

**The Report of the Basic Specialty**  
**Training Working Party in Obstetrics**  
**and Gynaecology**



**April 2006**

## **The Report of the Basic Specialty Training Working Party in Obstetrics and Gynaecology**

### **1.The Working party**

#### **Remit**

1. To consider the requirements for entry to specialist training in Obstetrics & Gynaecology during the third Postgraduate Year (ST1), following completion of the Foundation Years.
2. To consider the recruitment/appointment possibilities for such a programme.
3. To consider the educational objectives and clinical competences that should be acquired during basic specialty training (ST1 and 2) and to permit continuation of specialty training in Obstetrics and Gynaecology.
4. To consider the workforce implications of providing training opportunities in the third Postgraduate Year, and the subsequent arrangements for Specialist Training.

#### **Working party Membership**

**Chair** Dr David Sowden (Lead Dean for Obstetrics and Gynaecology)

Dr Maggie Blott

Professor Jim Dornan (replaced by Professor Sabaratnam Arulkumaran in Dec 2005)

Miss Belinda Grantham-Hill

Mr Tahir Mahmood

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Other major contributors Dr Sarah Kaufman  
Dr Maire Kerrin  
Professor Fiona Patterson  
Professor Allan Templeton

## **2. Recommendations**

The Working party recommends the following:

1. Selection from Foundation Programme Year 2 (F2) to specialty training year 1 (ST1) should be via a process of harmonised appointment built on existing appointment practice in Obstetrics and Gynaecology Page 15
2. The method of selection from F2, delivered at a local level (Postgraduate School or Deanery), should incorporate existing work on Selection Centres to improve the validity and reliability of the selection process ( see Appendices 3,4,5). This approach will identify trainees with an interest and aptitude for specialty training in Obstetrics and Gynaecology. Page 16
3. ST1 should be extended to a formal 2 year basic specialty training (BST) programme comprising specialty training year 1 and 2 (ST1 and 2). Page 9
4. Progress to specialty training year 3 (ST3), and the remainder of specialty training, should be determined by the demonstration of specified competences expressly linked to the curriculum for basic specialty training, and confirmed by the completion of a range of assessments(see paragraphs 6.19 to 6.49), satisfactory RITA panel reports at the end of ST1 and 2; and passing part one of the membership (MRCOG) examination. Page 24
5. Assessment methodology should build on existing practice within the Foundation Programmes but include specific operative competence based assessments (OSATS - Objective Structured Assessment of Technical Skills). Consideration needs to be given to developing additional assessments linked to the demonstration of effective team working and patient satisfaction. Page 26
6. Assessment of educational progression should be supported by a Faculty approach which allows for a corporate decision to be reached on a trainee's current competence, clinical performance and confirmed aptitude for obstetrics and gynaecology practice. Such an approach together with robust and consistent application of assessment methodology will inform the annual record of in training assessment (RITA) process. Page 25
7. The curriculum, competences and assessment requirements for basic specialty training must be seen as an explicit foundation for the remainder of specialty training (intermediate and advanced) in and for Obstetrics and Gynaecology Page 21
8. The 2 year basic specialty training programme competences are best delivered through a balanced programme of posts that offers experience in both smaller and larger units; programmes will need to be organised to ensure the delivery of this and other educational requirements specified by the content of the curriculum. Page 27
9. Consideration should be given to the early implementation of a system for the accreditation of assessors in consultation with Deaneries and the College. Page 28
10. The arrangements for specialty training, and in particular the run-through grade, have workforce planning implications for obstetrics and gynaecology and for the delivery of obstetric and gynaecological service in localities. These will need careful analysis in each Unit or Department. Page 30
11. Postgraduate Schools of Obstetrics and Gynaecology should be explored by the College, in co-operation with COPMeD and AoMRC, as they offer perhaps the best model for the organisation and successful delivery of specialty training in Obstetrics and Gynaecology, within a defined geographical locality. Page 33

### **3. Executive Summary**

3.1 *Modernising Medical Careers; the next steps* visualised a seamless or run-through specialty training programme commencing immediately after Foundation Programme training leading directly to the award of a Certificate of Completion of Training (CCT) by the Postgraduate Medical Education and Training Board. Entry to such run-through training will be competitive but subsequent progress needs to be determined by robust, valid and varied assessment methodology summarised annually through Deanery based panels reviewing the Record of In Training Assessment (RITA). The outcome of specialty training remains a doctor capable of delivering high quality patient care, who is employable as a consultant or specialist practitioner working within the NHS. The Postgraduate Medical Education and Training Board (PMETB) has stated this should be to the same standard as for a Certificate of Completion of Specialist Training (CCST).

3.2 It is critical for the future of specialty training in Obstetrics and Gynaecology that the experience of the specialty at medical school, and subsequently within Foundation Programme training (F1 and F2), should be sufficiently positive and supportive to encourage a cohort of young doctors to enter specialty training in ST1 by virtue of expressed preference for and aptitude in the specialty.

To a large extent this will depend on consultants in the specialty promoting it effectively, and engaging with the local medical school and deanery career management events, and mechanisms. There must also be sufficient F1 and F2 placements to offer practical experience of the specialty post – graduation for as many doctors as possible who might be interested in obstetrics and gynaecology as a career.

This has become especially pertinent with the recent changes in immigration arrangements. No specialty can now rely on a large number of international medical graduate filling posts.

3.3 Selection to specialty training for Obstetrics and Gynaecology will be predominantly from F2. As such prior experience of the specialty cannot be guaranteed as the number of F1 and F2 posts in Obstetrics & Gynaecology will remain limited. Selection centre methodology offers a means of identifying aptitude for the specialty without prior experience, whilst also adhering to the key principles for selection to specialty published by the PMETB<sup>1</sup>, and including the acquisition of F2 competences and demonstration of the applicant's adherence to the professional standards of *Good Medical Practice*.

It is probable that any selection process will be required to build on the electronic application platform currently being procured by the Department of Health (DH).

3.4 Basic specialty training (ST1 and ST2) will be the time when the scene is set for specialty education in Obstetrics and Gynaecology. It will establish the educational and professional "tone" for what is to follow in intermediate & advanced training.

3.5 The period of basic specialty training (BST) will establish key educational principles for specialty education in Obstetrics and Gynaecology, and provide an opportunity for young obstetricians and gynaecologists to determine whether their initial career choice is appropriate. It is vital that individuals are able to make a continuing career choice on a sound experiential basis within the specialty, and at the same time the local training programme and trainer body must be able to determine reliably whether individual trainees possess the

aptitude and capacity to continue to train successfully in obstetrics and gynaecology, and the award of a CCT.

3.6 The new competency based curriculum for Obstetrics and Gynaecology allows for a modular training pattern which will establish a training programme that is overall shorter and more focused, particularly in the early years, than existing arrangements. The modular training pattern will also support learning in the changing environment of the NHS with shorter working hours (European Working Time Directive) and consequent shift patterns of work which preclude the preservation of the previous norm of a specialty firm. Whilst the curriculum is competency based it currently sets a minimum duration of specialty training to ensure adequate clinical experience, so that the trainee can acquire a level of confidence in their abilities whilst having their performance in the speciality confirmed.

There will be no further points of selection in specialty training, therefore, the confirmation of satisfactory educational progression, at the RITA panel meeting, will define whether a trainee can progress to the next year of annual training or to CCT.

3.7 These constraints place an important and significant burden on those charged with overseeing training, particularly in ST1 and ST2. There is a need for a faculty of educator's approach in units, departments or directorates which must seek to identify reliably those trainees unlikely to succeed in an Obstetrics and Gynaecology career, and to confirm the educational progression of those who are deemed "fit for purpose" and able to move on to the next stage of specialty training in ST3 (intermediate training). Protected time, for these educators, will be needed to deliver this approach to the confirmation of educational progression in specialty training.

3.8 The faculty of educators and clinicians (both need not be exclusively medical) in Obstetrics and Gynaecology need to build a reliable and consistent view of a trainee's competence and performance on the basis of valid, robust and feasible assessment methodology which ensures well evidenced summative decisions confirmed annually by the deanery RITA panel. This approach should relieve individual consultants of unilateral high stakes judgements about a trainees' career.

This process should also help to clarify the teaching and learning needed, and to support appropriate formative feedback.

3.9 Emphasis must also be placed on the learners developing capacity to reflect on their own day to day practice including their involvement in multi-professional team working, and ensure they are able to produce a meaningful personal development plan. This will form part of the trainee's specialty training portfolio or log book.

3.10 This report seeks to define the BST period of training in terms of a wider specialty curriculum for Obstetrics and Gynaecology. It builds on the competency and assessment framework developed for Foundation Programme training. However, the report also wishes to recognise the unique nature of Obstetric and Gynaecological practice, and in particular the need to develop complex surgical and interventional technical skills which require additional assessment methods from those applied during Foundation Programme training. The Objective Structured Assessment of Technical Skill (OSATS) provides a validated assessment tool in this context. It can be used both as a support for learning and as a means to confirm competence at the level of independent practice.

3.11 The arrangements for specialty training have significant workforce and service planning implications and these are discussed, in brief, in this report.

3.12 Finally the BST component of Obstetrics and Gynaecology training, to a large extent, determines the content of intermediate specialty training, which has to be completed before the end of ST5 (together with part 2 of the Membership exam) and influences the requirements for advanced specialty training which should culminate in the award of a Certificate of Completion of Training (CCT) at the end of ST7, and confirmation of employability as a consultant or specialist practitioner within the NHS.

3.13 Advanced specialty training is designed to ensure the development of higher level skills, and to support the trainees post CCT performance. Time will also be dedicated to advanced training skills modules (ATSMs) which will allow the development of special skills or interests. Consideration will need to be given as to whether access to particular ATSMs should be determined by future service needs.

3.14 At the end of ST5 a small number of sub specialty training opportunities will be available. The number will be determined by the current workforce planning needs of the NHS in these areas of practice. Entry will be by a process of competitive selection.

3.15 The organisation and management of specialty training will become increasingly complex as a result of these changes, and therefore, a possible organisational model for the delivery of specialty training is explored. This model builds on the joint consultation paper *Developing Local Postgraduate Schools*, a discussion document produced by the Conference of Postgraduate Medical Deans (COPMeD) and the Academy of Medical Royal Colleges (AoMRC) in December 2005 (JACSTAG communication).

3.16 Specific arrangements for academic training in Obstetrics and Gynaecology will need to be developed as part of the Walport<sup>2</sup> proposals. The College needs to ensure sufficient clinical fellowships and lectureships are identified to preserve academic practice within the specialty.

Appendix 1 provides an overview of the proposed structure for specialty training in Obstetrics and Gynaecology, and appendix 2 the present overall postgraduate training model for Modernising Medical Career (MMC).

#### **4. Background**

4.1 *Unfinished Business: the Proposals for reform of the Senior House Officer Grade*<sup>3</sup> was published in August 2002 as part of a process to address the perceived deficiencies in Senior House Officer training in the United Kingdom (the so called "lost tribe of trainees").

It had been previously highlighted in the *NHS plan*<sup>4</sup>, where the following statement was made:

"We will modernise the Senior House Officer grade, with the aim of providing better and broader educational experience and a reduction in inappropriate workload."

4.2 In its initial iteration it is clear that the process of reform was intended to emulate the Calman<sup>5</sup> re-organisation, twelve years earlier, when Senior Registrar and Registrar posts were amalgamated and continuous Specialist Registrar (SpR) training programmes instituted.

#### 4.3 *Unfinished Business* proposed:

- SHO reform
  - : Two year Foundation Programmes
  - : Subsequent broad based specialist training in eight generic areas
  - : Supporting individual programmes (e.g. managing educational issues, career change)
  - : Competency/competence assessment
  - : Informed career choice
- A single training grade/generalist CCST and shortened specialist training
- Re-structuring of the non consultant career grade (NCCG) with opportunities to re-enter specialist training.

4.4 Following consultation, the government published *Modernising Medical Careers*<sup>6</sup> (the result of consultation on *Unfinished Business*) in February 2003 and *Modernising Medical Careers: The next steps*<sup>7</sup> in April 2004 which proposed a more radical overhaul of immediate post graduation training, and subsequent specialty training.

A separate paper (*Choice and Opportunity*<sup>8</sup> in July 2003) was also produced, proposing the reform of the non consultant career grade. This remains the subject of continuing national negotiation, and is not specifically referred to elsewhere in this paper.

4.5 *Modernising Medical Careers: The next steps* highlighted the following proposed changes:

- Foundation Programmes:
  - : 2 year programmes post graduation
  - : Year 1 and Year 2 to be linked
  - : Year 2 to “imbue trainees with basic practical skills and competences”
  - : A variety of posts to (help) inform career choice
  - : Possibility of Year 2 experience to count towards certificate of completion of training (CCT) (note: this has not been implemented)
- Establishment of the Postgraduate Medical Education and Training Board (PMETB)
- New type of consultant who will not have experienced “deep specialisation”
- Continuing professional development to offer post CCT “further competences” (note: arrangements for this are not clear at present)
- Options for research/academic medicine (covered in the Walport<sup>2</sup> report)

4.6 Since the publication of *Modernising Medical Careers: The next steps* a considerable industry has developed which has sought to flesh out these ideas and approaches, but for many in the medical profession (especially postgraduate trainees, but not exclusively) and those studying medicine at University the various iterations, documents, models and proposals have seemed confusing, complicated, and often lacking in clarity.

4.7 However, a number of key themes have remained constant throughout this period.

4.8 Foundation Programmes, and the competences achieved during these two years (F1 and F2) are intended to provide a solid, practical base on which to build further progress through specialty training and to confirm the acquisition of the key attributes of professional practice. The focus is on the recognition and early

management of the acutely ill patient irrespective of the clinical setting i.e: physical or psychiatric illness; primary or secondary care; child or adult. It is also intended that trainees will demonstrate their adherence to the principles of *Good Medical Practice*<sup>9</sup>.

