**Training and CPD Record**

**Introduction**

This Training Record is designed to meet the requirements of the GMC to keep adequate documentary records of training and learning activities.

The Training Record will also help the monitoring of the trainee’s progress through the period of Higher Specialty Training. It will allow educational supervisors to assess both the achievements and the requirements of the trainee throughout this period, and will support planning and setting of educational objectives.

The Training Record must be retained by the trainee, and maintained in a way that is appropriate to the work routine. Experience gained during the training programme must be collected and recorded as official documentary evidence, to be reviewed at the annual review (ARCP) as well as regularly in educational meetings with the supervisor. It should be updated regularly by the trainee - this is a condition in the model training agreement.

A Training Record that accurately reflects acquired competencies and professional experience should be able to be used as supportive documentation for professional revalidation with the General Medical Council (although governance appraisals, as dictated by the employing organisation and employment contract, will probably need to run in parallel).

**Explanatory Notes**

The Training Record should be regularly updated throughout the period of specialty training. It is designed in loose-leaf form so that supporting documentation can be easily inserted within the Record. Replacement or additional pages can be downloaded from the Faculty’s web site at [www.fom.ac.uk](http://www.fom.ac.uk/education/speciality-training/training-handbooks-for-occupational-medicine/specialty-training-handbook-4th-edition-april-2008).

A copy of the Training Record will need to be submitted for each annual review (ARCP). It is recommended that the original document is retained by the trainee for reference during the ARCP process.

The Training Record is subdivided into six sections (A - F). Brief details of the contents of each section are given below. It should be noted that some sections require more frequent updating than others. Supporting documentation should, where possible, be typed using a standard word processor package. Tables and charts can be included where this is felt to be helpful. The aim of the supporting documentation is to help demonstrate the acquisition of core competencies.

The Training Record will be kept under review and will be updated to reflect changes in:

* the Faculty’s curriculum for higher specialist training
* the assessment of competencies in occupational medicine

# Summary of Contents of Sections A to F

#### Section A – Personal Information

Personal details – Name, DoB, GMC Registration, Address

#### Section B – CV

A brief CV including details of general professional training, details of employment whilst a trainee in occupational medicine, and details of educational supervisors

#### Section C – Learning objectives and core competencies

This section provides an aid to educational planning. For each of the core competencies that need to be acquired, details are given of the main learning scenarios, the formal methods by which trainees will be assessed, and suggested target activities.

Early discussions between the trainee and educational supervisor are encouraged. At the start of each year of training a Learning Plan should be drawn-up jointly by the educational supervisor and trainee. This will identify the **learning objectives** that need to be completed during the coming year and will take into account information gained from the previous ARCP and other assessments. These plans should be included in the training record. In addition, we recommend that trainees and their supervisors meet *at least quarterly* for formal **educational appraisal** – i.e. a review of progress against targets, and a review of the plan in relation to learning needs and opportunities.

Section C suggests some target learning activities, and provides space for a record of these to be incorporated into the Training Handbook. They include:

* four workplace assessments by the end of ST4
* details of advice given on first aid arrangements to two workplaces by the end of ST4
* details of the evaluation of two health surveillance programmes by the end of ST4
* details of assessment of environmental impact of two organisations by the end of ST6
* details of the evaluation of a health promotion programme by the end of ST6
* details of two clinical audit projects by the end of ST6
* details of dissertation protocol by ST4 and dissertation by the end of ST6
* details of teaching and policy development undertaken whilst a trainee

Supporting documentation can be inserted in the relevant sections of the Training Record. Summary details of tasks (e.g. workplace assessments, audits etc) can be entered into Section C where indicated.

Section D – Personal Training Information

This section should include loose leaf insertions of any other relevant training documentation. Examples of the types of documents to include are:

* Confirmation of enrolment for Higher Specialist Training with the FOM
* ARCP forms
* Personal appraisal reports
* Copies of training plans agreed with the educational supervisor
* Feedback from formal examinations
* Any other relevant training information

#### Section E – Workplace-based assessments

“Workplace-based assessments” (WBAs) are an important component of the higher specialist training programme in occupational medicine.

These are on-the-job assessments of day-to-day performance. Most supervisors will have sat in on some of their trainees’ consultations, discussed problem cases with them, checked over a sample of their correspondence, made sure they can perform everyday clinical procedures correctly, and helped them plan a portfolio, recording a set of learning experiences and objectives. These are WBAs. The new arrangements formalize the process, ensuring a more systematic approach to their conduct, recording and end use.

This section outlines the different types of WBA and provides guidance on how many are needed, how the content and assessor are selected, what forms need to be completed, and what is being tested.

Each WBA generates an **assessment form** (a formal record with scores in different components of performance). The form details what went well, what might need to improve and an agreed action form countersigned by the trainee. Each assessment form should be stored in this Section of the Training Record and a copy retained by the Educational Supervisor as a support to educational appraisal. The trainee will receive an **annual summary form** for each type of WBA, which should be kept in the Training Record. Copies will be submitted to the ARCP panel as part of the evidence considered in annual assessment for progression.

**Section F: Continuing Professional Development (CPD)**

CPD section including details of courses, conferences, publications, and clinical attachments.

The GMC’s revalidation process will require all doctors to maintain a record of CPD activity. This record will help trainees and educational supervisors to plan the forthcoming year’s Learning Plan.

**Section A – Personal Details**

Full Name:

Date of Birth:

GMC registration number:

Address:

Degrees & Diplomas:

Membership of Learned Societies:

Date of commencement of Specialist Training:

NTN/NTN(I):

Expected date of CCT:

Date of achieving S3 exam:

Date of achieving ST6 exam:

Date of achieving MFOM:

Date of award of CCT:

Educational supervisor’s name and qualifications:

Regional Specialty Adviser(s):

**Section B – CV**

This section should contain a brief CV that includes details of qualifications, general professional training, details of employment whilst a trainee in occupational medicine and details of training supervisors.

