

Annex 9

Annual college/faculty Summary Form per specialty or sub-specialty

This form is a **summary of the minor changes** made to the curriculum and/or assessment system for each specialty or sub-specialty during a given period.

The changes must be in accordance with the definition of a minor change and should comply with PMETB's Standards for curricula, March 2005 and the *Principles for an assessment system for postgraduate medical training*, September 2004.

ALL SECTIONS OF THE FORM MUST BE COMPLETED AND ONE FORM SHOULD BE COMPLETED PER SPECIALTY OR SUB-SPECIALTY

Section 1. Details of the medical Royal College/Faculty/ Specialist Association

Details of the medical Royal College/Faculty/Specialist Association	
Name	Royal College of Paediatrics and Child Health
Specialty	Level 2 Training in Paediatrics
Sub-specialty	
Contact details for the person responsible for submitting this form to PMETB	
Name	Lara Smith
Address	Royal College of Paediatrics and Child Health 5 – 11 Theobalds Road London WC1X 8SH
Job Title/Role	Training and Assessment Advisor
Telephone number	
Mobile number	
Email	

Section 2. Details of changes made for the period

Section 2(a) Please tick ONE box: 2008/9 2009/10 2010/11

Section 2(b)

Minor changes made	Page reference in original document*	Proposed new wording	Rationale for changes made
There have been no changes made to the curriculum or the assessment strategy since PMETB approval in 2007.			

[* please stipulate whether this refers to the curriculum or the assessment system]

Section 3. Details of proposed changes for the forthcoming period

Please use this section to inform PMETB of any changes proposed for the forthcoming reporting period as far as the college/faculty is aware.			
Proposed changes	Page reference in original document*	Proposed new wording	Rationale for changes proposed
Minor amendments to the curriculum	Curriculum document	Please see detail following	The curriculum has been reviewed by all committees from the College and the feedback has been collated to make the following changes. The amended syllabus will be available on the website and all trainees will be informed. All of the minor amendments do not impact on the assessment strategy. The majority of the changes are to ensure there is no unnecessary repetition (highlighted by the training committee and the trainees committee) or for further clarification of the competence.
Insert	Curriculum Page 15	Have developed strategies to anticipate and respond sensitively to children and young people who are suggesting unease or unwillingness about a physical examination	To ensure the non-verbal communication skills are addressed and to progress a new competence at Level 1
Move from a speciality area to general	Move to Page 20 from Page 38, bullet point 15	Begin to use principles of evaluation, audit, research development and standard-setting in quality	This is an important generic skill as well as speciality specific, considering the development of management skills and the medical leadership framework. This follows on from changes at level 1
Insert	Page 20	Begin to work in managed clinical networks and in outreach clinics	Following on from the introduction of a new competence at Level 1, this competence was devised to make progression to the Level 3 competence
Remove	Page 23, bullet point 8	n/a	Repetition of competence from page p.14 bullet point 1

Replace	Page 25, bullet point 8	Identify and understand the patterns of normal and abnormal development patterns from birth to adulthood	Follow on from Level 1 amendments of combining similar competences
Changes to Musculo-skeletal speciality specific competences	Page 57 – 59	See appendix 1	The Musculoskeletal CSAC, on reviewing their area made minor amendments. The reasons for this were both trainers and trainees felt that the terminology needed to be removed
Layout of curriculum	Whole curriculum document	There will no new wording	To provide trainees and educational supervisors with an electronic format of the curriculum, which improves accessibility, navigation and decrease carbon foot print and will. The document will have hyperlinks from the contents page and links within the document to take trainees to linking areas. There will be a search mechanism to enable quick referencing
Assessment minimum for Directly Observed Procedures (DOPs)	Assessment system Page 14, table 1 and Appendix 10 of the Assessment Strategy	See appendix 2	Following a ranking exercise completed by the Assessment Committee, guidelines are being produced to ensure the most important procedures are observed. Following on from this, the Assessment Committee will draft guidelines to ensure sufficiency of coverage for DOPs
Change of wording	Pages 15 and 16 and Appendix 15 of the assessment strategy	See appendix 3 and 4	At a recent Regional Advisors Committee issues were raised about clarity of trainees who were not ready to progress in their training. Statements are being made more explicit and the current language refers to the individually being unsatisfactory as opposed to their progression being unsatisfactory.
e-portfolio launch			After a year of piloting the e-portfolio, the launch will start in late summer of 2008

