Foundation programme assessment: the trainee's guide

Introduction

The enormous process of reforming the training grades is described in the Department of Health document, *Modernising Medical Careers* (Department of Health, 2003). The changes are being made in sequential order, with the preregistration house officer (PRHO) and first senior house officer (SHO) year being the first to change. These 2 years have been combined into one foundation programme (FP), intended to produce doctors with a range of generic core competencies (Department of Health, 2005) (i.e. skills and knowledge common to all doctors completing their FP) that match the areas covered by the General Medical Council's *Good Medical Practice* (General Medical Council, 2001).

One difference between the old PRHO/SHO years and the FP is the style, quantity and quality of assessment and feedback. The assessment process has been formalized and made more uniform so that doctors can see how they are doing compared to their peers. This in turn means that they can have insight into their strengths and target training on areas which need development (Davies et al, 2005; Junior Doctors' Committee, 2005; Wilkinson et al, 2005).

The first year of the FP, F1, will be similar to the PRHO year, with posts in medicine and surgery and usually another specialty as well. The second year, F2, will be composed of specialty placements, with accident and emergency (A&E) being an important component of most programmes, and general practice featuring prominently. Other specialties might include obstetrics and gynaecology or intensive care, or shorter placements in specialties like microbiology or public health (Junior Doctors' Committee, 2005; Wilkinson et al, 2005).

The trainee will carry a learning portfolio through the 2 years with all his/her assessment feedback and learning objectives in it. There will be (unlike at present) an explicit definition of what a doctor should be able to do by the end of F1 and F2 (the foundation competencies), and along the way there will be various assessment tools used to guide his/her development.

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Wishy-washy educationalist processes, or useful for the trainee?

From a trainee's point of view, this might seem like an awful lot more work on top of what is still expected in terms of training. However, those who have already done several years of postgraduate training would probably agree that trying to work out how one is doing without getting any feedback from seniors is very difficult indeed. These assessment processes are designed to give the trainee that feedback, while only taking a total of around 6 hours per year.

Another advantage is that the data collected in this way can be used as evidence to support the trainee's submission for the General Medical Council's revalidation processes, saving a lot of extra effort in accumulating proof of good medical practice. Revalidation processes are not yet decided so this may change, but every indication is that assessment data will be able to be used in this way (L Bond, 2005, personal communication).

What is an 'assessment tool'?

This educationalist term refers to different ways of testing the trainee, such as short cases, multiple choice questions (MCQ) or structured interviews. To make the assessment and the feedback received more valid, it should come from a number of different sources. These tools will be clinically based, directly or indirectly involving real patients and real-life practice.

What training will the assessors get?

All the people assessing case-based discussions and mini-CEX (clinical evaluation exercise) should have been trained to do so, often 'in-house' by senior people specializing in this area. Some people carrying out the directly observed procedural skills (DOPS) assessment will not have been trained for that, but the assessment form is so easy to follow that this will not matter. Others (especially consultants) will have been coached by the deanery.

What standard is a trainee expected to achieve? Can a trainee fail these assessments?

The FP is designed for the trainee to achieve a set minimum standard by the end of 2 years. Along the way, the trainee is assessed against that standard, so to start with he/she will be getting worse scores (e.g. 2 or 3 out of 6), and by the end he/she should be getting 4 (pass) or above in every category.

The idea is that no-one should get to the end and be surprised at getting a 'failing' mark. All along the way, the trainee will get feedback on how he/she is doing and which areas need to be addressed. Clinical supervisors should be helping the trainee bring his/her scores up in areas where he/she is underachieving.

These assessments are to some extent summative as well as formative, i.e. if the trainees do get to the end of the FP still unable to achieve a good enough standard overall then various aspects may have to be re-done. The assessments provide actual solid evidence of the need for this, whereas before it was a rather subjective process. The possibility of 'failing' the FP does exist, but the idea is that struggling doctors will be picked up early in their FP by these assessments, when remediation is possible and much easier.

The assessment tools

Mini-PAT (peer assessment tool)

The peer assessment tool (PAT) is designed to give feedback from a range of people who work with the trainee. He/she is sent a form in the first two placements of F1 and F2 and nominates 8 people by whom he/she would like to be assessed. These can be consultants, other junior doctors, nurses, physiotherapists or other health-care professionals, but not non-clinical staff (except in general practice) or patients. People should be asked before putting their names down.