It should be inserted in loose-leaf form after this page and updated as necessary.

**Section C: LEARNING OBJECTIVES AND CORE COMPETENCIES**

### Educational planning

This Section provides details of the main learning situations and assessment methods for each of the curriculum competencies that you need to acquire during training, as well some suggested target activities.

Please use these notes as **an aid to planning** and discuss them with your educational supervisor. Learning objectives should be revisited frequently throughout training: you should meet with your educational supervisor **at least quarterly** to review your progress and learning needs, and to check on training plans.

### Workplace-based assessments

You should also plan to undertake and record in your log-book the required annual number of formal **workplace-based assessments** (Mini-CEX, CBD, SAIL(OH), MSF, DOPS), as set out in Section E of this Handbook. The onus is on you, the trainee, to ensure these are done.

NB These workplace-based assessments are in addition to any of the suggested target activities you take up from this section.

Keeping your records

1. The output from appraisals and ARCP reviews, as well as results and feedback from formal examinations should be incorporated into Section D of this Training Record.
2. The output from the WBAs should be incorporated into Section E of this Training Record.
3. The supporting documentation for any additional target activities suggested in this Section can be recorded at the end of this Section.

**1.1 Good Clinical Care**

**(i) History, Examination, Investigation & Record Keeping Skills**

**Competency:** *To be able to carry out specialist assessment of patients by means of clinical history taking, physical examination and use of relevant investigations.*

**Main learning situations:** Occupational health clinics, case management meetings, tutorials, formal courses and educational meetings.

**Main assessment methods:** Workplace-based assessments – Mini-CEX, Case-based Discussions, SAIL(OH). Certain components (e.g. empathy, respect, sensitivity for others, respecting the role of other team members) may be assessed in part through MSF. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

See section 1.5 for suggestions.

Sample levels of achievement

By the end of ST3: Be able to recognise common conditions in occupational clinical practice (e.g. psychological, musculoskeletal, dermatological); be able to assess them by use of focused history, examination and investigation; information-gathering should include relevant work considerations; conclusions should be clear, recorded, and explained clearly to the patient.

By the end of ST4:

1) Be able to handle a wide range of conditions relevant to attendance at work or ill-health retirement.

Ensure that assessments are in line with published evidence-based best practice.

2) Be able to construct a competent and comprehensive report for managers and other parties (e.g. sufficient to provide a good legal record).

By the end of ST5:

Be able to manage complex cases with psychosocial or psychological elements of presentation overlaying potential work attribution – e.g. cases of work-related upper limb disorder or ‘work-induced stress’.

**(ii) Managing Chronic Disease**

**Competency:**

To be able to carry out assessment of patients with chronic disease or rehabilitating from acute injury or ill health and to demonstrate effective management of chronic disease states in a workplace setting.

**Main learning situations:** Occupational health clinics, case management meetings, tutorials, formal courses and educational meetings, peer discussions.

**Main assessment methods:** Workplace-based assessments – Mini-CEX, Case-based Discussions, SAIL(OH). Certain components (e.g. advocacy, involvement of stake holders, professional advice) may be assessed in part through MSF. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

See section 1.5 for suggestions.

Sample levels of achievement

By the end of ST3:

1) Be able to hold a consultation, and assess and communicate outcomes to the client (manager) and customer (patient) in writing in relation to:

* Long-term sickness absence
* Short-term sickness absence

This might cover a range of common conditions among workers e.g. musculoskeletal or psychological disorders, diabetes, epilepsy, or cardiovascular disease.

2) Assess fitness for work against an existing standard.

Performance should observe relevant clinical, legal and ethical competencies and where appropriate should recommend adjustments to the work.

By the end of ST5:

Extend such assessments to complex scenarios involving third person safety, in which significant support and workplace adjustments are likely to be necessary.

**1.2 Time Management & Decision making**

**Competency:**

*Demonstrate that the knowledge, skills and attitudes are used to manage time and problems effectively.*

**Main learning situations:** Occupational health clinics, case management meetings, committee work, managerial activities, tutorials, observation of peers.

**Main assessment methods:** Workplace-based assessments – Mini-CEX and Case-based Discussions.

Sample levels of achievement

By the end of ST3: Manage one’s own time effectively to achieve self-directed objectives; prioritise appropriately and in line with departmental standards; be organised and punctual; meet deadlines and function effectively within team; delegate appropriately.

By the end of ST4: Demonstrate the ability to manage a project over a 3 to 6 month time frame from planning to completion.

By the end of ST5: Demonstrate the ability to deal with novel/complex/critical problems involving delegation, leadership of a team and other project management skills.

**1.3 Information**

1. **Education & Disease Prevention**
2. **Health promotion**
3. **Information management**

**Competencies:**

*(i) Assess the need for, organise, deliver and evaluate health promotion in a range of working environments.*

(ii) Ensure that the knowledge, skills and attitudes are used to educate patients and others in a workplace setting effectively.

*(iii) Demonstrate competence in the use and management of health information.*

**Main learning situations:** Occupational health clinics, planning and evaluation of occupational health services with peers (e.g. through team and management meetings, audit), independent study, formal courses and educational meetings.

**Main assessment methods:** Workplace-based assessments – mainly Case-based Discussions. For (iii), research dissertation. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

1. During ST3 and ST4, two health surveillance programmes should be assessed for their appropriateness and effectiveness in identifying cases of occupational ill health, e.g. respiratory surveillance, hearing conservation or skin protection programme, surveillance for Hand-arm Vibration Syndrome. Training (e.g. in spirometry, audiometry) should be provided as necessary. Details of both assessments can be included later in this section of the Training Record.