[* please stipulate whether this refers to the curriculum or the assessment system]

Section 4. Declaration

I confirm that the information given on this annual college summary form is correct and I understand that failure to disclose relevant information may result in the curriculum and/or assessment system no longer being approved.	
Signature: _____	Date: _____
Position held: Training and Assessment Advisor	

This form must be submitted electronically to: curriculum.eval@pmetb.org.uk

And in hard copy (1 copy) to:

Curriculum & Evaluation
Postgraduate Medical Education & Training Board
Hercules House
Hercules Road
London
SE1 7DU

Appendix 1

Musculo-skeletal Medicine - LEVEL 2

Continuing development from the Level 1 document

- know the differential diagnosis of musculoskeletal presentations including inflammatory, non-inflammatory and idiopathic causes
- take an appropriate musculoskeletal history and examination (screening and approach to regional examination)
- recognise when to request the opinion of a paediatric rheumatologist or orthopaedic surgeon
- recognise features in the clinical presentation or investigation findings which suggest serious pathology e.g. inflammation, malignancy, infection and vasculitis
- recognise features in the clinical presentation or investigation findings which suggest physical abuse, emotional abuse and neglect
- understand the role of the multi-disciplinary team and other professionals involved in the care of children with musculo-skeletal conditions
- understand the disease associations of rheumatological conditions, in particular juvenile arthritis and eye disease
- understand the association of musculoskeletal presentations and common chronic diseases (such as psoriasis, inflammatory bowel disease)
- understand the initial investigations to establish a diagnosis

Change of wording from the Level 1 document

- understand the indication for and complications of immunosuppressive treatment

Substantial re-wording or new statement of competence for Level 2 Training

- be aware of congenital bone, inherited or metabolic conditions and their musculoskeletal presentations
- interpret investigations that are helpful in establishing a differential diagnosis

Acute presentations

The patient presents with	Knowledge and understanding	Skills
Joint swelling	Know the causes of joint swelling at single and multiple sites Know when to refer for a specialist opinion	Be able to perform musculoskeletal assessment including a screening examination and an approach to more detailed examination Be able to identify joint

		swelling and abnormal range of joint movement on clinical examination
Musculoskeletal pain	<p>Know the varied causes of musculoskeletal pain including referred pain and features that suggest serious causes</p> <p>Know when to refer for a specialist opinion</p>	Perform a musculoskeletal examination including a screening examination and appropriate regional examination
Limp	Know the differential diagnosis of a limp at different ages and clinical presentations	

Outpatient presentations

The patient presents with:	Knowledge and understanding	Skills
Limb pains	<p>Know the differential diagnosis of limb pains</p> <p>Know the clinical features and be able to recognise benign hypermobility and non-benign hypermobility (e.g. Marfans syndrome)</p>	<p>Be able to assess joint laxity</p> <p>Be able to distinguish between inflammatory and non-inflammatory conditions and recognise features that suggest serious pathology</p>
Back pain and neck pain	<p>know the causes of back / neck pain</p> <p>Know the indications for further / urgent investigations and referral for specialist opinion</p> <p>Know the common causes of Torticollis</p>	Be able to recognise scoliosis
Leg alignment (normal variants)	<p>Know normal patterns of leg alignment and foot posture (bow legs, knock knees, in-toeing and flat feet) at different ages</p> <p>Be aware of indications for investigation and when specialist opinion is required</p> <p>Know the predisposing factors and presentation of rickets</p>	be able to recognise the clinical presentation and radiological features of rickets
Multi-system disease	Know the clinical presentations and investigations that may suggest autoimmune disease	