These programmes were begun in August 2005, and will complete their first full cycle at the end of July 2007. There is an established curriculum<sup>10</sup>, assessment methodology<sup>11</sup>, and a detailed guide to the management of the Foundation Programmes<sup>12</sup> already published. A revision of the curriculum will be published in Spring 2007.

4.9 *Modernising Medical Careers: The next steps* stated clearly that it:

*“would support and encourage the (PMETB), working with the Royal Colleges, to develop competency (sic) based training and assessment and to review the length of training programmes. (It was intended that this would be) done on a specialty basis and include training for General Practice. It (was intended) to provide seamless training leading to a certificate of completion of training (CCT). The time (spent) in these specialist training programmes would count towards a CCT.”*

4.10 *Modernising Medical Careers* went on to say that:

*“this signalled that thinking had moved beyond the basic specialist programmes foreseen in Unfinished Business and reflected the growing view that a single, run through approach was not only desirable but also achievable.”*

It also stated that:

*“specialist programmes and the General Practice programme will, therefore, be developed to provide a seamless training process which will see all those emerging from Foundation Programmes entering a training programme leading directly to the award of a CCT. Entry will be competitive but, subject to satisfactory (educational) progress, no further competition will be needed before the completion of training (though robust assessment may form part of progress into later stages of some specialties). Special pathways for academics will be designed.”*

4.11 The plans have moved, therefore, from an initial proposal to maintain the separation of basic and higher specialist training programmes to a system which sees the progressive acquisition of basic and higher specialist competences in a single run-through programme beginning, in most cases, with a single point of initial selection or entry to specialty training during F2.

4.12 The most recent iteration of the career framework for the delivery of *Modernising Medical Careers* (see Appendix 2) adheres to these basic principles but has introduced some additional and practical proposals which imply important workforce planning considerations discussed elsewhere in this report (see section 7).

4.13 The working party has, to some extent, mirrored the development in thinking that saw the progression from *Unfinished Business* to *Modernising Medical Careers – the next steps*. In particular, whilst it began looking only at the entry to ST1, the pattern of training therein and exit to the next stage of specialty training it became increasingly apparent that decisions made with respect to ST1 (and ST2) would have a significant impact on the remainder of specialist training in Obstetrics and Gynaecology. Consequently, the report covers (in brief) some of the main principles for all the stages of specialty training. These have been

produced in consultation with other working parties in the College, the Specialist Training Committee and Educational Board.

4.14 The working party has been challenged by the practical arrangements for the first year or two of specialty training. Initial modelling proposed a flexible temporal envelope for ST1, comprising a minimum of one year and a maximum of two years of posts in a structured programme.

However, this created a number of practical difficulties and proved to be very confusing.

If they had achieved the specified competences, and passed part one MRCOG earlier than the maximum allowed period of 2 years, the post they occupied at this point and any subsequent post, and consequently the experience offered, would need to be amended to deliver the requirements for ST3 and the remainder of core training. This was felt to be logistically complex, and difficult to deliver within present service constraints.

In addition, concerns had been raised about the impact on service provision of trainees moving to ST3 with as little as one year of practical experience in Obstetrics and Gynaecology.

Whilst these doctors might have a series of confirmed competences (see section 6) it was felt unlikely they would be reliably competent to undertake resident on-call responsibilities for the labour ward and gynaecology (particularly out of hours) without some other resident senior support. Trusts and units or directorates would need to take a judgement in each individual trainee's case, balancing probable performance with potential clinical risk before deciding whether they should or should not be on call without additional resident cover at a more senior level.

The working party concluded that such uncertainty would pose unnecessary demands and problems for smaller units, in particular, where there are currently only enough trainees to provide a single competent tier, resident on-call. Further, the working party concluded that this situation was likely to become more important following the implementation of the EWTD 2009 requirements.

4.15 The working party has also been influenced by the Colleges Working party report on *The Future Role of the Consultant*<sup>13</sup> (published December 2005). Speciality training must seek to produce a doctor (a CCT holder) who is capable of meeting the needs of patients and the service within the NHS in the future.

**Recommendation 3**

ST1 should be extended to a formal 2 year basic specialty training (BST) programme comprising specialty training year 1 and 2 (ST1 and 2).

4.16 Thus the working party report seeks to establish an educational foundation that will:

“produce consultants with excellent core training in obstetrics and gynaecology but each with different special skills to match the developments and service needs of the future”

Hence one of the key outcome measures of these arrangements for specialty training is the extent to which a CCT holder is capable of successful employment as a specialist obstetrician and gynaecologist working within the NHS.

The working party concluded this final objective of specialty training could only be met if trainees were allowed sufficient time and experience to acquire the overall competency to manage, and to have confidence in their ability to manage, the initial presentations of obstetric and gynaecological emergencies during the initial phase of specialty training. Without this solid foundation, the working party members were concerned about the capacity of trainees to develop the higher order skills and competences associated with the remainder of intermediate and advanced training.

## **5. Selection and Appointment**

5.1 In *Unfinished business* – it was argued that

*“Reform must take account of (existing) weak selection and appointment procedures; these are not standardised and are frequently not informed by core competences”*

5.2 The Royal College of Obstetricians and Gynaecologists has engaged in research, and a feasibility project looking at selection into the specialty, in preparation for the changes to specialist training in 2007. This has been undertaken by Professor Fiona Patterson and colleagues from the City University, London and the Work Psychology Partnership.

5.3 The aim has been to:

- identify appropriate criteria for selection into specialty obstetrics and gynaecology training (ST1)
- develop appropriate selection tools
- develop a blueprint for a national (harmonised) model of selection

5.4 The working party, working with Professor Fiona Patterson and Dr Maire Kerrin, have concluded that the research literature confirms the following key points:

- Selection centres are the most accurate (available) predictor of future work performance
- Reliability and validity gains are achieved by combining different selection tools, and standardised scoring systems to measure key competences and/or aptitudes.
- There is evidence to support the use of work related exercises and behavioural observations by independent and trained assessors in selection centres within the medical context.
- Research consistently demonstrates that application form data, and references have limited validity and reliability when used alone, but can add incremental value if structured and used alongside selection centres.

(See appendix 3 for more information on selection centre methodology)

### **Methodology and point of selection into Obstetrics and Gynaecology specialty training**

#### **Point of Selection**

5.5 Recent MMC and PMETB papers and consultations have debated the point of entry for all specialist training, including Obstetrics and Gynaecology. Whilst the RCOG has responded to these consultations and indicated concerns about early and final selection to the specialty for most trainees from F2, the latest MMC

career framework diagram (see appendix 2) identifies entry from F2 into ST1 (run through training) as the predominant selection point for all specialist training.

The recently published PMETB Principles for Entry to specialist training, in particular principle 7, supports this view (see figure 1).

**PMETB : principles for entry to specialist training.**

**Figure 1**

1. PMETB is committed to maintaining the generic nature of UK Foundation (Programme) training.
2. The selection process must be fair to all candidates who may apply, whether UK, European Economic area or international medical graduates
3. The selection process will be competitive, and must be designed to identify the candidates most likely to complete the programme successfully.
4. A mandatory requirement for entry to specialty training is that candidates must be able to demonstrate the competences required at the end of the Foundation Programme either by successfully completing that programme or by demonstrating that they have gained competences in another way.
5. Other evidence that may be sought or presented as part of the selection process may include evidence of excellence in terms of attributes such as motivation, career commitment etc, but no requirement for the completion of a particular post.
6. Entry to specialist training programmes may be at different stages, a candidate must demonstrate any competences required for the level of entry as defined in the curriculum approved by PMETB for that specialty.
7. Any trainee accepted on to a programme leading to the award of a CCT will be able to continue in specialist training to an award of a CCT as long as the trainee passes all necessary assessments at each stage of progression, and does not give other cause for concern, which would include health issues, professional conduct and adherence to principles of good medical practice and the trainee wishes to continue in the training programme.
8. The application of principles for entry to specialist training will be monitored by PMETB by the inclusion of entry standards in PMETB's generic standards for training, and as part of the associated statutory quality assurance process.

5.6 This leads to a number of issues regarding selection, assessment and workforce planning that need to be considered.

These include:

- what is to be assessed at selection?; (aptitude not attainment)
- implications for subsequent work based assessments?; (this will be at a premium with early selection)
- information for applicants?; (criteria and process for selection)

Consideration of these points have led the working party to propose the following preferred methodology for selection into Obstetrics and Gynaecology training.

**Entry to ST1**

5.7 Selection into ST1, predominantly from F2, will be the principle route of entry to the specialty. Entry criteria and selection processes will be subject to the rigour of intensive scrutiny from the profession, trainees, the public, and the PMETB; because for those entering by this route there will be no further competitive hurdle on the way to CCT. Instead, continuation of speciality training will be

controlled by rigorous checks on educational progress, deposition of competence acquisition & clinical preference.

### **Overseas route of entry to ST1**

5.8 Most trainees will choose to attempt to enter Obstetrics and Gynaecology specialty training from F2. This may include International Medical Graduates, (IMGs), who have previously competed successfully for entry to F1 and/or F2 programmes.

5.9 The recent changes in immigration rules for doctors in training, with the removal of permit free training arrangements and the requirement to obtain a work permit, will undoubtedly impact on the number of IMGs entering the specialty. Nonetheless it is anticipated that some IMGs will continue to be successful in appointments to Obstetric & Gynaecology training but the majority of these are likely to be at the ST2 or ST3 level, and will probably only continue in significant numbers over the next few years.

### **Time Limited Training and Career Posts**

5.10 MMC has recently proposed a set of time limited training posts (see appendix 2). They will be available to UK and EEA graduates. They may be available to IMGs if vacancies remain after selection processes are complete.

The MMC career framework has also proposed a variety of potential career or service posts (see Appendix 2). These are at an equivalent level to current Trust and Staff Grade appointments, and both will offer a capacitance which will aid workforce planning and service needs (see workforce planning section 7).

5.11 The time limited training posts will comprise a time limited fixed term contract no more than two years in length. They will offer doctors training with competences which will map onto the equivalent specialty training curricula, predominately at the level of BST. One objective of such programmes is to prepare the individual to undertake a career or service post; although there will be further opportunities for these doctors to compete for run-through training.

These opportunities will exist where ST1, ST2 and ST3 are left vacant due to run through trainees failing to make educational progress in BST, decisions to leave Obstetrics and Gynaecology, illness, maternity leave etc.

5.12 Once doctors have completed time limited training posts, and if they cannot enter run through specialist training, they will move in to career or service posts or possibly apply for other ST1/ST2 training opportunities. For IMGs it will probably mean they must return home unless they are successful in further job applications.

Those who develop, over time, the necessary full range of competences defined in the specialty training curriculum within career or service posts will be able to apply to the PMETB to be considered for eligibility for the Specialist Register via Article 14. These positions will provide useful employment and experience for those who have been unsuccessful at BST application, or for those who wish to enhance clinical experience before moving on to specialty training or service posts.

### **Transitional arrangements**

5.13 There will be a transitional period within the context of MMC. This period has already commenced with the national restriction on the duration of SHO training

programmes in all specialties. No SHO programme or SHO post can continue beyond the end of July 2007.

5.14 Currently there are a large number of trained doctors in existing Obstetrics and Gynaecology SHO and non training (Trust grade) posts, or even between jobs, who will not be accommodated into the post Foundation Programme specialty arrangements that commence with ST1 in August 2007. Those doctors who are already in a position to apply for National Training Numbers/Specialist Registrar posts should do so as soon as possible. This is particularly relevant as there will be an embargo on new appointments to SpR/NTN vacancies from January 1st 2007 until the start of the new arrangements for MMC in August 2007.

The embargo means, however, that there will be a significant number of NTN's available in August 2007 to which more experienced trainees can apply as part of the planned initial appointment processes for MMC commencing in later Autumn/early winter 2006.

Less experienced trainees will also have the opportunity to apply for ST2 vacancies for August 2007 entry, and these will form part of the appointment arrangements for the initial phase of MMC appointments.

The RCOG, working with deaneries, will propose a set of distinct person specifications which seek to differentiate between those doctors who should/could apply for ST1, ST2 or ST3 (SpR/NTN) vacancies. This information will be made available nearer the time of the national application process for MMC.

The group of doctors who are currently in specialty training face the most substantive change of any group during the transitional phase, and they will therefore need very strong local support and mentorship with respect to their career intentions in Obstetrics and Gynaecology, or other specialties.

5.15 There is another element of transition which applies to trainees already in receipt of an NTN or VTN. These trainees can continue to train according to the standards that applied before the implementation of MMC and the specialty curriculum, though they will have the option to transfer to the new specialty arrangements if they wish.

This means that the old and new system will run in parallel for a number of years and the transition phase will not end until all trainees using the old system have completed or left training.

## **Selection Methodology**

### **The Selection Process: ST1 from F2**

5.16 Best practice in selection should be based on a thorough job analysis that identifies the criteria required for the job, and upon which the appropriate selection tools can be determined. Identification of the criteria for selection into Obstetrics and Gynaecology specialty training has been researched as part of a parallel project. The detailed outcomes of both the job analysis and development of selection tools has been reported back to the working party (Patterson and Kerrin November 2005) and embedded in the present selection process proposal. The criteria to be used in the selection process are a set of core competences that are important in Obstetrics and Gynaecology. These are detailed in appendix 4. All parts of the system must test those, required, attributes set out by PMETB:

- their potential to acquire the skills and knowledge needed for the award of a CCT;
- their commitment to training in that specialty;
- their ethical conduct and behaviour(s);
- their fitness to practise;

The proposed selection process is founded on a competence based approach to selection and involves the following phases. (see appendix 5 for a pictorial overview of the selection process)

### **Phase 1: Pre-Application**

5.17 This phase involves in prospective specialty trainees building a picture of both specialty training in Obstetrics & Gynaecology, and acquiring an understanding of their likely “life as an Obstetric & Gynaecology specialist.”

