

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

Second Edition August 2015  
(First edition Sep 2014)



# RCPCH

Royal College of  
**Paediatrics and Child Health**

*Leading the way in Children's Health*

Created by:

Hannah Baynes, Paediatric Consultant, Hillingdon Hospital

With contributions from:

Stephen Goldring, College Tutor, Hillingdon Hospital and the Education & Training Support Centre Team at the RCPCH

Edited by:

Bob Klaber, Consultant Paediatrician, St Mary's Hospital

Andrew Long, Vice-President Education, RCPCH

David Long, Officer for Assessment, RCPCH

David Evans, Officer for Assessment, RCPCH

David James, Chair, Trainees' Committee, RCPCH

Nick Prince, PICU Grid trainee, London

Laura Waddoups, Shared Services

With thanks to:

Christopher Hands, Paediatric trainee

Emily Cadman, Paediatric trainee

Natasha Bearpark, Paediatric trainee

Elizabeth Boot, Paediatric trainee

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# 1. Introduction

## *Engage... Do... Reflect... Learn... (and record).*

Workplace-based assessments have great potential in the assessment of doctors where it really matters – in the workplace. The assessment tools have evolved into Supervised Learning Events (SLEs – formative) and Assessments of Performance (AoPs – summative). The major determinants of whether the assessments achieve their intended aim of promoting learning and ensuring standards are being met are not the tools themselves but rather how they are used by trainees and trainers.

I hope this Guide will be an important aid to engagement with the assessments. It describes the purpose of each assessment tool, where it fits within the RCPCH assessment strategy and offers examples of how each tool can be used.

- Build them in to the routine; we are doing the clinical work anyway, the additional time should be for the feedback and planning next steps.
- It is more likely that the assessor will recognize the potential for a “teachable moment”, so remember that SLEs and AoPs can be initiated by assessors – they don’t have to be initiated by the trainee every time.

## *Quality... (not quantity)*

- With the SLEs, in particular, concentrate on the verbal feedback – it needs to be formative, encouraging, safe, challenging, caring and based upon what just happened. This is the quality element of the assessment.
- There needs to be a recorded summary of the feedback but remember that is only the start of the learning process – it also needs to be followed by reflection and an action plan.

We are still requiring minimum numbers of SLEs – although their true value is measured in the learning they serve to promote. As part of the ongoing evolution, the RCPCH is working on ways of making it easier for trainees and their supervisors to measure quality and coverage of the curriculum. I hope that in the future there will be less emphasis on mere numbers of assessments required.

## *Be innovative... (and have fun)*

Use the assessment tools to achieve your educational objective; the tools are not an objective in themselves.

I am very grateful for Hannah Baynes & the RCPCH for producing this Guide. I hope you find it useful. We are always happy to receive suggestions for improvements (formative feedback, obviously).

**Dr David Evans**

Officer for Assessment, Royal College of Paediatrics & Child Health



@RCPCH\_Assess

## 2. Workplace based Assessments: Supervised Learning Events (SLEs) and Assessments of Performance (AoPs)

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 SLEs 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/AoPs in a busy unit.

## 3. Types of Assessment Tools

### 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?

- Out of the minimum number of 12 SLEs per training year, **the suggested numbers of CbDs are at least: 4 (level 1 trainees), 6 (level 2 trainees) and 8 (level 3 trainees)**, with the trainee aiming to complete more than the minimum.
- At all levels, **one of these should be a Safeguarding CbD** per training year, 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 and senior 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 the potential to create challenge, doubt or difficulty.

How many?

- Out of the minimum number of 12 SLEs per training year, **the suggested numbers of mini-CEX are at least: 8 (level 1 trainees), 6 (level 2 trainees) and 4 (level 3 trainees)**, 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 mini-CEX with staff such as SASG doctors 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 at 32 weeks. 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 SASG doctors.

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 should be repeated until satisfactory level is reached (i.e. the trainee is competent to perform without supervision)

#### 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”*

## Specific CbD and Mini-CEX assessment tools

The Handover Assessment Tool (HAT), Acute Care Assessment Tool (ACAT) and LEADER CbD should be conducted as Supervised Learning Events and are included in the target and minimum numbers of SLEs to be recorded each training year.