Appendix 2

Appendix 10 DOPS Procedures for each level

Level 1 (ST1-ST3)

The following procedures must be assessed at least once

MANDATORY

- bag, valve and mask ventilation
- capillary blood sampling
- lumbar puncture
- peripheral venous cannulation
- tracheal intubation of newborn babies
- umbilical venous cannulation

SUPPLEMENTARY

The following procedures maybe assessed to achieve inform the annual review process and progression from ST3 to ST4

- Administer intradermal, subcutaneous, intramuscular, intravenous injections
- Administration of surfactant
- Collection of blood from central lines
- Non-invasive blood pressure measurement
- Electrocardiogram
- Suprapubic aspiration of urine
- Umbilical artery cannulation
- Umbilical vessel sampling
- Urethral catheterisation
- Venesection
- External chest compressions

Level 2 (ST4-ST5)

The following procedures must be assessed at least once

MANDATORY

- Administration of surfactant
- Intubation of preterm babies
- Percutaneous long-line insertion
- Umbilical artery cannulation
- umbilical venous cannulation

SUPPLEMENTARY

The following procedures maybe assessed to inform the annual review process and progression from ST5 to ST6

- Chest drain insertion
- Insertion on interosseous needle
- Needle thoracocentesis for pleural effusion or pneumothorax
- Perform basic ling function tests
- Peripheral arterial cannulation

Appendix 3

From the assessment strategy

Synthesising assessment evidence

Together with MRCPCH and workplace assessments, trainees are expected to maintain evidence of their progress in a portfolio and this, together with structured trainer's reports, contributes to their overall assessment. The range of instruments within our assessment system enables us to obtain data on a trainee's progress from different sources, on different occasions and from different assessment methods. This will enable us to triangulate evidence and come to an overall assessment of an individual trainee's progress, attainment or difficulties.

The evidence provided by the required collection of workplace assessments will be synthesised in the Trainer's report. According to the Guide to Postgraduate Specialty Training in the UK (Gold Guide), there will be an annual assessment of a trainee's progress within each Deanery; the Annual Review of Competence Progress (ARCP). The ARCP panel will then determine whether a trainee **has the required competences** and accordingly may progress. (see 1.4d and Appendix 11 and 14).

The number and nature of assessments required for each stage of training is determined by **the RCPCH Assessment Committee** and will be reviewed **when** quality assurance data and relevant published research **is available**. The number of **satisfactory** assessments currently required is the MINIMUM deemed necessary to demonstrate adequate performance (Table 1 and Appendix 15).

We recognise that the majority of trainees will reach satisfactory levels of competence, but that a few will fall below expected standards in some areas. These trainees may require additional training and targeted assessments. (1.9)

The paediatric trainee making satisfactory progress:

*The following criteria must **all** be satisfied to identify the **trainee making satisfactory progress***

- The trainee will have passed the required stage of the MRCPCH examination for the level of training **(See Appendix 15)**

- The trainee will have reached the expected standard for all the required workplace assessments for the level of training (See Appendix 15).
- The trainee will have submitted all the required workplace assessments with appropriate sampling of the range of the required clinical content using a range of assessors
- There will be no outstanding concerns in relation to fraud or probity in respect of the trainee.

The paediatric trainee making unsatisfactory progress

*The following criteria **taken individually would** constitute unsatisfactory performance*

- The trainee will not have passed the required stage of the MRCPCH examination for the level of training. Trainees cannot progress beyond ST2 without having passed Part 1A and Part 1B, and trainees cannot progress beyond ST3 without passing MRCPCH Part 2 written and clinical.
- The trainee will not have reached the expected standard for all the required workplace assessments for their stage of training despite developmental needs being identified and an action plan agreed.
- The trainee will not have presented sufficient evidence to the ARCP panel.
- There is evidence of fraud or probity in respect of the trainee.