As previously indicated it is important that existing specialists promote the specialty whilst offering an objective view of its prospects and challenges. Specialty tasters, and formal 4 month posts in F2 will form an important part of such a process. Present restrictions on the distribution of F2 posts will preclude some trainees who wish to undertake a 4 month post from doing so.

### **Phase 2: Eligibility – tested by longlisting from an application form**

5.18 Obstetrics & Gynaecology will need to set explicit person specification requirements for entry at ST1. Prior experience in Obstetrics & Gynaecology cannot be included (ie the Womens Health Module) but the following could be specified:

- Satisfactory completion of Foundation Programme (or the equivalent, one year of SHO experience)
- No more than 2 years prior experience of SHO training (would include no more than 1 year in Obstetrics & Gynaecology)
- Evidence of interest in the specialty e.g. attending taster sessions in F2.

Such a person specification can be used to exclude those who do not meet the minimum required specification through long listing processes.

5.19 Alternative person specification requirements for ST2 will be modified to take account of a more extended period of SHO training in the specialty (for example 2 years).

### **Phase 3: Short listing**

5.20 This phase can operate without the need for candidates to attend a selection process. It might include:

- Competence based application form questions relevant to the specialty and identified in recent research e.g. communication skills, problem solving, team working, vigilance and situational awareness etc. This will probably be part of the national electronic recruitment platform currently being procured by the DH.
- Assessment of clinical and technical knowledge (for example a generic MCQ). The use of knowledge based assessment should only be promoted if used in conjunction with other selection methods, and primarily only as a

“selecting out” mechanism at short listing. The evidence suggests that trainees do not fail training because of lack of medical knowledge, but rather due to poor performance in other areas of clinical and professional practice that have been identified as an important part of obstetrics and gynaecology. Therefore, a selection process that focused solely on knowledge based assessment would not be fit for purpose. In addition, a stand alone knowledge test would not adhere to current PMETB guidelines on assessment. While a knowledge test could be incorporated into the short listing stage, it would also have to be demonstrated that the test adds value to the process by (reliably and validly) differentiating between candidates.

- Structured referees reports –based on competence domains e.g. ethical conduct and behaviour, team working and communication skills.

#### **Phase 4: Selection – Harmonisation and Selection Centres**

5.21 This process will need to be operated from selection centres. In order to make best use of existing resources – especially the many unpaid hours put in by consultants – it is suggested that local ownership is retained by basing the centres on deaneries, or groups of deaneries.

5.22 Applicants should choose no more than 2 centres at which their applications will be considered. Each of these two will then conduct all 4 selection phases on behalf of the whole. This means, of course, that it would not be a single central body conducting, for instance, the long listing, but there is good evidence that if too large a volume of work is undertaken at a single centre it is not dealt with evenly – for instance those forms seen earlier in the day may get different treatment from those seen later.

5.23 Spreading the task over many centres means no central set-up costs, and a reduction in the traditional workload for each centre. At the same time, local ownership is enhanced, and the chances of a local placement for candidates improved.

5.24 Each candidate may apply to two centres. If deemed not appointable by the process, then that is the final decision. If deemed appointable but there is no local post, then at the end of the national process, a database of successful reserves will be shared and placements made to the remaining vacancies on the basis of the locality results or scoring.

This will include details of aggregate marks across the assessment exercises (all centres will be operating the same exercises). The reserve list will also include details of applicants’ rank order of deaneries where they would like to be considered for a post if one arises. In this way, their application to two Centres acts effectively as an application to as many centres as they wish.

5.25 Such an approach avoids the present high rate of multiple applications to speciality training –recent experience in Obstetrics and Gynaecology selection demonstrates that a process of harmonisation can and does work, whilst retaining local involvement in, and ownership of, the process of selection. Mr Laurence Wood’s excellent work over the past two years has already laid a solid foundation for this process.

#### **Recommendation 1**

Selection from Foundation Programme Year 2 (F2) to specialty training year 1 (ST1) should be via a process of harmonised appointment built on existing appointment practice in Obstetrics and Gynaecology.

## **Phase 4: Selection – the Selection Centre**

5.26 All selection centres will operate the same system, based on proven assessment methods, and using trained assessors, with built-in methods for evaluation and statistical analysis of the system.

5.28 The selection centre would comprise a number of exercises (designed to target defined criteria) around which applicants would rotate. A nationally agreed scoring system would operate.

Exercises have been designed and piloted in South Yorkshire and South Humberside and Yorkshire deaneries that assess the identified selection criteria and competency domains. ( See appendix 3)

These include:

- a simulated consultation (e.g. to assess communication, empathy and sensitivity);
- a written test plus written reflection (e.g. to assess clinical prioritisation and problem solving);
- a group exercise (e.g. to assess team working, empathy and professional integrity);
- a semi-structured interview that will focus on career options and commitment to Obstetrics and Gynaecology

### **Recommendation 2**

The method of selection from F2, delivered at a local level (Postgraduate School or Deanery), should incorporate existing work on Selection Centres to improve the validity and reliability of the selection process. This approach will identify trainees with an interest and aptitude for specialty training in Obstetrics and Gynaecology.

5.29 Inevitably, there will be drop-outs higher in the system, or trainees who opt to train less than full time and thus vacancies will occur beyond the point of ST1 entry. Selection in these circumstances must take into account the same criteria that are considered at entry from F2, using the same standards. It will also take into account, however, subsequent parameters for instance based on confirmed competences, experience, skills, propensities etc. within obstetric and gynaecological practice. This will be especially relevant for those doctors attempting to enter run through training from time limited training programmes. This will require the establishment of a different person specification for each point or year of entry.

## **6. The Curriculum : Educational Objectives, Competence, Assessment and Educational opportunities**

### **Competence**

6.1 The working party has sought to develop a plan for BST which supports the delivery of the new specialty training curriculum which in turn is designed to meet the key principles and standards for postgraduate medical education training programmes as originally set out in *Modernising Medical Careers: The next steps*, (henceforth referred to as MMC) and reinforced by subsequent documentation produced by the Postgraduate Medical Education and Training Board (PMETB) (see Appendix 6).

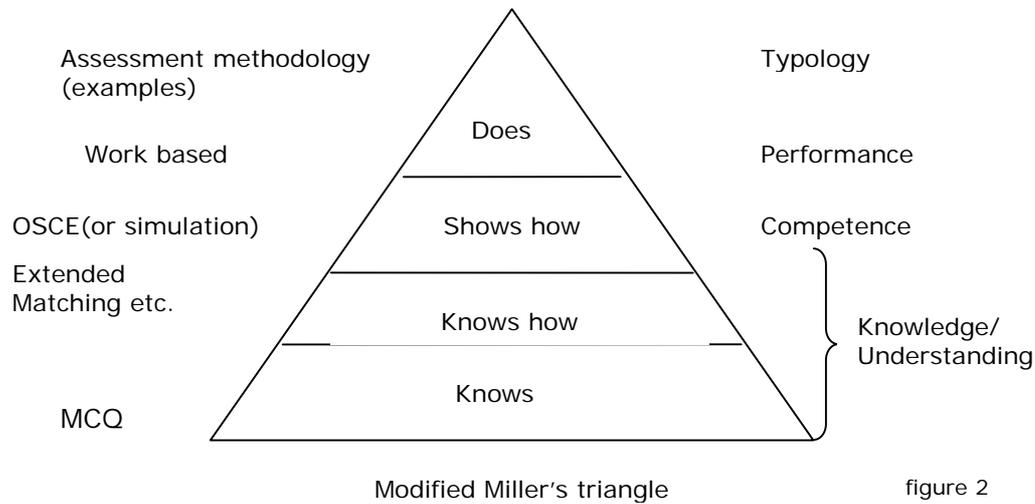
6.2 Before detailing the approach proposed by the working party it is important to explore, in some detail, the concept of competence and to consider its implications for a specialty training programme.

6.3 It is useful, therefore, to consider the potential differences between competence and competency.

The following are both commonly used definitions of competence and competency:

1. Clinical competence can be defined as *"the degree to which an individual can use the knowledge, skills and judgement associated with their profession to perform effectively in the domain of possible encounters defining the scope of professional practice"*  
M T Kane 1992<sup>14</sup>
2. *Competence is the condition of being capable; ability. Having sufficient skill, knowledge, power, ability, capacity (to do, for a task).*  
Dictionary definition.

6.4 The difference between these two definitions is significant and critically important. In addition it is somewhat confusing and apparently contradictory. The first relates to a professional level of performance which is equivalent to the "does" section of Miller's<sup>15</sup> triangle and encapsulates the concept of a wider, global professional competency, proficiency and expertise whereas the second definition relates to the "shows how" section, (figure 2) sometimes referred to as "can do", and only refers to specific skills or approaches to aspects of clinical care.



The competence of the second definition clearly refers to task or discrete activity competence, and is consistent with the terminology used in the Foundation Programme curriculum. The first definition refers to a summation of individual competences together with other aspects of professional practice, for example judgement, to create either competency or the concept of the competent practitioner.

For the purposes of this report, and the wider curriculum, this important semantic differentiation will be maintained.

6.5 The difference has significant implications for the level of supervision that specialty trainees, and indeed those who have completed their Certificate of Completion of Training (CCT), may require.

6.6 The MMC documentation indicates that the concept of competence(s), with respect to specialty training, is intended to ensure the “shows how” element Miller’s triangle but not necessarily the wider concept of clinical competency expressed by M T Kane <sup>14</sup> above which generally arises from an extended period of supported practice.

Therefore, it is important that we introduce trainees to a model of professional performance which highlights the difference between competence and competences and competency and excellence.

Figure 3 gives an example of such a model of different levels of performance.

### Figure 3

#### Competent/competency

- Makes appropriate diagnoses
- Makes basic risk assessment
- Mechanistic approach to clinical problem
- Displays uncertainty as to knowledge and skills
- Skill may decrease under pressure

#### Proficient

- Where appropriate, can make and modify or defer diagnoses
- Makes appropriate and sensitive risk assessment
- Attempts to base management plan on evidence based practice principles
- Fluent approach to problem solving
- Aware of knowledge gaps and shows some ability to address them
- Skill sustained under pressure

#### Expert

- Where appropriate, forms and challenges diagnoses, and appreciates patient’s understanding
- Makes appropriate and sensitive risk assessment and responds appropriately
- Management based firmly on up-to-date evidence based practice principles where appropriate
- Problem solving often demonstrates apparent intuitive elements
- Manages knowledge and skill gaps
- Expertise remains functional under pressure

With acknowledgements to LNR Deanery Trainer’s workshop (after Dreyfus)

Using such a model it is reasonable to anticipate that trainees will be able to perform reliably at a proficient level by the end of specialty training; with expertise being demonstrated on occasions and in certain aspects of practice. However, expertise cannot be legitimately expected across the breadth of obstetric and gynaecological practice at this stage but should remain the focus for continuing professional development.

6.7 The working party has been mindful of the impact that the definitions of competence and competency will have on the development and delivery of the curriculum, and in particular the assessment of educational progress leading to the completion of specialty training and the consequent award of a CCT.

6.8 It is clear that the ultimate purpose of assessments and acquisition of individual competences and competency in specialty training must be to improve the standards of patient care. The assessment of competences and an aspiration to move closer to a model of confirmed and consistent performance (Miller's triangle, figure 2) and models of proficiency (figure 3) is vital in order to provide trainees, and their trainers, with the confidence that the trainee will be able to perform effectively in the next stage of their training and subsequently perform reliably in practice.

Assessors should not only be interested in how the individual trainee performs in observed, and often controlled, formally assessed situations, but also in generalising about the individual's ability to perform a variety of other tasks in a range of similar and potentially less predictable work situations. That is, estimating overall true professional/clinical competency.

Several studies have shown that there are differences between what doctors can do in controlled, though high status, situations and what they do in actual practice. However, the relationship between demonstrating competence in structured assessments or examinations and behaviour in actual practice appears, at the very least, problematic.

Consequently basing educational progression on formal and structured assessments alone is unlikely to be sufficient to reliably identify developing competency and performance in practice. Rather references must be made to what doctors actually do day to day.

The published literature<sup>16</sup> shows that for work based performance assessments to be reliable and valid, multiple judgements need to be made of individuals by different assessors in a large sample of diverse practice situations. Thus valid assessment methods must aim to reflect, as far as possible, actual professional practice. A trainee's competency profile should be based on multiple measures from a range of individuals, including peers, self, trainers and patients (recipients of the practice) – this process of triangulation of assessment evidence should inform the annual RITA review.

6.9 Assessments should be integrated into the learning process and equip the learner to be more effective in judging their own learning – so called sustainable assessment.

6.10 Assessment methodology should judge against explicit standards whilst not compromising future learning needs, and establish a basis for trainees to undertake self assessment activities in the future. Research<sup>17</sup> has shown convincingly that using assessment as a tool for learning, including good and well timed feedback, promotes the capacity for lifelong learning and confirms professional reflective practice.

Care must be taken to ensure that, that which is assessed does not become the effective and exclusive curriculum. Therefore, attention must continue to be given to the trainees achievements in all areas of the curriculum including those that cannot or are not planned to be formally assessed. A process of continuing feedback is the best means to achieve this. Such feedback should, wherever possible, be given as soon as possible after the witnessed event or activity and must include positive and critical feedback to motivate and reinforce trainee learning and behaviour. The exclusive provision of critical feedback, however constructive, may undermine the confidence of trainees and can inhibit the development of self criticism and constructive reflection.

6.11 While it is clear that we must strive to ensure that there are no significant defects in the competence profile of specialist trainees it is important to recognise that the absence of defects does not confirm the presence of excellence, proficiency or even competency (see figure 3). In this regard it is how the trainee applies individual competences seamlessly to provide effective, safe patient care that is critical. It is at this point that senior colleagues judgement on overall performance should come to the fore.

Consequently they need to be able to make a judgement of the trainee's development of competency.