2. During ST3 and ST4, two workplaces should be visited and advice given on the appropriateness of first aid arrangements. Details of both assessments can be included later in this section of the Training Record.

3. At some stage during training, assess the need for health promotion in a workplace and organise, provide and evaluate a health promotion programme: at some stage in training, deliver a health promotion programme to a group of employees and evaluate its effectiveness by, for example, a questionnaire survey. Details may be included later in this section of the Training Record.

Sample levels of achievement

By the end of ST3:

1) Understand the relevance of occupational risks to health at work.

2) Understand the impact of individual/lifestyle factors upon health and demonstrate how these may be modified.

3) Identify suitable opportunities for health promotion initiatives.

4) Be able to use information resources relevant to occupational medicine (e.g. toxicological, medico-legal, governmental).

By the end of ST4:

1) Set up and implement a health surveillance programme (e.g. for respiratory or skin sensitizers).

2) Understand the hierarchy of control measures in a workplace sufficiently well to plan a preventive strategy

3) Use IT to undertake a critical analysis of clinical practice.

By the end of ST5:

Deliver a health promotion initiative.

By ST6:

1) Use multiple sources of information to analyse a workplace health concern and generate reports for management and for the workforce.

2) Advise on improving workplace mental well-being in relation to an identified organisational problem area; deliver recommendations by way of a report and oral presentation.

3) Prepare a case to managers for improvements in health and safety systems at the workplace.

**1.4 General Principles of Assessment & Management of Occupational Hazards to Health**

**Competencies:**

*(i) Correctly carry out specialist assessment and management of Occupational Hazards to Health in a range of working environments.*

*(ii) Be able to assess health problems and disease and evaluate fitness for work. Potentially any health problem might have to be assessed, but those seen more commonly in occupational health practice relate to Mental health, Ergonomics, HAVS (Hand-Arm vibration Syndrome), Toxicology, Rheumatology, Respiratory Medicine, Dermatology, Cardiology and ENT.*

*(iii) Demonstrate the capacity to apply specialist competencies in Occupational Medicine to a particular workplace.*

**Main learning situations:** (i)workplace visits, meetings with line managers and health and safety specialists; (ii) Occupational health clinics, case management meetings, tutorials, formal courses and educational meetings, peer discussions; (iii) experience in clinics, meetings, management activities, tutorials, self-directed learning.

**Main assessment methods:** Workplace-based assessments – mainly Case-based Discussions [an assessment for workplace visits is under development]. Certain components (e.g. advocacy, involvement of stake holders, professional advice) may be assessed in part through MSF. Aspects of knowledge could feature in Faculty examinations.

**Some target activities (for (i)):**

1. Practice your skills in:

* assessment of workplace hazards
* evaluation of risks
* advice on control measures
* evaluation of the need for specialist assessment of working environment

2. Prepare written assessments for at least **two** workplaces each year which:

* identify potential hazards to health
* assess existing controls
* assess pertinent environmental measurements that have been undertaken
* undertake some basic environmental measurements, e.g. noise, dust, fume
* assess risks of the hazards
* incorporate a written report for management with recommendations

Details of both assessments can be included later in this Section of the Training Record.

3. During years ST3 and ST4 ensure you have formal meetings with a) a Safety Officer, b) an Occupational Hygienist, c) Managers and d) Union representatives at one or more workplaces.

4. See target activity 1.3 1 above (health surveillance).

Sample levels of achievement

By the end of ST3:

1) Demonstrate competency to undertake a basic workplace visit and assess health and safety compliance and/or job-person fit.

2) Perform a Display Screens Equipment assessment where a client (patient) complains of a musculoskeletal problem.

By the end of ST4:

1) Be able to evaluate the health hazards of a chemical, with reference to the data sheet and other sources of information; produce an effective written report and oral presentation, identifying required actions.

2) Be able to investigate a case of suspected workplace ill-health – incorporating data from various sources (data sheets, workplace visit, assessment of health risk, investigations in the individual, policy documents); recommend actions in relation both to the individual and the workplace. Sample cases might involve work-related wheezing and noise-induced deafness.

3) Recognise risks in specialist areas. Organise input from specialists appropriately and incorporate it into advice to managers; organise and implement a health surveillance programme as appropriate.

By the end of ST5:

Develop a framework of risk management for a workplace, including at least two specific work areas. Write a legal report.

**1.5 Assessment of Disability and Fitness for Work**

**Competency:**

*Be able to assess functional capacity and evaluate fitness for work.*

**Main learning situations**: Occupational health clinics, case management meetings, tutorials, formal courses and educational meetings, peer discussions.

**Main assessment methods:** Workplace-based assessments – Mini-CEX, Case-based Discussions, SAIL(OH). Certain components (e.g. effective liaison with other team members) may be assessed in part through MSF. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

1. Practice your skills in:

* advising on fitness for work placement
* advising on impairment and disability in relation to work
* advising on rehabilitation and redeployment
* advising on absence attributable to sickness
* managing cases of work related ill health
* advising on ill-health retirement
* diagnosing cases work -elated ill health

2. Meet with a representative of a disability service such as a Disability Employment Adviser and a representative of the Benefits Agency.

3. Make sure you become familiar with the process of ill-health retirement and injury benefit by gaining knowledge and experience in the operation of pension schemes for a variety of employers.

Sample levels of achievement

By the end of ST3:

1) Identify and assess individual factors relevant to employment in specific work.