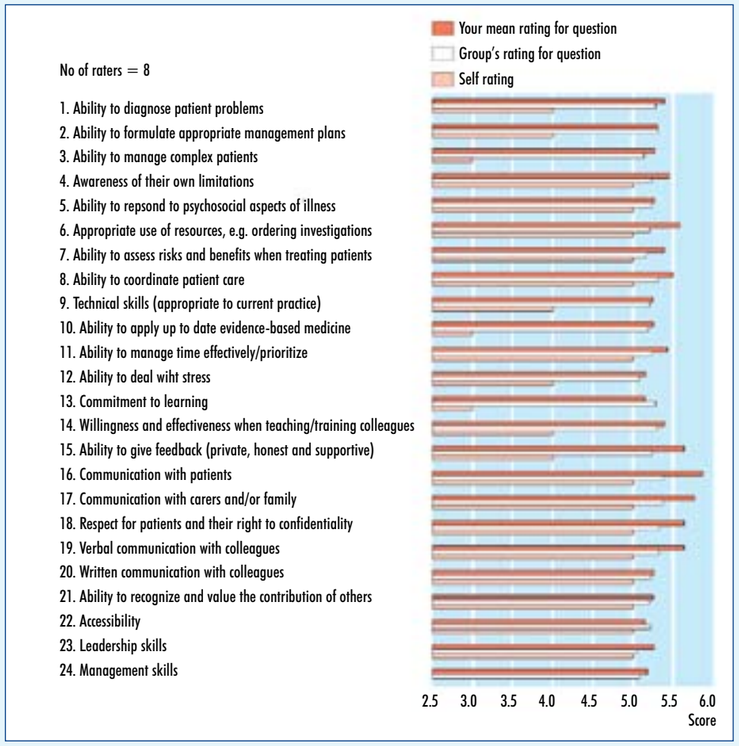

Figure 1. Example of feedback chart given to a doctor after mini-PAT (peer assessment tool) assessments. From Archer et al (2005).

Raters must spread out across a range of occupational groups. If only fellow SHOs are asked to assess the trainee, then the national assessment unit in Sheffield will note this and the evidence will be considered less strong. Evidence should be gained from a wide range of sources, so the trainee should try and spread his/her net quite widely and remember that he/she has a lot of interaction with nurses who can give useful feedback (Vallis et al, 2003).

These people will each be sent a form asking them to rate the trainee in sixteen areas that relate to *Good Medical Practice* (General Medical Council, 2001) (e.g. 'Ability to formulate management plans' or 'Written communication with colleagues'), with scores out of 6. The trainee is also sent a similar sheet to rate his/herself in the same areas. These results are all collated at the national centre in Sheffield, and the trainee is sent a sheet a few weeks later (*Figure 1*) showing how the self-ratings compared to the mean scores for his/her 10 assessors and to the mean scores for all doctors at the same stage as the trainee.

The trainee can then see where he/she is relatively strong and which areas might benefit from further development. He/she has to take responsibility for acting on this information, and should come up with an improvement plan to discuss with his/her supervisor at the next session.

This process is carried out twice a year, with new assessors each time (the same people can be nominated again, but by then the trainee will probably have moved on to a new post anyway).

DOPS (directly observed procedural skills)

Here the trainee is observed carrying out various procedures on real patients in the workplace. The trainee can pick anyone to be his/her assessor provided they are a suitable person to judge how well the procedure went, i.e. they should be able to carry out the procedure themselves. As with the mini-PAT, the trainee should try and get a number of different people to do this for him/her. It doesn't require any special training to assess someone with this form, so the trainee should have a large pool of people to draw on and should independently choose which procedure to perform (*Table 1*).

The trainee should simply set up the equipment and give the form to his/her assessor, who will stand and watch the trainee do the procedure and then mark him/her throughout by ticking the boxes to score each area (for example, 'technical ability' or 'seeks help where appropriate').

Then the assessor and the trainee both sit and talk about how the procedure was performed, what he/she did, what went well, what could be improved and how he/she could go about improving it. This last bit is very important – the trainee is supposed to learn from these assessments, in terms of how or whether he/she should change his/her practice.