6.12 It is one of the recognised major faults of the existing Record of In-Training Assessment (RITA) system for specialty training that a small number of trainees reach the latter stages of training with apparently satisfactory educational progress but who are viewed by their consultant trainers and other professional staff, and often their peers, as possessing significant and fundamental deficiencies in their clinical and professional performance which will prevent them from becoming effective specialists and/or team members at the end of training. This problem must be avoided in run-through training, with particular attention paid to the very earliest stages of specialty training (ie BST) when career change will be more easily arranged, and when trainees will be most receptive to constructive feedback on their progress and professional development.

6.13 It is important that the curriculum is seen as a tool to deliver a satisfactory outcome at the end of specialty training rather than a means in itself. In this regard it will become increasingly important for groups of clinicians (a genuine educational faculty) involved in the training of individual specialty trainees to ensure that there is a corporate or faculty view on that individual's progress with regard to individual competences and extent of educational progress towards competency in the professional practice of Obstetrics and Gynaecology.

In the event of disagreement or doubt about a trainees performance it is critical that the trainers within a Unit, Department or Directorate place themselves in a position to provide a valid and reliable assessment of that individual's competency profile, competency and performance at a particular point in their training. This may require additional assessments, or supervision, where uncertainty or major concerns persist, and should be done with the full knowledge of the trainee and incorporated in the RITA documentation. Where relevant, additional support will need to be sought from the programme as a whole (or local Postgraduate School), or the local deanery.

### **BST and the Specialty Training Curriculum**

6.14 The new core specialty training curriculum has been developed to clarify learning outcomes, knowledge criteria, clinical competences, professional skills and attitudes and, where relevant, the required training support and evidence or assessment needed to support the acquisition of competences or to meet the

described learning outcomes. It has been prepared and written (predominantly by Dr Maggie Blott and Mrs Brenda Nathanson) to meet the eight standards for curricula published by PMETB (March 2005) and is enclosed as Appendix 6.

6.15 The curriculum contains 19 modules which are detailed in figure 4.

Figure 4.

1.	Basic Clinical Skills
2.	Teaching Appraisal and Assessment
3.	Information Technology, Clinical Governance and Research
4.	Ethics and Legal Issues
5.	Basic Surgical Skills
6.	Post Operative Care
7.	Surgical Procedures
8.	Antenatal Care
9.	Maternal Medicine
10.	Management of Labour
11.	Management of Delivery
12.	Post Partum Problems (the puerperium)
13.	Gynaecological Problems
14.	Sub Fertility
15.	Sexual and reproductive health
16.	Early Pregnancy Care
17.	Gynaecological Oncology
18.	Uro-Gynaecology and Pelvic Floor Problems
19.	Professional Development

Curriculum module 8; Antenatal care, can be found in Appendix 7 as an example of the structure and content of the modules.

6.16 Reference to the sub section on competence levels (observation, supervised and unsupervised) in module 8 highlights the extent to which the competences set out for BST determine the subsequent competences required for the remainder of the core training (ST3 to ST5), and those required of advanced training (ST6 and 7).

6.17 The working party recommends that the RCOG supports the present model, where BST in the overall specialty training model represents the acquisition of basic knowledge, skills and competences and which seeks to confirm an individual's aptitude for the specialty of Obstetrics and Gynaecology and a continuing interest in pursuing specialty training.

**Recommendation 7**

The curriculum, competences and assessment requirements for basic specialty training must be seen as an explicit foundation for the remainder of specialty training (intermediate and advanced) in and for Obstetrics and Gynaecology.

6.18 It is a required element of any modern curriculum that both trainees and those supervising their progress can reliably identify their educational trajectory at regular intervals (way points), to ensure the individual is making the necessary progress to achieve the final curricular goals. For this reason the working party has identified a critical way point at the transit from ST2 (the end of BST) to ST3 (the beginning of intermediate training).

At this point the trainee must not only be able to demonstrate individual BST level competences through the defined assessment methodology but must also be able to perform at a level of overall competency which would allow them to undertake residential middle grade cover of labour and gynaecological wards without any more senior residential cover.

The RITA panel, informed by the wider educational faculty, must be in a position to make this judgement, and trainees must also be confident of their ability to fulfil this role.

A similar way point will need to be defined for the transit from ST5 (end of intermediate training) to ST6 (beginning of advanced training), over and above the need to pass part 2 of the membership examination.

Whilst the provision supports a chronological element to the curriculum it doesn't imply the curriculum is linear. Rather it is structured so that trainers and trainees can adapt the requirement of the curriculum to meet both the trainee's stage of training but also the post they occupy and the available educational opportunities at a specific time.

### Assessment

6.19 The assessment approach should be seen as part of a constructively aligned curriculum strategy. The main purposes of assessment are to help trainees improve their learning, to support a process of certification which confirms curricular outcomes and to contribute to the quality assurance of specialty training.

6.20 Assessment should be a progressive process designed to measure more advanced and integrated attainment as the trainee moves through the programme. This has important implications for the assessment approach required in intermediate and advanced training.

The main challenge will be the confirmed and documented progression to independent practice. As each trainee is signed off for direct supervision they should start the process of performing interventions or procedures with less and less supervision, as agreed by their trainer. Trainees should only be signed off for independent practice when both trainee and trainer(s) are fully confident that the trainee can perform reliably without any on site senior support, in a variety of settings or situations of clinical challenge.

The assessment load for an individual trainer should form a relatively small proportion of total training time.

Depending on the area of practice being assessed the faculty of assessors can include midwives (episiotomy repair for example), or advanced trainees for those in BST.

6.21 The working party has sought to build on the existing assessment tools developed for Foundation Programme training for BST. As a result the assessment tools - mini clinical evaluation exercises (mini-CEX), case based discussion (CBD) and multi source feedback (MSF) all form part of the assessment framework for the initial phase of specialist training (BST), and will remain relevant for the later stages of training. These assessments are described in greater detail in the Foundation Programme curriculum and are referred to in the speciality training portfolio introduction.

It is important to note that the present assessment methodology developed for Foundation Programme (FP) training only seeks to confirm the acquisition of competences; no work has been done yet on the overall assessment of performance or outcomes though both MSF and CBD can, with the correct approach, begin assessment in this area. Further tests may need to be developed in due course but will take a number of years to validate. As such work is completed, the assessment methodology for BST should be subject to review.

6.22 However, it is the working party's and Specialist Training Committee's (STC) view that the direct observation of procedural skills (DOPS) assessment tool for FP training is inadequate for the purposes of confirming competence in surgical practice or in those complex interventional procedures commonly associated with much of obstetric and gynaecological practice.

6.23 The RCOG has already done considerable work on the objective structured assessment of technical skills (OSATS) assessment model and it is felt appropriate to continue with this as it is familiar to the consultant and, hence, trainer body.

The working party, and a sub group of the Specialty Training Committee (STC), did consider the Royal College of Surgeons' alternative technical and procedural/operative assessment tool (Procedure Based Assessment) but felt that it was rather cumbersome to set up and would prove difficult for trainers to familiarise themselves with and to use in day to day practice.

Nonetheless it is recommended that OSATS are used with the generic technical skills assessment pro forma, an example can be seen in Appendix 8.

OSATS are currently being piloted for 10 key procedures:

- diagnostic laparoscopy
- manual removal of placenta
- uterine evacuation
- operative vaginal delivery
- perineal repair
- caesarean section
- foetal blood sampling
- operative Laparoscopy
- diagnostic Hysteroscopy
- lower transverse incision and closure

The procedures chosen are felt to be fundamental to the practice of obstetrics and gynaecology at this level. Taking valid consent is not part of any of the OSATS and must, therefore, be separately assessed using a mini CEX, as in Foundation Programme training.

It is intended that OSATS (as with other assessment tools) are used for 2 key tasks. Firstly to support learning by promoting structured feedback on developing technical skills and secondly to help the trainee and trainer(s) assess when a trainee is ready to move onto independent practice for a procedure. It is expected that at least 10 OSATS will need to be signed off, involving at least 2 assessors and conducted in a variety of clinical scenarios, before the trainee can be signed off for practice at this level.

It is intended that once a trainee has been signed off for independent practice they should undertake an annual OSAT assessment to confirm continued competence as part of revalidation.

Additional specific OSATS will be needed for advanced training (especially for advanced training skills modules - ATSMs) and sub specialty training.

More information on the use of these assessment tools is available in the trainee guidance in the new Postgraduate Training Manual.

6.24 As indicated previously it is vital that trainees are accurately assessed to confirm their educational progression and acquisition of knowledge, skills and individual competences. It is therefore important that trainers develop an increasingly consistent approach to assessment scoring, and this will need to be facilitated by regular meetings within departments/directorates to discuss the educational progression of individual specialty trainees. (see also para 6.45 – 6.48)

In this way it is hoped that trainers in other units can be fully confident of the documented level of competence, and hence implied capability and performance of an individual trainee when they move between units thus avoiding the present situation where trainees often have to demonstrate competences afresh in a new unit before being allowed to continue with their programme of educational development.

This latter point is important as the time frame for specialty training is relatively short, and any unnecessary delays are likely to lead to extensions which have the potential to cause organisational and resource problems for the local training programme, local Deaneries and the trainee.

6.25 Such an approach will also help fulfil the clinical negligence scheme for Trusts' (CNST) requirements (from October 1999) that state:

*“all medical staff in training, when taking up a new post, are required to be given, by their supervisor, a list of technical skills they are expected to be able to perform. The trainee must indicate their competence (note: how, is not made explicit) to perform the specified tasks. A supervised training programme must rectify any deficiencies in initial, or continuing, competence”.*

6.26 The other key assessment component in ST1 and ST2 is the completion of part I of the membership examination (MRCOG) which should confirm the knowledge base relevant to obstetric and gynaecological practice at this stage of specialty training. Not only will this formal assessment hurdle confirm specialty relevant knowledge but it will also, legitimately, test the trainee's commitment to the specialty.

No trainee can pass on to ST3, and intermediate training, without all assessment components being completed satisfactorily; together with a series of satisfactory reports to the RITA panel from trainers and/or supervisors.

#### **Recommendation 4**

Progress to ST3, and the remainder of specialty training, should be determined by the demonstration of specified competences expressly linked to the curriculum for BST, and confirmed by the completion of a range of assessments, satisfactory RITA panel reports at the end of ST1 and 2; and passing part one of the membership (MRCOG) examination.

6.27 As previously indicated individual trainers should not be placed in a position to make unilateral high stakes judgements about their trainees' educational

progress or careers. Within a unit, department or directorate a professional faculty view needs to be developed about each trainee working in that unit. Where there are significant differences in opinion, additional assessment and review will need to be undertaken so that a commonly agreed report can be submitted to the annual RITA panel, and shared with the trainee.

The report can also include, preferably contemporaneous, records of trainees involvement and performance in audit, presentations at meetings etc.

6.28 Such a faculty approach to monitoring of educational progress must take account of outlying assessors who will be either too critical or too permissive of a trainees' performance. Regular discussion within units, and the sharing of index material (e.g. video tapes/DVDs of OSATS) between units will reduce variation but cannot eliminate it.

**Recommendation 6**

Assessment of educational progression should be supported by a Faculty approach which allows for a corporate decision to be reached on a trainee's current competence, clinical performance and confirmed aptitude for obstetrics and gynaecology practice. Such an approach together with robust and consistent application of assessment methodology will inform the annual RITA review.

6.29 The Foundation Programme curriculum emphasises a number of critical general professional or generic skills. Whilst many of these can continue to be developed through the process of regular feedback and case based discussion the working party is concerned as to the extent to which effective multi professional team working can be reliably implied by a combination of the present assessment tools.

6.30 Modern obstetric and gynaecological practice requires effective team work, and recognition of group problem solving where the combined capability of the team is greater than all the team members acting independently or individually. This is of considerable importance in delivering the highest standards of patient care. Consequently there should be a focus on a trainee's acquisition of understanding of other professional roles, and a demonstration of their capacity to adapt and collaborate particularly in rapid response situations. Further, they need a developing awareness of the differences of perspective and expertise that can broaden and deepen both individual and team based problem solving, capability and agreed processes for making decisions.

Because of the importance of this area of practice, the working party recommends the College consider the development of a new assessment tool (building at least in part on the team observation (TOI) methodology) taking account of the international literature in this key area of practice.

6.31 Further the working party also recommends the College considers the place of direct measures of patient satisfaction in the assessment framework for trainees. Dr Sue Granick produced a report on this, for the STC in February 2004, and the working party asks that the College considers funding (or seeking funding for) a project to validate a consumer/patient satisfaction questionnaire in a hospital setting. Further it would be valuable to pilot an exercise that looked at the educational value of such feedback, for trainees, even if it entailed using the existing tools which have only been validated for General Practice/primary care.

### **Recommendation 5**

Assessment practice in BST should build on existing methodology within the Foundation Programmes but include specific operative competence based assessments (OSATS). Consideration needs to be given to developing additional assessments linked to the demonstration of effective team working, and patient satisfaction.

### Educational Opportunities

6.32 The acquisition of individual competences, and the wider concepts of competency and satisfactory performance, needs to include the consideration of a trainee's ability to manage each stage of a case from diagnosis, through the main phase of clinical intervention/operation, post intervention care and discharge. The core curriculum describes a process that moves from observation, through direct supervision to independent practice but the effectiveness of this process will depend on the quality of observation, mentoring, supported reflection, feedback and the reliable assessment of progress at each stage.

6.33 If case experience is too patchy or infrequent, learning will be slow and more case experience will be needed than if there is better continuity of experience. It will also have important implications for the development of a trainee's confidence in their own abilities.

6.34 There are therefore two critical organisational factors that need to be considered;

- Allocation of cases
- Time allocated for training (both trainee and trainer)

To ensure efficiency in educational progression, outpatient work, ward work and operating sessions or interventional activity on the labour ward will need to be, as far as possible, actively planned with the trainee's present learning needs in mind. Whenever a trainee is supervised this must be an active process that encourages early reflection (generally mediated through feedback at this stage of training), and promotes learning.