By the end of ST4:

1) Perform a health assessment for ill-health retirement and write a competent report.

2) Undertake pre-employment assessments, and statutory and management referrals, informed by a working practical knowledge of legal requirements, and organisational and behavioural issues.

3) Present cases with evidence-based justification for recommendations.

By the end of ST5:

Write an organisational occupational health policy with a view to introducing fitness standards in relation to, say, blood borne virus clearance or working at heights.

**1.6 Environmental Issues Related to Work Practice**

**Competency:**

*Be able to recognise and advise on health risks in the general environment arising from industrial activities.*

**Main learning situations**: Formal courses, educational and specialist meetings, peer discussion.

**Main assessment methods:** Workplace-based assessments – Mini-CEX, Case-based Discussions, Faculty examinations.

**Some target activities:**

1. At some stage in training spend time with: a) an Environmental Health Officer, and b) a representative of the Environment Agency/NRA.

2. At some stage in training assess the environmental impact of the work activity of two organisations. Details can be included later in this Section of the Training Record.

Sample levels of achievement

By the end of ST3: None.

By the end of ST4: Demonstrate knowledge of the legislative framework in relation to major or common environmental toxicological agents.

By the end of ST5: Undertake an assessment of the environmental impact of routine industrial activities.

By ST6: Undertake major incident planning with respect to environmental issues.

**2.1 Learning**

**Competency:**

*Develop a commitment to the concept of life long learning.*

**Main learning situations**: all, but especially self-directed.

**Main assessment methods:** ARCP review, informed by regular educational appraisals, supervisor’s report and other assessment outcomes.

**Some required**[[1]](#footnote-1)\* **activities:**

1. Participate in the Faculty’s Scheme for Continuing Professional Development (CPD) and complete satisfactory annual returns in all of the training years – see Section F.

2. Lead in personal educational planning, participate in appraisals, reflect on feedback from assessments and ARCP annual reports.

**Some target activities:**

3. Keep up to date and reflect on articles in journals relevant to occupational medicine – e.g. Occupational Medicine, Occupational and Environmental Medicine, the British Medical Journal and the Lancet.

4. Access the Internet and other electronic databases to seek evidence-based information. Belong to (and participate in) an appropriate Internet-based discussion/news group.

5. Contribute to a journal club.

Sample levels of achievement

Throughout training: Complete satisfactory annual CPD returns.

By the end of ST3:

1) Develop and follow a detailed personal development plan.

2) Be able to conduct a reasonably thorough online search of electronic databases to seek evidence-based information.

By ST4:

1) Undertake an evidence-based review with written report.

2) Demonstrate self-directed and experiental learning.

By ST5:

Use evidence-based information and audit findings to modify practice.

**2.2 Research**

**Competency:**

*Demonstrate an effective involvement with a research project and to undertake research and have a good knowledge of research methodology.*

**Main learning situations:** Educational courses, meetings, tutor-supported learning, self-directed independent reading and preparation, learning from peers or experts.

**Main assessment methods:** Assessed research dissertation or other substantial published work(s) – see MFOM regulations and guidelines (Section 4) for details.

**Some target activities:**

1. Dissertation. The following stages of preparation and execution are envisaged:

* Convert a problem of practice into a researchable question
* Carry out a literature search
* Plan data collection for a simple survey (sample selection, record and storing of data)
* Carry out simple statistical manipulations to summarise data
* Use a computer for the storage and analysis of data
* Interpret scientific data in journals and from own research
* Recognise and initiate the investigation of clusters of disease in a workforce
* Use an external statistician or epidemiological expert for advice, as necessary.

This activity will be undertaken primarily in ST5 and ST6 of the training programme. You must produce a dissertation for the MFOM and if appropriate may also do so for a MSc. One or more manuscripts suitable for publication may also be written. The protocol of your project and draft manuscript can be included as appropriate later in this section of the Training Record. You should aim to get the initial proposal for the dissertation submitted to (and accepted by) the Faculty by the end of ST4.

2. Clinical audits. Aim to conduct at least **two** clinical audit projects during the training programme (ideally before the end of ST5). You can include details later in this Section of the Training Record.

Sample levels of achievement

By the end of ST3:

1) Practice some of the skills needed to prepare for the dissertation: (i) learn to conduct an evidence-based literature review; (ii) develop a basic knowledge of research methods; (iii) identify some questions from practice and consider how they might be investigated, convert one into a researchable question.

2) Contribute to a journal club.

3) Present a simple clinical audit.

By the end of ST4:

1) Understand research methodology sufficient to develop an outline plan for your dissertation; draft an outline protocol, setting out the background, proposed methods of data collection and a plan of how the data will be analysed. Seek Faculty approval for this outline.

2) Develop and deliver a clinical audit programme, moving from findings through recommended changes to monitoring of the impact.

By the end of ST5: Solve many of the practical problems related to your dissertation proposal – e.g. permissions and ethical approvals, resources, means of data storage and manipulation, specific measuring instruments etc. Have data collection underway.

By the end of ST6: Complete, write up and submit your dissertation (see MFOM guidance, section 4). Prepare the findings for presentation at a scientific meeting.

**2.3 Clinical Governance**

**Competency:**

Demonstrate an understanding of the context, the meaning and the implementation of Clinical Governance.

**Main learning situations**: Team and committee meetings, reports, tutorials and peer input, formal instruction and educational courses, appraisal and self-reflection.

**Main assessment methods:** Workplace-based assessments – mainly Case-based Discussions and MSF. Aspects of knowledge could feature in Faculty examinations.

Sample levels of achievement

By the end of ST3:

1) Maintain appropriate OH records and participate in an audit, supplying a report.

2) Participate effectively in clinical governance committees, including those involving feedback and review regarding own performance.