This is intended to be a two-way process and the trainee can express an opinion

Table 1. The list of procedures to be observed, taken from the directly observed procedural skills (DOPS) form

Venepuncture
Cannulation
Blood culture (peripheral)
Blood culture (central)
Intravenous infusions
Electrocardiogram
Arterial blood sampling (radial/femoral stab)
Nasogastric tube insertion
Subcutaneous injection
Intradermal injection
Intramuscular injection
Urethral catheterization
Intravenous injection
Airway care
'Other' (specify):

about why he/she did it in a particular way, and discuss whether the assessor's way is necessarily better.

The trainee would normally complete six of these DOPS assessments in each year, although he/she can do more if there is a concern that his/her performance could be improved. The assessment takes about 5–10 minutes in addition to the time taken to carry out the procedure itself.

Mini-CEX (clinical evaluation exercise)

The mini-CEX is slightly more involved than DOPS. It is about being watched interacting with a patient, and is often focussed on one aspect, e.g. examination of the nervous system or taking the history.

Again, the trainee should prepare by warning the patient that he/she is being assessed (reassuring the patient that he/she is not a medical student or in some way not a 'proper doctor' because of this), and the assessor comes in with the form, and watches the trainee as a fly on the wall.

These are usually focussed assessments and the trainee has to cover the main areas of airway, breathing, circulation, neurological, psychological/behavioural and pain, but not necessarily all these areas in every observed session. For instance, the trainee might ask a registrar to observe him/her clerking a patient in A&E for 15 minutes or so, and he/she will assess the trainee on the areas he/she sees covered in that time. The trainee will then get feedback straight away, based around the form (Norcini et al, 1996; Holmboe et al, 2004).

The forms are also sent back to Sheffield and the trainee will receive an overall assessment profile at the end of the year. He/she are expected to submit at least six of these mini-CEX forms each, year with a different assessor and different clinical problem for each but the trainee can do more if he/she wishes.

CbD (case-based discussion)

The essence of case-based discussion (CbD) is that the trainee and a senior doctor sit and go through a case that the trainee has seen, with the patient's notes there, focussing on an actual entry by the trainee in the notes. The trainee would normally take two sets of notes with him/her, and the assessor picks one and the trainee would talk them through the clerking he/she has done.

CbD looks at clinical reasoning: Why did the trainee mention this and not that? What was his/her differential at this point? How did the trainee decide what tests to order and how did he/she think it would modify the probability of a particular diagnosis being the answer? Once he/she had seen the results, how did that modify his/her thinking on this patient? It is not a discussion of the entire case like a viva, but more an exploration of the trainee's reasoning in relation to a particular aspect of the case.

At the end, the senior doctor then fills out the feedback form, which has marks for categories like 'clinical assessment and 'follow-up and future planning', and discusses it with the trainee. Areas of strength and areas needing development are agreed, and the trainee can then come up with a plan of how to address any areas that would benefit from further work.

The trainee would be expected to complete six of these discussions in each of the F1 and F2 years.

Conclusions

A new structure for postgraduate training includes a new emphasis on appraisal and assessment, for the benefit of the trainee. The assessment tools aim to draw evidence from a variety of sources and cover a range of knowledge, skills and attitudes, both usually chosen to some extent by the trainee.

By covering procedural skills (DOPS), clinical skills (mini-CEX), clinical reasoning (CbD) and team-working (mini-PAT), among other things, these assessment tools will give trainees a good idea of where strengths and weaknesses lie, and this information will be used to guide training at a personal level.

They will, however, also be used to determine in part whether the trainee will progress to the next stage in his/her career (F1 to F2, or F2 to specialty training). These decisions, like appraisals and training guidance, will therefore be based more squarely on actual evidence than at present, and theoretically related to a national standard.

There will be a period of adjustment while the assessment tools are bedded in nationally, but they should prove beneficial to trainees and trainers alike in the end. **BJHM**

Conflict of interest: The author is a trainee representative on the London Deanery's Modernising Medical Careers Steering Group and is in an F2 pilot post this year, currently in accident and emergency.

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KEY POINTS

- New training structures for junior doctors include new competency-based assessment methods.
- Evidence will be sought on many different topics and skills.
- Clinical examination and reasoning, procedural skills and professionalism will be assessed with these new tools.
- The assessment outcomes will guide training on an individual basis.
- They will also be used to determine if trainees progress to the next stage or not.