6.35 A key aspect of clinical practice remains continuity of care. There are significant problems associated with part clinical episode experience or reductionism. It is difficult for trainees (particularly during the earliest stages of training) to build a picture of the whole dynamic of case management from separate and disjointed parts. There must, therefore, be some opportunities to follow individual patients from diagnosis to discharge. Without this, proficiency and more particularly expertise will be difficult or impossible to acquire and will be left, in the majority of instances, to post CCT practice. This would clearly have serious implications for the development of clinical judgement, and the provision of safe and effective care for patients.

6.36 In the absence of appropriate educational opportunities, trainee's clinical behaviour risks being driven by the book or by internal guidelines that are less grounded in personal case experience, and therefore less reliable under pressure.

There is evidence to suggest that trainees, and their trainers, can compensate in part for the loss of continuity of care by focusing time on case follow up and the compilation of case reviews.

This places a premium on trainees developing the skills to allow them to compare present cases with others, which will allow them to build up a picture of a

particular disease or presentation. This will require effective support and senior facilitation.

6.37 However, the progression from competency, through proficiency to expertise can only be confirmed by the active demonstration of the trainee's personal knowledge via the observation of their clinical performance. Trainers and the faculty of trainers need to be certain that trainees' personal knowledge is reliably available and fully integrated so that there is a cohesive rather than fragmented approach to patient care.

6.38 Since the focus of MMC is on streamlined training it emphasises the need for trainees to have sufficient protected time to acquire professional experience of the relevant elements of the curriculum. In the event that a trainee is making poor educational progress the time spent on training may need to be increased at the expense of service delivery. This has important implications for overall service provision within individual obstetrics and gynaecology units.

6.39 Similarly trainers will need both the time and skills (see next section) to facilitate these processes, to deliver assessment and report authoritatively on the trainees' educational progress.

6.40 The working party also believes that the overall training programme needs to be structured to ensure a variety of different clinical environments. In BST, the working party recommends that this should normally comprise a balanced experience in a unit with less than 3,000 deliveries, and one with more (preferably significantly more) than 3,000 deliveries.

#### **Recommendation 8**

The 2 year BST programme competences are best delivered through a balanced programme of posts that offers experience in both smaller and larger units; programmes will need to be organised on this basis to ensure the delivery of this and other educational requirements specified by the content of the curriculum.

Similar consideration needs to be given to the organisation of the remainder of intermediate training and advanced training to ensure that trainees have sufficient opportunity to experience the breadth of obstetric and gynaecological practice.

6.41 All these points emphasise that clinical experience provides the principle resource for learning. However, trainees may need to be encouraged to recognise that experience or learning should be iterative, with situations re-visited not only to confirm maintenance of competence but also because something new can be gained each time.

#### Assessor Accreditation and Calibration

6.42 The working party considered the potential need for an accreditation scheme for obstetrics and gynaecology educators/trainers or assessors.

There is a substantial body of literature which identifies outlier assessor performance – often referred to as “hawks or doves”. Whilst a faculty approach has an important role in moderating the results of assessment it will be hard to achieve consistency of assessment outcome between units without a common assessor training programme, and subsequent calibration of assessor performance in specialty training assessment. This could lead to a process of formal assessor accreditation and quality assurances of assessment.

6.43 The College will need to ensure that all consultants actively involved in specialty training receive sufficient initial training to familiarise themselves with the details of the new curriculum including assessment tools and methodology, and that follow up training is provided to allow for discussion of practical experience of the delivery of the new curriculum, and where appropriate to support its further development.

This will equally apply to any midwives or advanced trainees engaged in formal assessment activity.

6.44 The working party would expect accredited assessors/educators to have a minimal level of competence with respect to the following areas:

- Appraisal
- Supervision
- Assessment (including knowledge and understanding of the tools)
- On-going feedback

However, the working party also recognises that such changes may not be feasible for the implementation of the new curriculum in August 2007 but should be considered for implementation as soon as possible after that. Such a system would provide important quality assurance information with respect to the delivery of the new curriculum.

In addition, assessors/educators will need sufficient time, protected within their job plan, to fulfil these requirements over and above the time needed to deliver or support education and training of trainees. It is also not unreasonable to expect some level of administrative support to support the timely delivery of assessments.

#### **Recommendation 9**

Consideration should be given to the early implementation of a system for the accreditation of assessors in consultation with Deaneries and the College.

6.45 The RCOG has a number of tested quality assurance methods designed to ensure that assessors' judgements are made reliably against common standards in membership and diploma examinations. However, the RCOG will also need to develop new systems to ensure that the judgement of trainees' performance in the workplace are made to common standards across the country once the new specialty curriculum is fully implemented in August 2007.

6.46 Whilst the first step towards quality assurance for work based assessment will be the training of assessors to develop a common understanding of the application of the assessment tools and the standards to be looked for, there is a need to establish a genuine "community of practice" amongst assessors. This is much more than an understanding of how to use the assessment tools. It requires practice in making assessment decisions on the same trainees with a group of peers, and arriving at a consensus on the standards of competence or performance reached.

6.47 A fit for purpose quality assurance approach to work based assessment will need to consider the following:

- Sampling of the internal consistency/reliability of individual assessors
- Sample consistency/reliability between different assessors within Trusts and within deaneries, and between different deaneries
- The approach needs to make the best use of consultant time
- Approach needs to be simple and not unduly bureaucratic

- There needs to be an internal correlation between success in work based assessments of competence, and overall clinical performance as judged by a faculty of educators

6.48 The following approaches could be considered to quality assure work based assessment.

- Peer comparison – trainers within the same Trust or Deanery observe each other assessing in a percentage of assessments (logistically difficult, no external corroboration)
- External verifier – trained group of expert assessors visit Trusts and observe a sample of assessments (too expensive and bureaucratic)
- Senior assessor – a third party with a broader remit, for example the Training Programme Director, observes each trainer on the programme (could achieve the objectives, but would be highly dependent upon a central approach to calibration between senior assessors)

The third option is probably the most cost effective and practical but is far from resource natural.

6.49 In conclusion, the RCOG, working with Deaneries, will need to seriously consider what quality control approach to work based assessment needs to be undertaken to convince the PMETB, the service and the public of the validity and reliability of the proposed assessment approach.

It is currently unclear to the working party how this aspect of quality control and monitoring will be funded in the present climate of resource constraint.

## **7. Workforce Considerations**

7.1 The current workforce planning model for Obstetrics & Gynaecology is predicated on a single point of selection from F2 with progression through run-through training being determined by satisfactory educational progression with no additional significant competitive hurdle (with the exception of access to sub specialty training); the number of trainees entering run-through training at ST1 must be equivalent to the number of trainees moving on to ST3 and achieving CCT and exiting the training programme.

7.2 Whilst an attrition rate during ST1 or ST2 can be anticipated with some confidence it cannot be taken for granted. As a result the workforce plan should presume 100% progression to ST3 for all ST1 entrants to avoid a situation where trainees complete BST without the availability of either approved posts (educational opportunity) or funding (salary in particular) to support their continued training.

7.3 Any vacancies arising at the transition from ST1 to ST2 or ST2 to ST3 can be filled from the pool of trainees completing or in the process of completing time limited (specialist) training contracts. This emphasises the importance of ensuring equivalence of training, assessment and competence between these 2 year time limited programmes and those designated for BST.

7.4 Matters are complicated by the current predicted out turn of CCT holders (see figure 4) since it is this which determines the vacancies at ST3, and hence the numbers entering ST1 for run through training.

Year	2007	2008	2009	2010
CCT Output	123	105	135	90

Figure 4 Estimated out put for current training programme (England only)  
Workforce review Team (April 06).

As can be seen the numbers fluctuate significantly; this means the balance between run through BST programmes and fixed term training programmes will need to be adjusted locally and nationally year on year to ensure a steady number of ST1 and ST2 equivalent posts whilst not over producing at the interface between ST2 and ST3 for those in a BST programme, since these doctors are guaranteed access at ST3.

7.5 The situation is made more difficult to plan for due to the uncertainties over the period of grace. This problem may be exacerbated if the number of consultant vacancies advertised fall significantly as a result of either resource constraint or service planning. In such a situation the availability of ST3 equivalent vacancies will fall significantly. This will not be possible to predict precisely 2 years in advance when BST run through programmes are advertised. Therefore the numbers of entrants to BST programme will need to be reduced to plan for such an eventuality.

7.6 The key decision that will need to be reached before the end of this year (2006) is, therefore, how many Obstetrics & Gynecology SHO posts should be designated for BST programme and for fixed term specialty training programme. Whatever happens the number of BST posts will be relatively small in terms of the totality of SHO posts currently occupied by trainees exploring intent to continue with specialty training. However, it could be prudent to have a significant number of fixed term placements/programmes for the first two years of post – F2 training.

The remainder of posts will be converted to F2 posts or allocated for GP vocational training, and some might be converted to non-specialist career posts.

7.7 The Workforce Review Team are currently discussing the extent to which Obstetrics & Gynaecology training posts should be expanded to increase CCT output. Whether this is enacted in one year or over several years, it is key that the number of specialty focussed ST1 and ST2 equivalent posts are designated prior to August 2007. Otherwise the specialty may wish to reconvert posts designated for F2 or vocational training, it is unlikely that this will be easy or indeed possible to implement.

7.8 As indicated previously the number of specialty focussed Obstetrics and Gynaecology posts will be less than those currently identified as such. Further more there will be no more SHO equivalent posts beyond ST2. Consequently the service in Obstetrics & Gynaecology will be dependant on a workforce that is predominately not training for the specialty itself, careful planning will be needed in each unit/Trust to estimate the likely impact this will have on local service provision.

7.9 It has not been the remit of the working party to consider the consequences of the proposed MMC career framework but the model in Appendix 2 demonstrates that consideration needs to be given to the extent to which career posts need to expand in the NHS to accommodate those exiting time limited specialist training contracts.

**Recommendation 10**

The arrangements for specialty training, and in particular the run-through grade, have workforce planning implications for obstetrics and gynaecology and for the delivery of obstetric and gynaecological services in localities. These will need careful analysis in each Unit, Department or Trust.

7.10 Finally more attention will need to be given to the Workforce Planning implications of sub-specialty and special interest training. In future there will need to be a far clearer relationship between the numbers of sub-specialty trainees in training and the actual needs of the service than is currently the case. The work of Dr David Richmond and College officials in this area will be of particular importance.

## **8. The Postgraduate School of Obstetrics and Gynaecology**

8.1 The organisation and management of postgraduate medical education currently varies enormously between specialties, and between individual deaneries. College and deanery functions overlap, and at times are still a cause of tension. Not surprisingly roles and responsibilities are poorly understood by the wider NHS, making it correspondingly difficult to argue for time and resources to be set aside for those undertaking important educational roles such as Training Programme Directors, and College Tutors.

8.2 Whilst the present system could probably survive if it were to manage a steady state situation, the twin challenges of implementing Modernising Medical Careers and meeting the regulatory requirements from PMETB make change essential.

A system is required that:

- cements the partnership between deaneries and Colleges in postgraduate medical education
- is capable of implementing large scale change successfully
- can support the systematic introduction of new curricula and assessment methodologies with associated training requirements for educational supervisors
- can support the introduction of nationally co-ordinated selection methods
- incorporates standardised quality control systems on which light touch quality assurance programmes will depend (present PMETB model)
- enables representatives of (local) NHS management to engage in key issues
- acknowledge the imperative of an inter-professional approach to patient care through education and learning

8.3 The Academy of Medical Royal Colleges and COPMeD are proposing that the basic organisational unit for the delivery and oversight of postgraduate medical education should be the Postgraduate School. The basic template builds on experience already gained in a number of specialties, and the detailed work undertaken by the Royal College of Surgeons (England).

The normal model would be for a single set of specialist Postgraduate Schools within a Deanery, though larger deaneries, for example London, West Midlands, might include more than one School in a particular specialty area. Smaller specialties may require School arrangements on a multi deanery or even national basis.

8.4 A Postgraduate School of Obstetrics and Gynaecology would clearly relate to a single specialty whereas other Schools, such as those for Surgery and Medicine, would incorporate training programmes for a range of individual specialties.

8.5 At establishment, Schools would have clear governance arrangements with defined relationships to the local Deanery, the College and Trusts. All

appointments within the Schools would be made jointly between Deanery and College. The functions within the school would cover the existing roles and responsibilities of Programme Directors, Specialty Training or Education Committee Chairs, College Tutors etc. At the level of the Trust, Tutors (or possibly Directors of Specialty Education) would be appointed by Trust and Deanery working with the College with the support of the local School.

8.6 It is proposed that each School would be headed by a Director or Head of School who would have a joint Deanery/College appointment and be accountable managerially to the Postgraduate Dean and professionally to a designated College Officer. Specific Deputy Directors could be appointed as justified by work load and available resources, some of whom might take on specific roles, such as Less than Full Time Training (flexible training).

8.7 It is intended that all the officers' of the School would report to a School Board. In the case of Obstetrics and Gynaecology this would comprise a Director, a Training Programme Director (TPD), the Tutors from the participating Trusts (the equivalent of present College Tutors) and other healthcare providers, together with representatives from the trainee employing Trusts, the Deanery and the training body.

8.8 The functions of the Postgraduate School would include:

- programme management
- placement management
- induction to the programme
- implementation of specialty curricula
- review of in-training assessment
- review of placements and overall programmes
- recommendation for certification (CCT)
- remediation/targeted training
- managing study leave budgets
- managing out of programme experience

8.9 The above is almost certainly not exhaustive but gives a perspective on the likely areas that will require attention.