3) Partake in critical incident analysis.

By the end of ST4: Develop risk assessment guidelines on a specific topic.

By the end of ST5: Audit a team or department activity and make out a reasoned argument for improvements.

By ST6: Develop and manage a clinical governance system.

**2.4 Occupational health in a global market**

**Competency:**

*Be able to determine the impact of the broader socio-political and cultural influence on occupational health practice*

**Main learning situations**: Courses, meetings, tutorials, learning from peers.

**Main assessment methods:** Examinations.

Sample levels of achievement

By the end of ST3: none.

By the end of ST4: Understand the impact of EU/UK government activity on labour markets and legislation.

By the end of ST5: Demonstrate awareness of the wider social and political climate in UK, where this is relevant.

**2.5 Teaching & Educational Supervision**

**Competency:**

*Demonstrate the knowledge, skills and attitudes to provide appropriate teaching, learning and assessment.*

**Main learning situations:** Personal preparation, practice in small groups and larger meetings.

**Main assessment methods:** [A workplace-based assessment (DOPS) is under preparation].

**Some target activities:**

You need to make clear oral presentations to an audience with effective use of audio-visual equipment. During the four-year programme you should aim to

* give at least one presentation to each of: i) a medical audience, ii) a group of managers, iii) a group of employees or their representatives
* participate in teaching of occupational health staff.

Sample levels of achievement

By the end of ST3: Be able to present effectively to a small group of peers and evaluate own performance.

By the end of ST4: Be able to present effectively to large audiences, medical or lay.

By the end of ST5: Demonstrate supervision and appraisal skills.

By ST6: Demonstrate mentoring skills in support of new/junior members of staff.

**3.1 Ethical/legal issues &   
3.2 Maintaining Trust & Professional behaviour**

**Competencies:**

*Ensure that knowledge and skills are used to cope with ethical and legal issues that occur in occupational health practice in a range of workplace settings.*

*Ensure that the knowledge, skills and attitudes are used to act in a professional manner at all times.*

**Main learning situations:** Patient contacts (e.g. occupational health clinics, case management), meetings, written communications and advice to managers;educational courses and meetings, tutor-supported learning, learning from peers.

**Main assessment methods:** Workplace-based assessments – MSF, SAIL(OH), Mini-CEX, Case-based Discussions. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

Key skills include (i) being able to advise managers, safety reps and employees of their responsibilities under health and safety law and (ii) being able to communicate effectively while observing legislative and other ethical requirements regarding confidentiality.

During the four-year programme you should:

1) aim to attend a course or meeting relevant to occupational health law and ethics

2) become involved in policy development

3) seek instruction and training from educational supervisor(s) in the Access to Medical Reports, Data Protection and Disability Discrimination Acts and the Guidance on Ethics for Occupational Physicians from the Faculty of Occupational Medicine.

Sample levels of achievement

By the end of ST3:

1) Demonstrate a working knowledge of the legal and ethical framework relevant to occupational medicine.

2) Recognise the need to seek guidance where necessary.

By the end of ST4:

1) Hold a case-conference, providing appropriate management advice within the bounds of ethics and confidentiality, demonstrating competencies related to

* Employment law
* Disability Discrimination Act
* Access to Medical Reports Act
* Health & Safety At Work etc Act 1974 and related regulations
* Personal injury/tort
* Human rights
* GMC/Faculty ethical standards

2) Demonstrate a sustained willingness to reflect/question practice; participate in appraisal and modify behaviour accordingly.

By the end of ST5:

1) Develop the ability to evaluate and manage complex ethical/legal situations demonstrating a careful approach and considered judgements.

2) Write a legal report.

**3.3 Communication Skills**

**Competency:**

*Be able to communicate effectively with patients, employers, employees’ representatives and professional colleagues in a range of working environments.*

**Main learning situations:** Learning through practice – in occupational health clinics, case-conferences, meetings with managers, other health professionals and workers, peer input and practice (e.g. at formal meetings, journal clubs, committee meetings, preparation of reports).

**Main assessment methods:** Workplace-based assessments –Mini-CEX, SAIL(OH), MSF. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

1. You need to:

* read, write and converse proficiently in the English language
* organise and write clear reports
* make clear oral presentations to an audience with effective use of audio-visual equipment
* communicate with people with different levels of intelligence and understanding
* participate effectively as a member, secretary or chair of a committee

2. During the four-year programme you should aim to

* write letters and reports to managers, employees and other doctors (some of these will be assessed regularly as part of SAIL(OH))
* write four reports of workplace assessments
* give at least one presentation to each of: i) a medical audience, ii) a group of managers, iii) a group of employees or their representatives
* attend several safety committee or infection control committee meetings and chair some meetings
* participate in teaching of occupational health staff

Sample levels of achievement

By the end of ST3:

1) Be able to write clear reports on straight forward cases, conveying relevant action plans to managers and relevant information to other health care professionals.

2) As part of routine practice, communicate verbally with patients and staff with clarity and appropriateness.

By the end of ST4: Demonstrate ability as a committee member.

By the end of ST5:

1) Be able to make an effective presentation to managers – sufficient, for example, to justify a proposed policy, an extension to an existing OH service, or a high profile topic of concern to the workforce or local residents.

2) Demonstrate ability as an effective committee chair.

3) Show skills in managing situations of conflict.

By ST6:

Demonstrate influencing and negotiating skills with management/workforce across a range of differing settings.

**4.1 Team Working & Leadership Skills; 4.2 Management**

**Competencies:**

*Demonstrate the ability to respect others, work in multidisciplinary teams and within a management structure, as well as to have the necessary leadership skills*.