Trainees should always aim to complete more than the minimum required number of assessments as determined with their educational supervisor to ensure they are demonstrating achievement of competencies.

### ***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.

Level 1 – trainees must do at least one HAT during their level 1 training.

Level 2 – trainees must do at least one HAT in each of their ST4 and ST5 years (and one HAT per year must be assessed by a consultant, additional HATs can be assessed by senior trainees or SASG doctors)

Level 3 – the HAT remains optional

### ***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”.

Level 1 – the ACAT is optional

Level 2 – trainees must do at least one ACAT during their level 2 training (and one ACAT must be assessed by a consultant, additional ACATs can be assessed by senior trainees or SASG doctors)

Level 3 – the ACAT remains optional

### ***LEADER: Clinical Leadership skills assessment***

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

Level 1 – the LEADER is optional but we would encourage its use to highlight the fact that leadership abilities are embedded in clinical practice and to encourage level 1 trainees to develop and refine their leadership skills from an early stage in training.

Level 2 and 3 – trainees must do at least one LEADER in each of their ST4, ST5, ST6, ST7 (and ST8 if undertaken) years (and one LEADER per year must be assessed by a consultant, additional LEADERS can be assessed by senior trainees or SASG doctors).

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.

More information on what is assessed during START and how:

<http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/start/start-structure-and>

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. In addition, it should lead to specific and SMART learning objectives which are recorded in the trainees 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 might 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.

## Reflection<sup>1</sup>

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

<sup>1</sup> 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 WPBAs 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 WPBAs to make sure they are being completed
- Invite trainees using 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)
- 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 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

### 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, clinical experience (not counted for training) or a career break (OOPR / OOPE / OOPC).

Note: OOPT (Out of programme for approved clinical training) must have an annual ARCP and would therefore be reviewed under outcome 1- 5; not outcome 8

### 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)

Assessment	Purpose	Who can assess?	Examples and tips
Mini CEX (Mini clinical evaluation exercise)	<p>Designed to provide feedback on skills essential to the provision of good clinical care.</p> <p>Cases should be chosen that have created challenge, doubt or difficulty.</p>	Consultants, SAS and more senior trainees.	<p>Observing an ST1 examining a patient and explaining the management plan to the parents.</p> <p>Observing an ST4 counselling a parent due to deliver at 32 weeks.</p> <p>Leave time at the end of the ward round for recording such assessments with trainees</p>
CbD (Case based discussion)	<p>Designed to assess clinical reasoning, decision making and the application of medical knowledge in relation to patient care.</p> <p>The discussion should focus on an actual entry made in the patient's notes, and should explore the thought processes that underpinned that entry.</p> <p>Cases should be chosen that have created challenge, doubt or difficulty.</p> <p>One of these, each training year, should be based on a Safeguarding related case</p>	Majority by a Consultant. SASGs, Senior trainees (senior to the assesse) also acceptable.	<p>Set up a dedicated CbD "clinic" one afternoon a week for trainees to perform CbDs during dedicated time.</p> <p>Trainees should get into the habit of photocopying the notes of interesting cases to use as later CbDs.</p> <p>After complex cases have been presented and discussed, ask trainees to write written reflection. This, along with learning points from the discussion, can form the written feedback for a WPBA.</p>
DOPS (Directly observed procedural skills – this is an AoP)	<p>Designed to assess practical skills. Aim to complete by the end of level 1 training. Must be repeated until a satisfactory level is reached.</p> <p>Compulsory AoPs</p> <ul style="list-style-type: none"> <li>• Bag, valve mask ventilation</li> <li>• Capillary blood sampling</li> <li>• Venesection</li> </ul>	Consultants, senior trainees, nurse practitioners and SAS. Must be proficient in the procedure, and have read and understood the guidance.	<p>Other practical skills should be recorded in the skills log of E-portfolio to demonstrate development and continued competence.</p> <p>Level 3 GRID trainees have additional compulsory DOPS</p>