8.10 The establishment of this model, in Obstetrics and Gynaecology, would go a long way to providing a suitable infrastructure to support the implementation of BST training and the subsequent progression of individual trainees to ST3 and the remainder of the run-through training programme. It would also provide an overview of trainees within the time limited training contracts, and allow for an assurance that these individuals were meeting the same standards of competence and experiencing the same quality of training required for BST. Especially relevant if they subsequently move to vacant ST2/3 posts following competitive selection.

8.11 This would allow the TPD to have an overview of the totality of run-through training; though they would be highly dependent on the support of Trust based Tutors or Directors of specialty education. These latter responsibilities match well with recent College documentation on the roles and responsibilities of the College Tutor.

8.12 The working party would strongly recommend careful consideration of this model. Without a clear structure such as this it is difficult to see how deaneries and the College can deliver the significant changes that will see the implementation of ST1 training in August 2007, the preceding arrangements for

selection, and the subsequent arrangements for run-through training and the assessment of educational progress and competences.

Foundation Year programmes, and a unified training grade system has been initiated in August 2005, and the new curriculum will be presented, taking all this into consideration.

The linkages of the curriculum to previous and subsequent stages of the trainee's education and training are shown in Appendix 1.

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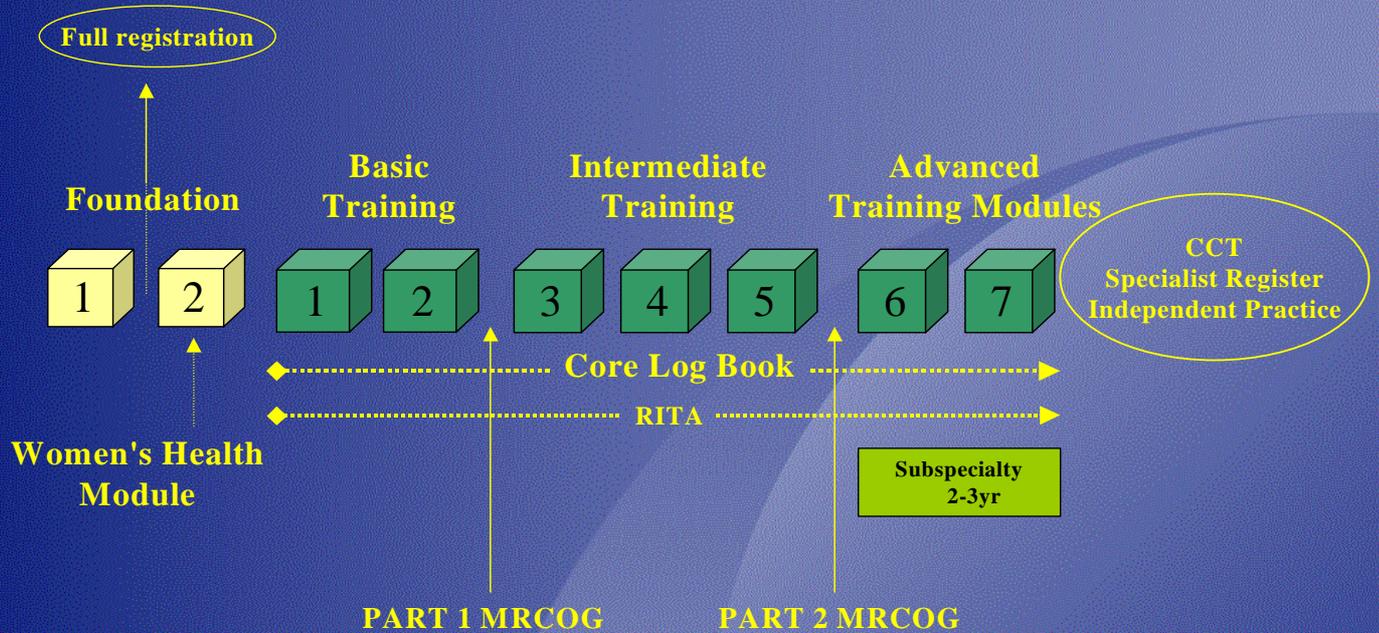
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## **10. Appendices**

Appendix 1 training	An overview of the RCOG proposed structure for specialty
Appendix 2	UK MMC Career Framework Proposal
Appendix 3	Selection Centres
Appendix 4	Selection Centre summary indicators
Appendix 5	Selection into O&G BST: Process Overview
Appendix 6	PMETB Standards for Curricula
Appendix 7	Curriculum Module 8: Antenatal Care
Appendix 8	Objective Structured Assessment of Training (OSAT)

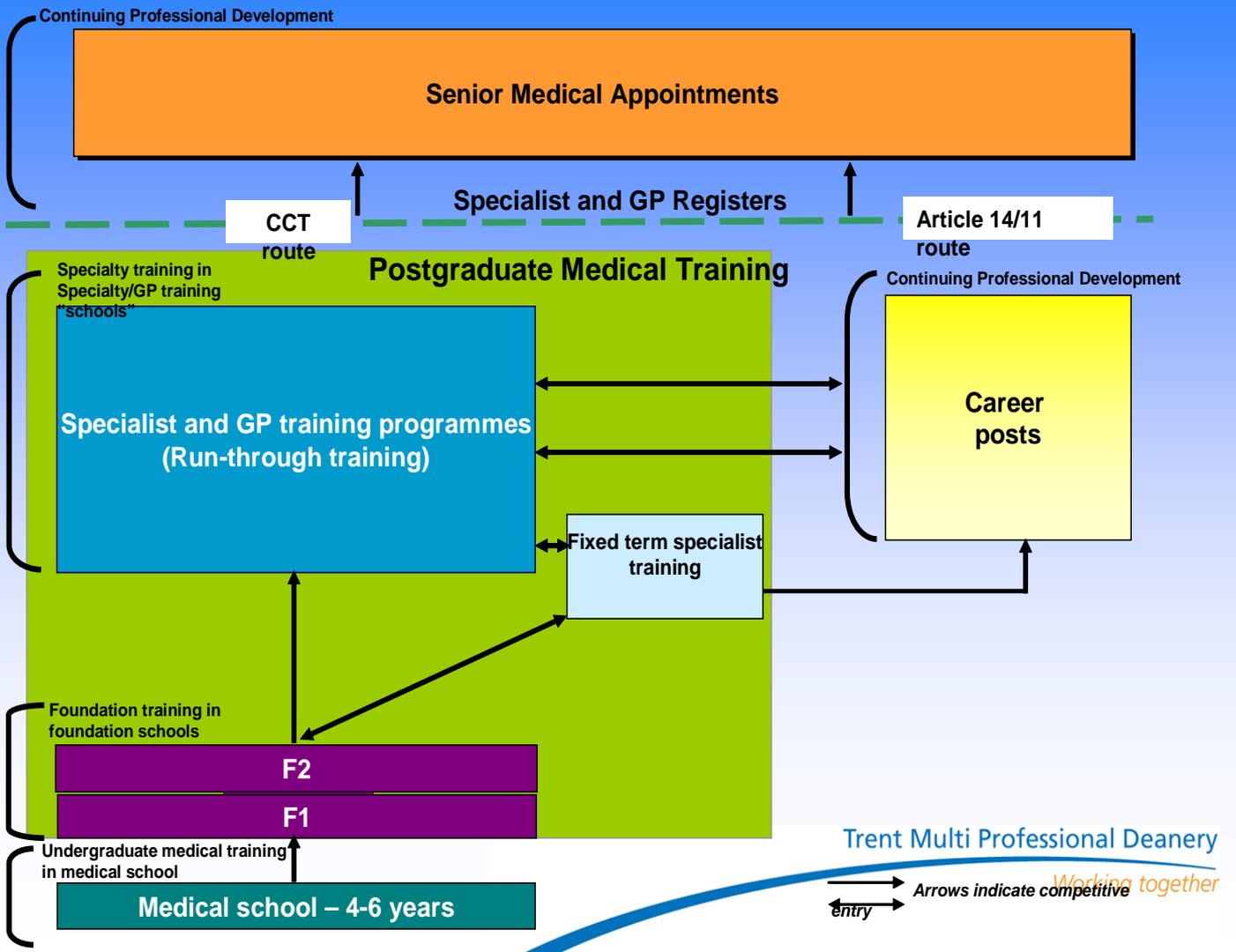


# Specialty Training & Education Programme



June 2006

# UK MMC Career Framework Proposal



## Selection Centres

### Introduction

A selection centre (SC) is a selection method, not a place. SCs make use of a combination of different selection tools and allow candidates to be assessed by multiple assessors. Research consistently demonstrates that SCs are better predictors of job performance than panel interviews. SCs usually involve a one day programme of activities and competency-based interviews designed to allow a wide-ranging assessment of an individual's effectiveness in a specific job.

### Key Elements

*Selection by a competency model:* An SC is designed to allow multiple demonstrations of the key competency domains known to determine performance in the job role. These competency domains, identified via a thorough initial analysis of the target job role, comprise the knowledge, skills, attitudes and personal qualities associated with performance in the role. For example, a job analysis might find that trainee surgeons have a particular need for effective decision making under pressure skills. This would then be deemed a core competency, and a set of specific indicators of the competency would be drawn up.

*Work based activities:* Having established a competency model, a series of work-relevant exercises are then developed to allow practical assessment of an individual's ability to demonstrate potential or aptitude in the competency domains. Importantly, exercises are pitched at the appropriate level for an individual's level of training and ability to ensure fairness. This might involve a simulation, group challenge, written exercise or a presentation. In addition, pencil and paper measures of general mental ability, hand-eye co-ordination and personality may be used to inform final judgements of performance.

Typically, in a one-day SC, three or four exercises would be developed in addition to a competency-based structured interview. This would involve a set of agreed questions designed to measure an individual's understanding of certain competences, their attitude to them, and – critically – past situations in which they have had to demonstrate those competences. When assessing competences, it is important that the domain is sampled widely enough to produce a reliable outcome.

*Multiple assessment, multiple assessors:* The use of a range of activities ensures that each individual has a number of opportunities to demonstrate their strengths. And to avoid potential bias, each activity is usually observed by a different assessor. The final piece in the jigsaw is the construction of a matrix specifying which competences are to be assessed in each activity or exercise. Ideally, each competence would be assessed at least three times, and usually four competences would be assessed in any one activity

*Standardised assessment:* Because all activities are carefully structured around a competency model, with specific behaviours being tracked within each competence, a single rating scale is used to measure performance in the various settings. Assessors are specially trained in behavioural observation and recording, ensuring that individual ratings can be explained via behaviours either within the competency model or closely related to it. As a result, when the final 'wash-up' discussions takes place, a rounded picture of each individual emerges, grounded in specific demonstrated behaviours.

## Potential Strengths

Research over the past 20 years has consistently demonstrated that SCs are successful in making valid predictions of future job performance across a wide range of occupations. Recent research has also been reported in medical selection (see Patterson et al, BMJ, 2005). Properly developed and designed, an SC offers a considerably more reliable and objective approach to assessing probable work-based performance than is possible with traditional selection and appraisal methods. Effective SCs are largely defined by four preparatory markers:

- a thorough job analysis, which ensures a representative and comprehensive set of competence domains
- properly tailored work relevant exercises, which strengthen the validity of the ratings given for performance within them
- a well balanced assessment matrix, which ensures that all core competencies are assessed at least three times
- appropriate and thorough training of assessors, which underpins the objectivity of the evaluation process

Too often, traditional selection methods (panel interviews) have relied on an assessment of performance that has been largely unstandardised and not based on core competences. In addition, traditional approaches are subject to the vagaries of individual assessors operating without a common perspective of what constitutes good, average and poor performance. A rigorously designed SC significantly overcomes the weaknesses of traditional interview approaches.

SCs represent a fairer process than more traditional interviews, for at least two reasons. Firstly, the more objective, standardised approach, using multiple assessors, limits the potential for biased or prejudicial assessments. Secondly, the use of multiple activities allows individuals less comfortable with some selection processes (e.g. interviews and written exercises) to demonstrate qualities in a more active context (as in a simulation or group challenge).

## Potential problems

The quality of an individual SC is heavily dependent on its design. Poor initial research and design will inevitably compromise the process: a poor job analysis, for instance, will probably lead to a poor competency model; inappropriate exercises will almost inevitably weaken the validity or relevance of the ratings; insufficient training and calibration of assessors may undermine the objectivity of the process; asking assessors to track too many competences in one activity will usually compromise their ability to offer sufficient detail on each competence and their ability to differentiate between competences.

Such a process is also demanding, especially in the development stages, in terms of time, manpower and costs. Having said that, SCs are increasingly popular and widely used, especially in businesses with larger numbers of employees or where the costs of mistakes are high. In fact, contrary to popular belief, once designed, SCs are considerably more cost-effective to run than panel interviews (see Patterson et al, 2005, BMJ). Further, initial costs are usually recouped, for instance, if the quality of individuals selected either raises the efficiency of the workforce and/or reduces attrition rates.