*Have sufficient knowledge of the principles and practices of management and industrial relations to be an effective occupational physician in a range of occupational settings.*

**Main learning situations:** Learning through practice (supervised management experience), tutorials, formal courses and educational meetings.

**Main assessment methods:** Workplace-based assessments (WBAs) – CBD, SAIL(OH), MSF. Aspects of knowledge could feature in Faculty examinations.

**Some target activities:**

* Manage an occupational health department
* Identify the occupational health needs of an organisation
* Define the goals and objectives of an occupational health service
* Define the role of occupational health staff and formulate job descriptions
* Organise record keeping using computers as appropriate
* Negotiate and manage a budget
* Market occupational health services
* Evaluate the quality of an occupational health service
* Select, appoint, supervise and appraise staff performance

Management training will be undertaken primarily in ST5 and ST6 of the training programme with the help if necessary of an external management training course. Where practicable you should be involved in the management of the department(s) in which you work.

Sample levels of achievement

By the end of ST3:

1) Demonstrate effective multidisciplinary working; use interpersonal skills to work effectively with others in team.

2) Understand how an effective team is built.

By the end of ST4:

Undertake a range of differing roles within the team.

By the end of ST5:

1) Lead your team for a particular project or task.

2) Develop interviewing, appraisal and recruitment skills.

By ST6:

1) Demonstrate sound knowledge, skills and attitudes in relation to financial management, clinical and corporate governance – a) produce a business case for investment in OH services and infrastructure; b) show evidence of understanding or responsibility for a budget, including corporate governance.

2) Provide evidence of effective staff management, including staff appraisal and performance planning.

3) Undertake an occupational health needs assessment.

4) Be able to manage a group of other workers or department.

Section C (continued) – Supporting Documentation

**WORKPLACE ASSESSMENTS – (Two per year in ST3 & ST4)**

To include the identification of hazards to health, a description of existing control measures, the interpretation and performance of environmental measurements, a description of any health surveillance programme, risk assessments for each of the hazards identified and recommendations for employer and employees.

A suggested length for each assessment is 2-4 pages. This could be presented as a chart or spreadsheet. Summary details should be included below with the assessments included after this page in the Training Record.

**Training Year Assessment No. Title Date Undertaken**

ST3 1

ST3 2

ST4 1

ST4 2

**EVALUATION OF HEALTH SURVEILLANCE PROGRAMMES   
(One per year in ST 3 & ST4)**

To include an assessment of the appropriateness and effectiveness of the programme’s ability to identify cases of occupational ill health.

A suggested length for each assessment is 1-2 pages. The assessments should be typed and included after this page within the Training Record.

Please include summary details of the two health surveillance programmes in the table below.

***Training Year Type of Surveillance Programme Date Undertaken***

*ST3*

*ST4*

**ASSESSMENT OF FIRST AID FACILITIES – (One per year in years ST3 & ST4)**

A suggested length for each assessment is 1-2 pages. These should be typed and included after this page in the Training Record.

Please include summary details of the two assessments in the table below.

***Assessment Type of Workplace & Facilities Date Undertaken***

*1(ST3)*

*2(ST4)*

**ENVIRONMENTAL MEDICINE**

To assess the environmental impact of two organisations during four years of training and should include details of the sources of information used as part of the assessment.

A suggested length is 1-2 pages for each assessment. These should be typed and included after this page in the Training Record.

Please include summary details of the two assessments in the table below.

***Assessment Number Description of Organisation Date Undertaken***

*1*

*2*

**HEALTH PROMOTION**

To evaluate the need for, and effectiveness of, one health promotion programme during four years of training.

A suggested length is 1-2 pages and should include details on the need for the programme, the actual programme itself and the results of an assessment of the effectiveness of the programme.

Details should be typed and included after this page in the Training Record.

Please include summary details of the programme below.

***Training Year Description of the Programme Date Undertaken***

**CLINICAL AUDIT**

Details of two clinical audit projects during four years of training of either the structure, process or outcome of a clinical intervention. To include as a minimum: standards, observation of practice, comparison with standards and recommendations for improvement.

Details of the two projects should be typed and included within the Training Record. A suggested length is 2-4 pages for each audit project.

Please include summary details of the two projects in the table below.

***Number Training Year Audit Project Title Date Undertaken***

***1***

***2***

**RESEARCH**

Details of initial proposal by end of year ST4, results and manuscript for dissertation or publication(s) by end of year ST6.

**Section D – PERSONAL TRAINING INFORMATION**

Insert copies of ARCP forms, annual appraisal reports, the output of educational appraisals, agreed training plans, feedback from examinations and any other relevant documentation.

A sample report form for use by the educational supervisor is appended. Employers may wish to use their own appraisal documentation, but educational supervisors must ensure that the information provided to the ARCP panel in the annual appraisal report contains the basic information in the attached sample form.

[***This Proforma is under review by the Faculty***]

The output of workplace-based assessments should appear in Section E.