	<ul style="list-style-type: none"> <li>• Peripheral cannulation</li> <li>• Lumbar puncture</li> <li>• Measuring non-invasive BP</li> <li>• Intubation (term/preterm)</li> <li>• UVC insertion</li> </ul>		defined by their CSAC.
LEADER (Clinical Leadership skills assessment) (CbD)	A CbD based around a clinical case or problem, with the discussion focusing on leadership issues.	At least one/year by a consultant (L2,3)	Observing a trainee lead a resuscitation. Discussing the implementation of a trainees quality improvement project
HAT (Handover assessment tool) (CEX)	A CbD 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/year by a consultant (L2).	Observing a trainee's morning handover. Observing a trainee handover to the retrieval team after a successful resuscitation.
ACAT (Acute care assessment tool) (CbD/CEX)	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 (L2).	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 (L2,3).	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)

Name		Aim	Structure/Format	Note
MRCPCH *CBT"	Foundation of Practice (FOP) (Formerly part 1a)	To assess knowledge, understanding and clinical decision making abilities	2½ hour CBT exam Same day as Theory and Science <ul style="list-style-type: none"> <li>• 'Extended-matching'</li> <li>• 'Best of five's'</li> <li>• 'True-false'</li> </ul>	Candidates are able to apply for the written examinations in any order as long as they have a primary medical degree  2 out of 3 (FOP, TAS, AKP) must be completed before entry into ST3
	Theory and Science. (TAS) (Formerly part 1b)	Emphasis on basic science, physiology and pharmacological principles  Also tests principles of evidence based medicine and applied knowledge	2½ hour CBT exam Same day as Foundation of Practice 'Extended-matching' 'Best of five's' 'True-false'	
	Applied Knowledge in Practice (AKP) (Formerly part 2)	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	2 x 2½ hour CBT exams on the same day <ul style="list-style-type: none"> <li>• Case histories</li> <li>• Data interpretation</li> <li>• Photographic material</li> <li>• Format</li> <li>• 'Extended-matching'</li> <li>• 'Best of' lists</li> <li>• 'n from many'</li> </ul>	
MRCPCH *Clinical	Clinical	To assess whether candidates have reached the standard in clinical skills expected of a newly appointed Specialist Registrar	10 clinical OSCE stations <ul style="list-style-type: none"> <li>• Hx and Mx planning (22mins)</li> <li>• Clinical video scenario (22mins)</li> <li>• Communication skills (9mins) x 2</li> <li>• Child development (9mins)</li> <li>• CVS (9mins)</li> <li>• Resp/other (9mins)</li> <li>• Abdo/Other (9mins)</li> <li>• MSK/Other (9mins)</li> <li>• Neurology/neurodis (9mins)</li> </ul>	Must have completed CBT exams (FOP, TAS, AKP) before sitting.  Must be completed before entry into ST4

START	Specialty Trainee Assessment of Readiness for Tenure	<p>To evaluate whether a trainee has the skills required to perform at the level of a newly appointed consultant</p> <p>Applies to all trainees who entered Level 3 training on or after 1 August 2011</p> <p>Completed at ST7 so that trainees can use the feedback to develop themselves in their final year of training.</p>	<p>12 stations (12 mins each)</p> <ul style="list-style-type: none"> <li>• Six sub-speciality (including general paediatrics)</li> <li>• Six generic scenarios</li> </ul>	<p>Feedback accessed through ASSET</p> <p>Not usually repeated</p> <p>Any highlighted difficulties addressed through educational supervision</p>
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\*MRCPCH structure, syllabus and specimen papers available at:  
<http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/examinations/examinations>

Table 3. Table of Assessments (please see explanatory notes)