The ultimate test of an SC, as indeed any assessment system, is whether it can reliably measure current performance or predict future performance. Research is generally supportive of SCs in this regard, but they are only more powerful than

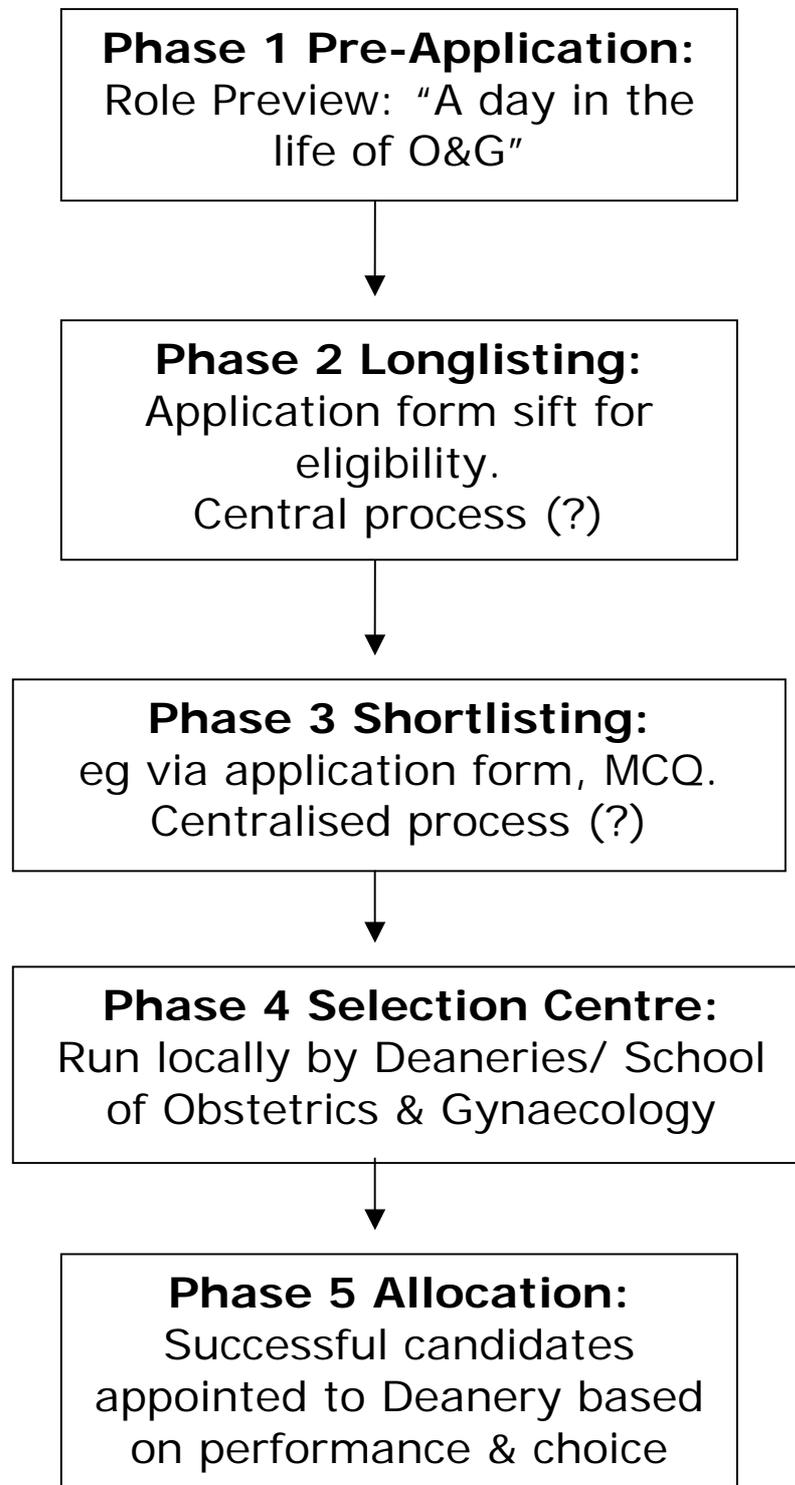
using other methods discretely if they are designed and implemented in a way that maximises their strengths and minimises their potential danger.

Prof. F Patterson  
Dr M Kerrin

## Obstetrics & Gynaecology Competence Model: Selection Centre summary indicators

Competence	Behaviours Indicative of the Competence
<b>Clinical and technical knowledge and expertise</b>	Technically proficient, and able to use one's judgement appropriately when identifying risks and treatment options
<b>Communication Skills</b>	Listens actively, understands body language, engages in social conversation, confident style and effective advocate
<b>Conceptual thinking, problem solving and decision making</b>	Thinks beyond the obvious to get to the root cause. Open to new ways of thinking; able to judge the quality of various pieces of information
<b>Coping with pressure</b>	Deals confidently and calmly with pressurised situations. Is aware of own limitations and recognises stress in self and others.
<b>Empathy and sensitivity</b>	Treats patients with sensitivity and personal understanding. Works to involve the patient and shows interest in them.
<b>Learning and personal development</b>	Reflects on, and learns from experience. Identifies gaps in one's own knowledge and acts of feedback.
<b>Legal, ethical and political awareness</b>	Aware of legal and ethical implications of actions, and aware of policy issues. Is able to lobby effectively on behalf of the patient.
<b>Personal organisation and administration skills</b>	Able to organise a mass of information in a structured manner. Prioritises and delegates effectively.
<b>Professional integrity and respect for others</b>	Open and honest with patients and colleagues. Demonstrates courage in one's own convictions, appreciates the value of others' contributions.
<b>Teamwork</b>	A team player who contributes to, and facilitates, decision-making. Works in partnership with colleagues.
<b>Vigilance and situational awareness</b>	Able to monitor, think ahead and anticipate, especially in volatile or unstable situations.
<b>Managing Others</b>	Provides leadership, delegates appropriately and is effective in the management of staff and resources.
<b>Teaching</b>	Demonstrates ability to deliver teaching to junior staff. Facilitates learning and on-going development in juniors.
<b>Personal attributes</b>	Flexibility, honesty, kindness, compassion, patience, reliability, warmth and commitment. Effective manual dexterity.

## Selection into O&G BST: Process Overview





**STANDARDS FOR CURRICULA**

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Revised March 2005

## Introduction

This paper sets out the characteristics that curricula should display to be effective in guiding learning, teaching, and experience. The term 'curriculum' is here defined as:

A statement of the intended aims and objectives, content, experiences, outcomes and processes of an educational programme including:

- a description of the training structure [entry requirements, length and organisation of the programme including its flexibilities, and assessment system],
- a description of expected methods of learning, teaching, feedback and supervision

The curriculum should cover both generic professional and specialty specific areas.

The syllabic content of the curriculum should be stated in terms of what knowledge, skills, attitudes and expertise the learner will achieve.

The standards set here will ensure that the curriculum can be the basis of blueprinting for the assessment system<sup>1</sup>.

Background rationale for both this definition and for the standards set out below are available in PMETB papers<sup>2</sup>.

### Standard 1: Rationale

- [a] The purpose of the curriculum must be stated, including its overall role in the relevant postgraduate training.
- [b] The curriculum must state how it was developed and consensus reached.
- How content and teaching/learning methods were chosen.
  - How the curriculum was agreed and by whom.
  - The role of teachers and trainees in curriculum development.
- [c] The appropriateness of the stated curriculum to the stage of learning and to the specialty in question must be described.
- [d] Linkages of the curriculum to previous and subsequent stages of

<sup>1</sup> See the PMETB document: Principles for an Assessment System for Postgraduate Medical Training by Lesley Southgate [Chair of the Assessment Committee] and Janet Grant.

<sup>2</sup> What is Curriculum?

Standards for Curriculum Development: Background Paper

the trainee's training and education should be clarified.

- [e] The curriculum must be presented in relation to programmes and posts within those programmes.

## **Standard 2: Content of learning**

- [a] The curriculum must set out the general professional and specialty specific content to be mastered.
- Knowledge, skills, attitudes and expertise must be addressed.
  - Recommendations on the sequencing of learning and experience should be provided, if appropriate.
  - The general professional content should include a statement about how *Good Medical Practice* is to be addressed.
- [b] Content areas should be presented in terms of the intended outcomes of learning benchmarked to identifiable stages of training, where appropriate:
- what the trainee will know, understand, describe, recognise, be aware of and be able to do at the end of the course.
- [c] Content areas should be linked to guidance on recommended learning experiences.

## **Standard 3: Model of learning**

The curriculum must describe the model of learning appropriate to the specialty and stage of training.

- General balance of work-based experiential learning, independent self-directed learning and appropriate off-the-job education.
- How learning for knowledge, skills, attitudes and expertise will be achieved<sup>3</sup>

## **Standard 4: Learning experiences**

- [a] Recommended learning experiences must be described which allow a diversity of methods covering, at a minimum:
- Learning from practice
  - Opportunities for concentrated<sup>4</sup> practice in skills and procedures
  - Learning with peers
  - Learning in formal situations inside and outside the department
  - Personal study

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<sup>3</sup> Based on Miller's pyramid which runs from 'knows', to 'knows how', to 'shows', to 'does'.  
Miller G. The assessment of clinical skills/competence/performance. *Acad Med* 1990;**65** [Suppl.]:S63-67.

<sup>4</sup> Concentrated practice involves repeated practice of a skill or procedure over a short period, such as might be gained, for example, in a day-surgery clinic where many patients of the same type might be seen on one list. .

- Specific teacher inputs.
- [b] Educational strategies that are suited to work-based experiential learning and appropriate off-the-job education should be described.

### **Standard 5: Supervision and feedback**

- [a] Mechanisms for ensuring feedback on learning must be recommended and required<sup>5</sup>.
- [b] Mechanisms for ensuring supervision of practice and safety of doctor and patient must be defined<sup>6</sup>.

### **Standard 6: Managing curriculum implementation**

Indication should be given of how curriculum implementation will be managed and assured locally and within programmes. This should include:

- Intended use of the curriculum document by trainers and trainees.
- Means of ensuring curriculum coverage.
- Suggested roles of local faculty in curriculum implementation.
- Responsibilities of trainees for curriculum implementation.
- Curriculum management in posts and attachments within programmes.
- Curriculum management across programmes as a whole.

### **Standard 7: Curriculum review and updating**

- [a] Plans for curriculum review, including curriculum evaluation and monitoring, must be set out.
- [b] The schedule for curriculum updating, with rationale, must be provided.
- [c] Mechanisms for involving trainees and lay persons in [a] and [b] must be set out.

### **Standard 8: Equality and diversity**

The curriculum should describe its compliance with anti-discriminatory practice.

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<sup>5</sup> The assessment strategy will be defined separately and will include feedback on learning.

<sup>6</sup> A separate paper will be made available on supervision prior to a statement of principles for supervision being developed.



**Curriculum Module 8: Antenatal Care**

## Curriculum Module 8: Antenatal care

### Learning outcomes:

To understand and demonstrate appropriate knowledge, skills and attitudes in relation to antenatal care

Knowledge criteria	Clinical competency	Professional Skills and Attitudes	Training Support	Evidence / Assessment
<ul style="list-style-type: none"> <li>➤ Preconception care</li> <li>➤ Purposes and practice of antenatal care</li> <li>➤ Recognition of domestic violence</li> <li>➤ Problems of teenage pregnancy</li> <li>➤ Awareness of drug and alcohol misuse</li> <li>➤ Management of normal pregnancy, birth and puerperium</li> <li>➤ Placental abnormalities and diseases</li> <li>➤ Genetic modes of inheritance, common genetic conditions and the diagnosis thereof.</li> <li>➤ Epidemiology, aetiology, pathogenesis, diagnosis,</li> </ul>	<ul style="list-style-type: none"> <li>➤ Undertake pregnant and non-pregnant abdominal examination</li> <li>➤ Take obstetric history. Relevant referral as a result of domestic violence</li> <li>➤ Conduct booking visit</li> <li>➤ Conduct follow-up visits</li> <li>➤ Arrange appropriate investigations</li> <li>➤ Manage:               <ul style="list-style-type: none"> <li>- Growth restriction</li> <li>- Mode of delivery after caesarean section</li> <li>- Multiple pregnancy</li> <li>- Antepartum haemorrhage</li> <li>- Malpresentation</li> <li>- Preterm Premature Rupture of the Fetal Membranes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>➤ <b><u>Liaise with midwives and other health professionals to optimise patient management</u></b></li> <li>➤ Empower and inform women to make appropriate choices for herself and her family in pregnancy and childbirth</li> <li>➤ Explain correctly, and place in context for the patient:               <ul style="list-style-type: none"> <li>- Detection rates and limitations of anomaly screening</li> <li>- Principles of screening for neural tube defects, Down's syndrome and haemoglobinopathies</li> <li>- Genetic disorders and their inheritance with examples such as Tay-Sachs disease, cystic fibrosis and</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>➤ Appropriate postgraduate education courses including CTG interpretation courses</li> <li>➤ Perinatal morbidity and mortality meetings</li> <li>➤ Risk assessment meetings</li> <li>➤ StratOG Modules 3 &amp; 4</li> <li>➤ Useful websites:</li> </ul>	<ul style="list-style-type: none"> <li>➤ MRCOG Part2</li> <li>➤ Core Logbook</li> <li>➤ Local meetings attended e.g. Perinatal in PDF</li> <li>➤ Case reports</li> <li>➤ Audit project</li> <li>➤ Certificate of completion of CTG training package (e.g. K2)</li> <li>➤ TO1/TO2</li> </ul>

Knowledge criteria	Clinical competency	Professional Skills and Attitudes	Training Support	Evidence / Assessment
<p>prevention, management, delivery, complications of:</p> <ul style="list-style-type: none"> <li>- Pregnancy induced hypertension</li> <li>- Haemorrhage:</li> <li>- Preterm premature rupture of membranes</li> <li>- Multiple pregnancy:</li> <li>- Malpresentation</li> <li>- Fetal growth retardation:</li> <li>- Fetal haemolysis:</li> <li>- Prolonged pregnancy:</li> <li>- Congenital malformation</li> <li>- Social and cultural factors:</li> </ul> <p>➤ Immunology and immunological disorders affecting pregnancy</p>	<ul style="list-style-type: none"> <li>- Reduced fetal movements</li> <li>- Prolonged pregnancy</li> <li>- Drug and alcohol abuse in pregnancy</li> </ul> <p>➤ Observe:</p> <ul style="list-style-type: none"> <li>- ECV and cervical cerclage</li> </ul> <p>➤ Counsel about:</p> <ul style="list-style-type: none"> <li>- Down's syndrome screening</li> <li>- Genetic disease</li> <li>- Fetal abnormality</li> <li>- Haemolytic disease</li> <li>- Infection</li> <li>- Mode of delivery</li> </ul> <p>➤ Assess fetal wellbeing by interpretation of CTG and ultrasound</p>	<p>thalassaemia</p> <ul style="list-style-type: none"> <li>- Effects upon fetus and neonate of infections during pregnancy, including HIV, measles, chickenpox, rubella, cytomegalovirus, parvovirus and toxoplasmosis</li> </ul> <p>➤ Identify and deal appropriately with domestic violence and child protection issues</p>	<p><a href="http://www.nice.org.uk">www.nice.org.uk</a>  <a href="http://www.rcog.org.uk">www.rcog.org.uk</a>  <a href="http://www.sign.ac.uk">www.sign.ac.uk</a>  <a href="http://www.show.scot.nhs.uk/spcerh">www.show.scot.nhs.uk/spcerh</a></p>	