**Educational Supervisor’s Structured Report**

The educational supervisor must complete this report for the Annual Review of Competence Progression panel, summarising the trainees learning portfolio and Workplace Based Assessments (WPBAs) since the previous assessment.-***typed information is preferred***

|  |  |
| --- | --- |
| Trainees Name |  |
| Name of Educational Supervisor submitting report |  |
| Site of Educational Supervisor |  |
| Training Programme Region |  |
| NTN |  |
| GMC Post approval number |  |

|  |  |  |
| --- | --- | --- |
| Previous annual assessments | | |
| Dates | | Outcome + comment if non-standard *i.e. no. extension months and why* |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Previous placements in OM programme | | | |
| Employer/ Trust |  | Clinical supervisor | Dates (from-to) |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Current placement ( Has your ES changed since the last ARCP outcome-Y/N) | | | |
| Location | Specialty | Clinical supervisor | Dates |
|  |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Work Place Based Assessments in current placements | | | | | |
| Assessment | Dates *( or summary attached)* | Number | Details ( median or range of scores if appropriate) | | Outcome *(satisfactory/ unsatisfactory/ insufficient evidence)* & Comments |
| Mini-CEX |  |  |  | |  |
| SLE-DOPs |  |  |  | |  |
| CBD |  |  |  | |  |
| Activity | Dates ( or summary attached) | Details (median or range of scores if appropriate) | | Outcome *(Required/ not required; satisfactory/ unsatisfactory/ insufficient evidence)* & Comments | |
| MSF |  |  | |  | |
| Patient survey |  |  | |  | |
| SAIL(OH) 1  SAIL (OH) 2 |  |  | |  | |

|  |
| --- |
| Feedback on practical skills areas for further development: |

|  |  |  |  |
| --- | --- | --- | --- |
| Experiential outcomes- attach separate expanded reflection/comments if needed | | | |
| Activity | Dates (or summary attached) | Details | Outcome *(Required/ not required ; satisfactory/ unsatisfactory/ insufficient evidence)* & Comments |
| Log-book |  |  |  |
| Audits |  |  |  |
| Research projects |  |  |  |
| Publications |  |  |  |
| Teaching/Presentations |  |  |  |
| Management development |  |  |  |
| DISSERTATION  Mandatory i.e. first aid, workplace visits, Environmental Health assess, Occ hygiene |  | Protocol-progressing/accepted/NA |  |
| Courses attended  (external) |  |  |  |
| Serious untoward incident  ( Form R (A/B related) |  |  | *(resolved/pending; no case to find/learning points)* |
| Complaints |  |  | *(resolved/pending; no case to find/learning points)* |
| MFOM Exams-taken |  | PART1-fail/pass/NA | PART2-fail/pass/NA |
| Other e.g. equality diversity/safeguarding training, GMC 7 domains trainer accreditation(ST6) |  |  |  |

|  |
| --- |
| Communication and consultation skills: |

|  |
| --- |
| Clinical Management |

|  |
| --- |
| Working with colleagues |

|  |
| --- |
| Absences- sick leave\* and study leave with dates ( or summary attached) \*More than 14 days- CCT recalculation maybe needed |

**Summary of Trainees Assessment**

(Educational Supervisor to complete: strengths, areas for improvement, specific recommendations- learning plan or PDP- must be completed)

|  |
| --- |
| Trainee comments/ reflections.   *Have you had an extension within the OM programme?- if yes by how many months* |

Anonymous Trainee GMC survey completed: Yes / No

CPD- appropriate to current level experience achieved: Yes/No

EXPECTED CCT/CESR COMPLETION DATE:

We confirm that this is an accurate description/summary of this trainee’s learning portfolio and WPBA, covering the period from DD/MM/YYYY to DD/MM/YYYYand has been discussed with the trainee concerned.

|  |  |
| --- | --- |
| Educational Supervisor's Name |  |
| Educational Supervisor's GMC number |  |
| Educational Supervisors signature |  |
| Date signed |  |

**Section E: WORKPLACE-BASED ASSESSMENTS – GUIDANCE AND PAPERWORK**

**What are workplace-based assessments? What is their purpose?**

“Workplace-based assessments” (WBAs) are an important component of the higher specialist training programme in occupational medicine. They are integral to the curriculum and assessment framework approved by the statutory regulator, the PMETB, and their delivery is a requirement of training post approval.

Traditionally, the assessment of trainees in medicine has given most emphasis to written examinations – tests of what a person *knows,* rather than what they *actually do in real practice*. Educational supervisors have also signed up trainees as ‘competent’ in their work, but by relatively informal subjective processes with limited evidence collected to support judgments; and the content of on-the-job training and on-the-job experience has been arrived at in a relatively informal way.

WBAs are on-the-job assessments of day-to-day performance. Informally, trainers have already been conducting them. For example, most supervisors will have sat in on some of their trainees’ consultations, discussed problem cases with them, checked over a sample of their correspondence, made sure they can perform everyday clinical procedures correctly, and helped them plan a portfolio, recording a set of learning experiences and objectives. These are WBAs. The old curriculum encouraged such activities; the new arrangements formalize this, ensuring a more systematic approach to their conduct, recording and end use.

Formal on-the-job assessments are useful in many ways. They have an important formative function, helping the trainee to: chart their progress (areas of strength and developmental needs), document the acquisition of competencies, receive regular feedback from experienced senior colleagues, and plan their educational objectives. More generally, they assist reflection and development – assessment is often the bolt on extra at the end, but regular constructive feedback should be an integral part of educational planning; they support and underpin the quality assurance of training, by confirming that developmental expectations are being met; and they drive learning. Naturally, trainees put most effort into those things that are examined – WBAs ensure that this effort is directed at everyday performance rather than abstract knowledge.

Finally, WBAs are the main vehicle for assessing certain important competencies that are hard to measure in other ways (e.g. professional behaviour, probity, team working); and for identifying trainees in difficulty who need special support. Ultimately they are needed to reassure the public that by the end of their training, the doctor is a rounded specialist, fit for purpose.

“The emphasis is moving rapidly away from gaining a certain number of marks in high-stakes examinations and more towards gathering evidence of clinical competence and appropriate professional behaviour and attitudes. Much of this evidence cannot be captured in the kind of formal examinations that have traditionally been the primary focus in postgraduate training. It is demonstrated, day in, day out, in the workplace and seen by educational supervisors, other team members, fellow healthcare workers, patients and their relatives and carers. Since it is both demonstrated and observed in the workplace, then it stands to reason that the workplace is where the evidence can be gathered.” **PMETB** **(2005)**1

WBAs are really important to trainees, and we appreciate the time supervisors give in support of the learning experience.

