities</td>
<td>2½ hour paper Same day as Theory and Science</td>
<td>Candidates are able to apply for the written examinations in any order as long as they have a primary medical degree. Must be completed before entry into ST4.</td>
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<tr>
<td>Foundation of Practice (Formerly part 1a)</td>
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<tr>
<td>Theory and Science. (Formerly part 1b)</td>
<td>Emphasis on basic science, physiology and pharmacological principles Also tests principles of evidence based medicine and applied knowledge</td>
<td>2½ hour paper Same day as Foundation of Practice ‘Extended-matching’ ‘Best of five’s’ ‘True-false’</td>
<td></td>
</tr>
<tr>
<td>Applied Knowledge in Practice (Formerly part 2)</td>
<td>To test clinical knowledge and decision making Includes research, audit, ethics and medical science applied to clinical care Standard of someone entering core specialist training</td>
<td>2 x 2½ papers on the same day • Case histories • Data interpretation • Photographic material • Format • ‘Extended-matching’ • ‘Best of’ lists • ‘n from many’</td>
<td></td>
</tr>
<tr>
<td>MRCPCH *Clinical</td>
<td>To assess whether candidates have reached the standard in clinical skills expected of a newly appointed Specialist Registrar</td>
<td>10 clinical OSCE stations • Hx and Mx planning (22mins) • Clinical video scenario (22mins) • Communication skills (9mins) x 2 • Child development (9mins) • CVS (9mins) • Resp/other (9mins) • Abdo/Other (9mins) • MSK/Other (9mins) • Neurology/neurodis (9mins)</td>
<td>Must have completed written exams before sitting.</td>
</tr>
</tbody>
</table>
| START | Specialty Trainee Assessment of Readiness for Tenure | To evaluate whether a trainee has the skills required to perform at the level of a newly appointed consultant. Applies to all trainees who entered Level 3 training on or after 1 August 2011. Completed at ST7 so that trainees can use the feedback to develop themselves in their final year of training. | 12 stations (12 mins each)  
• Six sub-speciality (including general paediatrics)  
• Six generic scenarios | Feedback accessed through ASSET  
Not usually repeated  
Any highlighted difficulties addressed through educational supervision |

# Table 3. Assessments for Level 1 trainees

<table>
<thead>
<tr>
<th></th>
<th>ST1</th>
<th>ST2</th>
<th>ST3*</th>
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<tbody>
<tr>
<td>Mini-Cex</td>
<td>8</td>
<td>8</td>
<td>8</td>
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<tr>
<td>CbD</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<tr>
<td>Safeguarding CbD</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>DOPS</td>
<td></td>
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<tr>
<td></td>
<td>A minimum of 1 satisfactory DOP for each compulsory procedure Skills log to be used to demonstrate development and continued competence</td>
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<td></td>
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<tr>
<td>LEADER</td>
<td>1 across level 1 training</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>HAT</td>
<td>1 across level 1 training</td>
<td>1</td>
<td>1</td>
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<tr>
<td>ACAT</td>
<td>Not essential</td>
<td></td>
<td></td>
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<tr>
<td>DOC</td>
<td>Not essential</td>
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<tr>
<td>ePaed CCF</td>
<td>Not essential**</td>
<td></td>
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<tr>
<td>ePaed MSF</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<tr>
<td>MRCPCH (Written)</td>
<td>1-2 papers desirable</td>
<td>2 out of 3 papers essential</td>
<td>All 3 papers essential</td>
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<tr>
<td>MRCPCH (Clinical)</td>
<td>Essential</td>
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<tr>
<td>NLS or similar</td>
<td>Must complete during level 1 training</td>
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<tr>
<td>APLS or similar</td>
<td>Must complete during level 1 training</td>
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<tr>
<td>Safeguarding</td>
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<tr>
<td></td>
<td>Trainees must achieve level 1 and 2 intercollegiate safeguarding competencies by end of ST3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainers report</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*ST3 may not be necessary in exceptional circumstances. **Used as an additional tool when required.

MiniCeX (Mini clinical evaluation exercise); CbD (Case based discussion); DOPS (Directly observed procedural skills); LEADER (Clinical Leadership skills assessment); HAT (Handover assessment tool); ACAT (Acute care assessment tool); DOC (Discussion of correspondence); ePaed CCF (Carers for Children Feedback); ePaed MSF (Multi source feedback); START (Specialty Trainee Assessment of Readiness for Tenure).
### Table 4. Assessments for Level 2 trainees

<table>
<thead>
<tr>
<th></th>
<th>ST4</th>
<th>ST5*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mini-Cex</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>CbD</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Safeguarding CbD</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DOPS</td>
<td></td>
<td>1 satisfactory DOP for each of the compulsory procedures outstanding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skills log to be used to demonstrate development and continued competence</td>
</tr>
<tr>
<td>LEADER</td>
<td>1</td>
<td>across level 1 training</td>
</tr>
<tr>
<td>HAT</td>
<td>1</td>
<td>across level 1 training</td>
</tr>
<tr>
<td>ACAT</td>
<td>1</td>
<td>across level 1 training</td>
</tr>
<tr>
<td>DOC</td>
<td>5</td>
<td>across level 1 training</td>
</tr>
<tr>
<td>ePaed CCF</td>
<td>1</td>
<td>during level 2 training**</td>
</tr>
<tr>
<td>ePaed MSF</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Safeguarding Trainees must achieve</td>
<td></td>
<td>the majority of level 3 competencies by the end of ST5</td>
</tr>
<tr>
<td>Trainers report</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*ST5 may not be necessary in exceptional circumstances, **To be used as an additional tool when required.

MiniCeX (Mini clinical evaluation exercise) CbD (Case based discussion), DOPS (Directly observed procedural skills), LEADER (Clinical Leadership skills assessment), HAT (Handover assessment tool), ACAT (Assessment of acute care), DOC (Discussion of correspondence), ePaed CCF (Carers for Children Feedback), MSF (Multi source feedback), START (Specialty Trainee Assessment of Readiness for Tenure).
Table 5. Assessments for Level 3 trainees

<table>
<thead>
<tr>
<th></th>
<th>ST6</th>
<th>ST7</th>
<th>ST8*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mini-Cex</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>CbD</td>
<td>7</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Safeguarding CbD</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DOPS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A minimum of 1 satisfactory DOP for compulsory procedures within a specific sub-specialty curriculum</td>
<td>Skills log to be used to demonstrate development and continued competence</td>
<td></td>
</tr>
<tr>
<td>LEADER</td>
<td>1 across level 1 training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HAT</td>
<td>1 across level 1 training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACAT</td>
<td>1 across level 1 training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOC</td>
<td>5 across level 1 training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ePaed CCF</td>
<td>1 during level 3 training**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ePaed MSF</td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>START</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Safeguarding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trainees must achieve all of level 3 competencies, along with the additional paediatrician competences by the end of ST8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trainers report</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*ST8 may not be necessary in exceptional circumstances, **To be used as an additional tool when required.

MiniCeX (Mini clinical evaluation exercise) CbD (Case based discussion), DOPS (Directly observed procedural skills), LEADER (Clinical Leadership skills assessment), HAT (Handover assessment tool), ACAT (Assessment of acute care), DOC (Discussion of correspondence), ePaed CCF (Carers for Children Feedback), MSF (Multi source feedback), START (Specialty Trainee Assessment of Readiness for Tenure).
8. Where to go for more information

Help on Workplace Based Assessments:  
http://www.rcpch.ac.uk/assess-exams

Email: training.enquiries@rcpch.ac.uk

Web: http://www.rcpch.ac.uk/trainee-resources