If ANY of these criteria are present then the outcome will be decided by the ARCP panel with reference to the Gold Guide (Appendix 14)

For further details of the assessments at each level see Appendix 15.

1.9 Doubt about satisfactory progress and use of additional standard assessments

The core assessments required are outlined in the road map. We recognise that the majority of trainees **will have achieved the required competences**. However for those few trainees whose performance falls below expected standards in some areas, additional training and targeted additional assessments may be required. It may be appropriate to use additional standard or alternative assessments, for example the Patient Consultation Assessment Tool (PCAT), which may be especially useful for those with problems with communication skills as it offers an opportunity to provide structured feedback on a consultation.

Additional Assessments

Increased numbers of assessments may be undertaken to increase the confidence that can be placed in the overall judgement being made. There are a number of ways in which extra assessments will increase the robustness of the judgement being made:

- 95% confidence interval (CI) around the mean are determined in relation to the number of assessors (see Appendix 1). As the number of assessors increase the confidence intervals narrow. For example, for mini-CEX for F1 trainees the 95% CI for 4 cases is 0.56 but for 12 cases is 0.31. In other words an overall mean of 4.33 would be needed with 12 cases to be 95% confident that a trainee was truly OK compared to an overall mean score of 4.57 for 4 cases.
- additional sampling will allow a broader qualitative perspective on the trainees performance enabling a clearer understanding of the nature of the problem and providing additional opportunities to identify action points and attempt remediation.
- Additional assessments will allow broader sampling of clinical problem areas for the case focussed assessments. In general, if possible, different clinical problem areas should be sampled for each of these assessments. However, if there is a particular clinical problem area that raises concern a focus on clinical cases representing a range of conditions in that clinical area may be appropriate.

Appendix 4

From the Assessment Strategy

Appendix 15 Detail of assessments at each level of training

Assessing Level 1 competences

Throughout Level 1 training, trainees will need to acquire the basic scientific knowledge associated with paediatrics and child health. Application of this knowledge will be tested in many of the workplace assessments but the full breadth of this knowledge will be tested in the MRCPCH examination, particularly in the written examinations.

Although trainees leaving Foundation training will have a wide range of generic skills related to the care of adults, few will have skills related to the care of children. This means that trainees entering paediatric training may have had little or no experience of caring for children or of the specialty. Basic skills, which are well developed in adult specialties at the same stage, are absent. For example, trainees would not be able to undertake a clinical examination and interpret the findings, taking into consideration what would be appropriate for the child's age and development. Assessment of these competences will begin in the workplace with PaedMiniCeX. These competences will also be tested in the clinical MRCPCH examination.

The ability to undertake even basic practical procedures in children will be extremely limited, even where trainees are competent to undertake technical procedures in adults. These will be assessed in the workplace using DOPS.

They will need to learn how to undertake three-way consultations, which are fundamental to paediatric practice. This will be assessed in the workplace using PaedMiniCeX. These competences will also be tested in the clinical MRCPCH examination.

They will have rudimentary or no knowledge of normal laboratory values and drug dosages for children. These are competences that are taken for granted in adult practice at this stage of training, but will need to be developed for paediatric practice. These will be tested in MRCPCH, particularly in the written part of MRCPCH Part 2.

Although trainees will be competent at acute resuscitation in adults, they will need to acquire these skills for paediatric practice. These skills will be tested in the formal assessment processes associated with the Acute Paediatric Life Support and Neonatal Life Support courses, which are a mandatory part of training at this stage.