Knowledge criteria	Clinical competency	Professional Skills and Attitudes	Training Support	Evidence / Assessment
<p><b>Role and use of ultrasound in antenatal care (Please refer to module 16 for principles of ultrasound examination)</b></p> <ul style="list-style-type: none"> <li>➤ Basic fetal and placental anatomy to define fetal orientation</li> <li>➤ Assessment of liquor volume</li> </ul>	<ul style="list-style-type: none"> <li>➤ Determine fetal viability by transabdominal ultrasound, if less than 14 refer for transvaginal scanning to confirm absent fetal heart beat</li> <li>➤ To perform a transabdominal scan after 14 weeks gestation</li> <li>➤ Identify features of the head, chest, abdomen</li> <li>➤ Determine fetal lie and presentation</li> <li>➤ Determine placental site</li> <li>➤ Assess liquor volume by deepest pool</li> </ul>	<ul style="list-style-type: none"> <li>➤ Use appropriate referral pathways and local protocols if abnormal findings suspected</li> </ul>	<ul style="list-style-type: none"> <li>➤ Mandatory education and training sessions</li> <li>➤ Theoretical accredited course (local or RCOG)</li> <li>➤ Supervised structured clinical learning sessions</li> <li>➤ Observation by attendance at sessions in an obstetric ultrasound department including anomaly and fetal assessment scans</li> </ul>	<ul style="list-style-type: none"> <li>➤ Certificate of course attendance</li> <li>➤ MRCOG Part 2</li> </ul>

## **Appendix to Curriculum Module 8 – details of knowledge criteria:**

### **Preconception care:**

- Sources of detailed information accessed by patients
- Effect of pregnancy upon disease
- Effect of disease upon pregnancy
- Principles of inheritance of disease
- Teratogenesis
- Drugs and pregnancy

### **Purposes and practice of antenatal care:**

- Arrangements for and conduct of booking visit
- Arrangements for and conduct of follow-up visits
- Use of imaging techniques
- Screening for abnormality
- Health education
- Liaison between health professionals
- Recognition of domestic violence

### **Physiology & management of normal:**

- Pregnancy
- Childbirth, including delivery outside specialist unit
- Puerperium, including lactation
- Neonate, including feeding

### **Placental:**

- Abnormalities (shape, size, implantation)
- Chorioamnionitis
- Infarction
- Chorioangioma
- Multiple pregnancy
- Intrauterine growth retardation
- Cord abnormalities
- Trophoblastic disease

### **Immunology:**

- Immunological pregnancy tests
- Rhesus and other isoimmunisation
- Auto-immune diseases

### **Genetic:**

- Modes of inheritance (Mendelian, multifactorial)
- Cytogenetics
- Phenotypes of common aneuploidies (Down's syndrome, Edward's syndrome, Patau's syndrome, Turner's syndrome, Klinefelter's syndrome, triple X, multiple Y)
- Translocation
- Miscarriage
- Molecular genetics (DNA transcription, DNA translation, DNA blotting techniques, gene amplification techniques, principles of gene tracking)
- Counselling (history taking, pedigree analysis)
- Population screening (genetic disease, congenital malformations)
- Antenatal diagnosis (chromosomal defects, inborn errors of metabolism, neural tube defects, other major structural abnormalities)
- Management [referral to specialist team, antenatal intervention, delivery, neonatal investigation, neonatal care (medical, surgical)]

### **Epidemiology, aetiology, pathogenesis, diagnosis, prevention, management, delivery, complications, prognosis with regard to the following: -**

#### **Pregnancy induced hypertension:**

- Definitions
- Aetiological theories
- Prophylaxis
- Assessment of severity
- Consultation
- Therapy
- Delivery (timing, method)
- Complications (eclampsia, renal, haemorrhagic, hepatic, fetal)

#### **Hypotensive disorders:**

- Hypovolaemia
- Sepsis
- Neurogenic shock
- Cardiogenic shock
- Anaphylaxis
- Trauma
- Amniotic fluid embolism
- Thromboembolism

### **Preterm premature rupture of membranes:**

- Fetal pulmonary maturity
- Therapy (steroids, antibiotics, tocolytics)
- Infection (risks, management)
- Delivery (induction of labour, timing, mode)

### **Haemorrhage:**

- Placental abruption
- Placenta praevia
- Vasa praevia
- Placenta accreta
- Trauma

### **Multiple pregnancy:**

- Zygosity
- Impact of assisted reproduction techniques
- Placentation
- Diagnosis
- Management (antenatal, intrapartum, postnatal)
- Special procedures (prenatal diagnosis, monitoring)
- Feeding
- Higher order multiple pregnancies (counselling, community care)

### **Malpresentation:**

- Types (breech, brow, face, shoulder, variable lie)
- Diagnosis
- Management (antenatal, intrapartum)
- Mode of delivery

### **Fetal growth retardation:**

- Aetiology (maternal, placental, fetal)
- Diagnosis (clinical, imaging, biochemical, genetic)
- Monitoring (ultrasound, cardiotocography)
- Delivery (timing, method)
- Prognosis (fetal, neonatal)

- Uterine inversion

### **Fetal haemolysis:**

- Relevant antigen-antibody systems
- Prevention
- Fetal pathology
- Diagnosis
- Assessment of severity
- Intrauterine transfusion (indications, techniques, referral)
- Delivery (timing, method)
- Counselling

### **Prolonged pregnancy:**

- Risks
- Fetal monitoring
- Delivery (indications, methods)

### **Congenital malformation:**

- Screening
- Amniotic fluid volume (polyhydramnios, oligohydramnios)
- Management [diagnosis, consultation, viability, delivery (time, place, method), counselling]
- Specific abnormalities:
  - Head (anencephaly, microcephaly, encephalocele, hydrocephalus, hydranencephaly, holoprosencephaly)
  - Skeleton (spina bifida, phocomelia, chondrodysplasia, intrauterine amputation)
  - Heart (major defects, other defects)
  - Lungs (pulmonary hypoplasia)
  - Urinary (renal agenesis, polycystic kidneys, urinary tract obstruction)
  - Genital (intersex, genital tract abnormalities, ovarian cyst)
  - Gastro-intestinal (abdominal wall defects, oesophageal atresia, duodenal atresia, diaphragmatic hernia, bowel obstruction)
- Other (cystic hygroma)
- Other fetal disorders:
  - Non-haemolytic hydrops fetalis
  - Tumours
  - Pleural effusion
  - Fetal bleeding

### **Social and cultural factors:**

- Effect upon pregnancy outcome
- Single parenthood
- Teenage motherhood
- Parent-baby relationships (factors promoting, factors interfering)
- Bereavement counselling

## **Appendix to Module 8 – Further Details of Knowledge Criteria**

### **Principles of ultrasound:**

- Basic physics
- Safety
- Relationship between two dimensional screen image and three dimensional object

### **Ultrasound assessment of fetal wellbeing:**

- Fetal biometry (pregnancy dating, gestational age, fetal growth)
- Biophysical profile
- Use of Doppler to assess blood flow (fetus, uterus)
- Indications and limitations of scanning in late pregnancy
- Ultrasound surveillance in twin pregnancy

### **Techniques of fetal anomaly scanning and non-invasive fetal diagnosis:**

- Use of nuchal translucency measurements to identify fetuses at high risk of Down's syndrome
- Combination of ultrasound and other risk markers to create an individualised risk profile for each patient

### **Invasive procedures:**

- Amniocentesis
- Chorionic villus sampling
- Placentesis
- Cordocentesis

### **Identify fetal position and fetal heart in later pregnancy and to create a three dimensional image of the fetus in the mind:**

- Identify the fetus
- Determine the lie of the fetus
- Be familiar with maneuvers to identify position of fetal heart
  
- Identify fetal heart pulsations (use of transvaginal ultrasound at less than 14 weeks)
- Demonstrate fetal heart pulsations to mother

### **Orientate ultrasound findings in the second and third trimesters and orientate the fetus correctly in the uterus:**

- Determine lie and position of fetus
- Identify features of the head
- Identify features of the chest
- Identify features of the abdomen
- Locate best position to measure abdominal circumference
- Identify the spine
- Identify the limbs
- Perform basic fetal measurements (e.g. those of BPD, HC, AC, femur length, estimation of fetal weight)

**Localise the placenta in the third trimester:**

- Find the placenta
- Describe its features
  - Texture
  - Echolucent areas
  - Chorionic plate
  - Echogenicity
- Define its upper and lower borders
- Relate it to other features such as bladder and cervix

<b>MODULE 8</b>	<b>TOPIC : Antenatal care</b>
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<u>Skill</u>	Competence Level <span style="color: green;">■</span> Basic Training <span style="color: yellow;">■</span> Intermediate Training <span style="color: red;">■</span> Advanced Training					
	<b>Observation</b>		<b>Direct Supervision</b>		<b>Independent Practice</b>	
	Date	Signature	Date	Signature	Date	Signature
Conduct a booking visit						
Conduct a follow up visit						
Arrange appropriate investigations						
<u>Assess fetal wellbeing by interpretation of:</u>						
<u>Maternal history</u>						
CTG						
Ultrasound assessment						
<b>Manage:</b>						
Oligohydramnios/polyhydramnios						
Growth restriction						
Multiple pregnancy						
Malpresentation						
Reduced fetal movements						

Prolonged pregnancy						
Drug and alcohol problems in pregnancy						
Infections in pregnancy						
Preterm premature rupture of the membranes						
Antepartum haemorrhage						
External cephalic version						
Insertion of cervical cerclage						
<b>Counsel about:</b>						
Screening for Down's syndrome						
Screening for other fetal abnormalities						
Haemolytic disease						
Mode of delivery after caesarean section						
Cervical cerclage						
<b><u>Basic Obstetric Ultrasound</u></b>						
Identify features head, chest, abdomen						
Transvaginal confirmation viability <14 weeks						
<b>Third trimester scanning</b>						

Viability						
Fetal presentation						
Assess liquor volume by deepest pool						
Placental localisation						

<b>Training Courses or sessions</b>		
<b>Title</b>	<b>Signature of educational supervisor</b>	<b>Date</b>
CTG Interpretation		
Basic obstetric ultrasound theoretical course.		

<b>Authorisation of Signatures – please print your name and sign below</b>	
<b>Name (please print)</b>	<b>Signature</b>



## FETAL BLOOD SAMPLING

Trainee Name:		Assessor Name:		Date:
Level of training:		Post:		

Preparation of the patient	Done independently	Needs help	Not applicable
Ensures patient and partner understand procedure			
Establishes level of pain relief and acts appropriately			
Supervises positioning of patient – corrects as required			
Appropriate use of assistants			
Assembles / positions equipment			
Demonstrates knowledge of equipment and can trouble shoot problems			

Operative procedure	Done independently	Needs help	Not applicable
Assesses dilatation and position of cervix			
Obtains clear, well lit view of fetal scalp			
Collects uncontaminated good sized sample without air bubbles			
Applies pressure to scalp wound			
Has strategies to overcome technical difficulties e.g. high head, inadequate bleeding etc.			
Correct interpretation of results			

***Both sides of this form to be completed and signed***

**GENERIC TECHNICAL SKILLS ASSESSMENT**

*Assessor, please ring the candidate's performance for each of the following factors:*

<b>Respect for tissue</b>	Frequently used unnecessary force on tissue or caused damage by inappropriate use of instruments.	Careful handling of tissue but occasionally causes inadvertent damage	Consistently handled tissues appropriately with minimal damage.
<b>Time, motion and flow of operation and forward planning</b>	Many unnecessary moves. Frequently stopped operating or needed to discuss next move.	Makes reasonable progress but some unnecessary moves Sound knowledge of operation but slightly disjointed at times	Economy of movement and maximum efficiency. Obviously planned course of operation with effortless flow from one move to the next.
<b>Knowledge and handling of instruments</b>	Lack of knowledge of instruments.	Competent use of instruments but occasionally awkward or tentative	Obvious familiarity with instruments.
<b>Suturing &amp; knotting skills as appropriate for the procedure</b>	Placed sutures inaccurately or tied knots insecurely, and lacked attention to safety.	Knotting and suturing usually reliable but sometimes awkward	Consistently placed sutures accurately with appropriate and secure knots, and with proper attention to safety.
<b>Technical use of assistants Relations with patient and the surgical team</b>	Consistently placed assistants poorly or failed to use assistants. Communicated poorly or frequently showed lack of awareness of the needs of the patient and/or the professional Team	Appropriate use of assistant most of the time Reasonable communication and awareness of the needs of the patient and/or of the professional team	Strategically used assistants to the best advantage at all times. Consistently communicated and acted with awareness of the needs of the patient and/or of the professional team
<b>Insight/Attitude</b>	Poor understanding of areas of weakness	Some understanding of areas of weakness	Fully understands areas of weakness
<b>Documentation of Procedures</b>	Limited documentation Poorly written	Adequate documentation, but with some omissions, or areas that need elaborating	Comprehensive legible documentation, indicating findings, procedure and postoperative management

Based on the checklist and the Generic Technical Skills Assessment, Dr .....has achieved/failed\* to achieve the OSAT competency

Needs further help with: * * Date Signed (trainer) Signed (trainee)	Competent to perform the entire procedure without the need for supervision Date Signed Signed
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\* Delete where applicable, and date and sign the relevant box