	LEVEL 1			LEVEL 2		LEVEL 3		
	ST1	ST2	(ST3)	ST4	(ST5)	ST6	ST7	(ST8)
<b>Supervised Learning Events (SLE) – Aim for 20 SLEs per training year<sup>(2)</sup> (FTE); MINIMUM MANDATORY requirements are as follows:</b>								
<b>Mini CEX &amp; Cbd</b> Including:	Minimum 12 /year Ratio of mini CEX to Cbd 2:1 <sup>(3)</sup>			Minimum 12/year Ratio of mini CEX to Cbd 1:1 <sup>(3)</sup>		Minimum 12 /year Ratio of mini CEX to Cbd 1:2 <sup>(3)</sup>		
ACAT (CEX/Cbd)	Optional			1 <sup>(note 6)</sup>		Optional		
HAT (CEX)	1			1 <sup>(note 6)</sup>	1 <sup>(note 6)</sup>	Optional		
LEADER (Cbd)	Optional			1 <sup>(note 6)</sup>	1 <sup>(note 6)</sup>	1 <sup>(note 6)</sup>	1 <sup>(note 6)</sup>	1 <sup>(note 6)</sup>
Safeguarding Cbd	1	1	1	1	1	1	1	1
<b>DOC</b>	Optional			5 <sup>(note 6)</sup>		5 <sup>(note 6)</sup>		
<b>Assessment of Performance (AoP)</b>								
<b>DOPS</b>	A minimum of 1 satisfactory AoP for the compulsory procedures <sup>(7,8)</sup>			1 satisfactory AoP for the compulsory procedures outstanding <sup>(7,8)</sup>		A minimum of 1 satisfactory AoP for the compulsory procedures within the relevant sub-specialty curriculum <sup>(7,8)</sup>		
<b>Paed CCF</b>				1 <sup>(note 11)</sup>		1 <sup>(note 11)</sup>		
<b>ePaed MSF</b>	1	1	(1)	1	(1)	1	1	(1)
<b>Other assessments that contribute to ARCP</b>								
<b>START</b>						1		
<b>MRCPCH Examinations</b>								
<b>MRCPCH Written exams</b>	1-2 written exams (desirable)	2 out of 3 written exams (essential)	All written exams (essential)					
<b>MRCPCH Clinical Exam</b>			Essential					
<b>Trainer's Report</b>								
<b>Trainer's Report (inc. ePortfolio)</b>	1	1	(1)	1	(1)	1	1	(1)

## NOTES

### SUPERVISED LEARNING EVENTS (SLE)

1. The purpose of SLEs is as a means of engaging in formative learning; therefore a trainee who presents evidence of SLEs that cover only a restricted area of the curriculum runs the risk of being judged as having poor strategic learning skills. All trainees are therefore advised to plan how they will demonstrate coverage of their relevant curriculum in partnership with their Educational Supervisor.
2. Trainees should aim for 20 SLEs per training year (20 per year for full time, pro-rata for LTFT trainees); this includes all types of SLEs (CEX, CbD, ACAT, HAT, LEADER, Safeguarding)
3. The ratios given for the balance of mini CEX to CbD assessments are for guidance only and the exact ratio should not be used as a criterion for determining satisfactory progression.
4. Trainees are also encouraged to undertake the assessments indicated as optional.
5. The numbers of SLEs given for ACAT, HAT, LEADER and Safeguarding CbD are minimum requirements; senior trainees in particular should bear in mind that each of the SLEs is designed for formative assessment of different aspects of the curriculum and more than this minimum number of some types of SLE might be required, depending upon the specific requirements and clinical context of a subspecialty. Trainees are therefore advised to consult their relevant subspecialty CSAC curriculum, in case there are additional specified assessment requirements.
6. At least one of each of these SLEs must be assessed by a senior supervisory clinician (e.g. Consultant or senior SASG/Specialty Doctor) – i.e. ACAT and HAT during level 2 training, LEADER during level 2 and level 3 training and at least one of the five DOC during level 2 and level 3 training.

### ASSESSMENT OF PERFORMANCE (AoP)

7. The compulsory procedural skills are listed on the RCPCH website:  
<http://www.rcpch.ac.uk/training-examinations-professional-development/quality-training/work-based-assessments-asset/assess-0>
8. The e-Portfolio skills log should be used to demonstrate development and continued competence.

### ADDITIONAL REQUIREMENTS

9. Trainees must also complete accredited neonatal and paediatric life support training during Level 1 training.
10. Trainees must achieve the level 1 and 2 Intercollegiate Safeguarding Competences by the end of ST3, the majority of Level 3 competences by the end of ST5 and all Level 3 competences along with the additional paediatrician competences by the end of ST8.
11. The Paed CCF can be used as an additional tool if required.

## 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](mailto:training.enquiries@rcpch.ac.uk)

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