Satisfactory completion of Level 1 training requires

- MRCPCH. **Trainees cannot progress from beyond Level 1 (ST3) without passing MRCPCH Part 2 written and clinical.**
- Minimum of 6 mini-Cex per year at or above the expected level, performed by a range of assessors
- Minimum 4 CbD per year at or above the expected level, performed by a range of assessors
- All 6 “core acute conditions” to be covered in the miniCEX and CbD assessments (respiratory, gastroenteritis, convulsions, fever, rash, abdominal pain)
- Satisfactory DOPS assessments to cover each practical procedure in the level 1 framework
- Accredited paediatric and neonatal life support training
- Minimum of 1 satisfactory MSF per year to cover neonatal and general paediatric practice
- A portfolio which is kept up to date
- An annual trainers report supporting this evidence

Failure to meet any one of these criteria will raise serious concerns about the trainee’s ability to proceed to the next level of training. Where additional training is required, the content of such training and overall duration of the extension to training will be decided at the ARCP and will be at the discretion of the Postgraduate Dean (see Appendix 14).

Assessing Level 2 competences

At this stage, trainees are expected to apply the knowledge they have acquired and will need to have opportunities to take on responsibility. They will be expected to develop clinical reasoning and decision-making. Case-based Discussion is particularly suitable for assessing these skills hence the emphasis on this form of assessment at this stage of training. Trainees will learn further skills by taking on a more senior clinical role and by being involved in wider professional roles, including teaching, clinical governance and multi-professional working. A trainee at this stage should be learning through feedback and reflection, learning through teaching others and learning through assessment itself. The use of the portfolio will become

particularly important for recording reflection on clinical governance activities, critical incident reporting, report-writing and teaching activities.

Completion of Level 2 training requires

- Minimum of 4 mini-Cex per year at or above the expected level, performed by a range of assessors
- Minimum 8 CbD per year at or above the expected level, performed by a range of assessors
- Mini-CEX and CbD to cover work in general, neonatal and community paediatrics, on wards and in clinic settings
- Minimum of 5 satisfactory SAIL assessments
- Satisfactory DOPS to cover each practical procedure in the level 2 framework
- MSF to cover neonatal, community and general paediatric practice
- A portfolio which is kept up to date
- An annual trainers report supporting this evidence

Failure to meet any one of these criteria will raise serious concerns about the trainee's ability to proceed to the next level of training. Where additional training is required, the content of such training and overall duration of the extension to training will be decided at the ARCP and will be at the discretion of the Postgraduate Dean (see Appendix 14).

Assessing Level 3 competences

At this stage, the trainee is learning to work independently within a team and developing further many of the non-clinical competences which will, as at level 2, be assessed through use of the portfolio. They will also be developing expert clinical reasoning, which again makes CbD particularly valuable as an assessment method at this stage. Throughout training, communication skills are emphasised and, at this stage, these will be assessed, from the perspective of parents, through the use of SHEFFPAT.

Those entering sub-specialty training will encounter a new in-depth knowledge-base. We are aware of the fact that our assessment system does not fully cover this area and we are planning to develop either a multi-station structured viva or targeted CbD, as discussed above, to do this.

Completion of Level 3 training requires

- Minimum of 4 mini-Cex per year at or above the expected level, performed by a range of assessors and to include all core conditions required by subspecialty
- Minimum 4 internal and 2 external CbD per year at or above the expected level, performed by a range of assessors and to include all core conditions required by subspecialty
- That the assessments should include clinical and non-clinical skills
- Satisfactory DOPS to cover each practical procedure in the level 3 framework relevant for subspecialty
- Minimum of 1 satisfactory MSF per year to cover all aspects of subspecialty
- An annual trainers report supporting the evidence presented to the ARCP that satisfactory progress has been made and providing an opinion on the trainee's suitability for consultant practice

Failure to meet any one of these criteria will raise serious concerns about award of a CCT. Where additional training is required, the content of such training and overall duration of the extension to training will be decided at the ARCP and will be at the discretion of the Postgraduate Dean (see Appendix 14).