**What types are? How have they been developed and tested?**

Our training curriculum refers at present to five types of WBA (which are in addition to two centrally administered examinations):

* [**The Mini-Clinical Evaluation Exercise**](#_top) **(Mini-CEX)** involves sitting in on, and formally scoring a trainee’s consultation with a patient;
* [**Directly observed procedures**](#_top) **(DOPS)** marks the trainee’s ability to perform commonly required procedures;
* [**Multi-source feedback**](#_top) **(MSF)** is a form of questionnaire-based 360 degree appraisal;
* [**Case-based discussion**](#_top) **(CBD)** requires trainers and trainees to discuss a selection of cases and trainers to score the trainee’s performance against a pre-specified range of competencies;
* [**Sheffield Assessment Instrument for Letters**](#_top) **(SAIL(OH))** is a tool for assessing the quality of a trainee’s correspondence to managers and health professionals.

These tools have been adopted by many Colleges and Faculties. Mini-CEX, DOPS and MSF were piloted by the Royal College of Physicians in 2003 and tested for their reliability, feasibility and validity; the reliability of Mini-CEX and MSF have also been evaluated by researchers2. SAIL has been assessed for its validity and reliability in the context of correspondence between health care professionals3,4; while Mini-CEX, DOPS, MSF and CBD have been piloted and widely used in Foundation Training5. Further developmental work on these tools is ongoing in many specialties, including ours.

The forms and guidelines on this website have been adapted by a Steering Group of the Faculty of Occupational Medicine, to fit the context and everyday content of occupational physicians’ jobs. They have been piloted in use by a sample of trainers and trainees as a check on feasibility, clarity, ease of use, and acceptability.

**How much time will they take? When should they be done?**

In general, each WBA should take no more than 30 minutes to conduct, including feedback to the trainee and the completion of the forms.

WBAs/SLEs should be undertaken in every training year. For Full Time Trainees, please see the table below which indicates how often WBAs/SLEs should be undertaken & by whom, as a minimum every year of training.

More assessments may be appropriate where concerns are identified. Additional formative assessments are in any case encouraged (from a trainee's viewpoint sampling from a number of assessors is beneficial); and for such additional WBAs/SLEs, trainees can approach a variety of assessors, including other consultants and peers. A few tools even lend themselves to self-completion to support reflective learning.

For Less Than Full Time Trainees, WBAs/SLEs MUST be undertaken in every year of training; a pro rata number of WBAs/SLEs (rounded up to the nearest whole number) is the minimum acceptable.

|  |  |  |
| --- | --- | --- |
|  | **Who (times/year)?** |  |
| **What?** | **Clinical Supervisor** | **Educational Supervisora** |
| Mini-CEX | 4 |  |
| CBD | 8 |  |
| DOPS | 4 b |  |
| MSF | 1 | 1 |
| SAIL(OH) | 4 |  |
| Logbook | At least quarterly | At least quarterly |

a – If different from the clinical supervisor

b – Certain DOPS may be conducted better by another qualified person (e.g. occupational hygienist).

The process is generally ‘trainee-led’ (i.e. the onus is on the trainee to organize each WBA with an assessor, and to ensure the paperwork gets completed and the minimum target number of assessments are done for each year of training). The educational supervisor will help the trainee to select a range of relevant material across the breadth of the training syllabus, suitable to the training needs.

**Forms, support materials, assessor training**

Although the details of each type of WBA differ, most are supported by a similar panel of forms and guidelines, comprising:

1. general guidelines to the tool
2. instructions for the assessor
3. instructions for the trainee
4. an assessment recording form (comprising a series of tick boxes against different areas of performance, with a space to record the lessons learned and actions planned or taken)
5. a form/instructions that allow the educational supervisor to summarise, in one place, the outcome of a family of related WBAs for a training year (e.g. all the min-CEX WBAs for year 1).

These instruction sheets and recording and summary forms are available from the [Faculty website](http://www.fom.ac.uk/education/speciality-training/work-based-assessments). Sample material appears below.

Additionally, where available, we offer details of other support material – e.g. contact details of organizations that offer assessor training in WBAs, self-learning CD-ROMs, web links to video clips, and advice from deaneries and other Colleges.

We recommend that all clinical and educational supervisors familiarize themselves carefully with the basic forms and instructions. We also recommend that, insofar as these are available, all WBA assessors seek further training in WBAs (e.g. courses by organizations that offer assessor training, self-learning CD-ROM) to gain practice in the methods.

RSAs, Training Programme Directors, and local STC committee members will wish to acquaint themselves with the forms and processes.

Two copies of each WBA (one original and a photocopy) need to be kept – one each for:

1. the trainee (to enter into the learning portfolio);
2. the educational supervisor (to support quarterly educational appraisal and feedback to the trainee);

The annual summary form for a given WBA is maintained and built up through the course of a training year by the educational supervisor. Following an end of year review with the trainee, this form feeds into the ARCP, with copies retained by supervisor and trainee.

**The Mini-CEX**

### **General Guidance**

**What is a Mini-CEX and what does it assess?**

Trainers/Educational Supervisors often sit in on trainees’ consultations with patients, especially early on in their training, to ensure that all is going well and to impart their experience, advice and hints for better practice. The **Mini-CEX** is a tool that formalises this process, enabling the trainer’s assessment to be written down systematically and with structured feedback.

It is a 15-20 minute observation or “snapshot” of a trainee-patient interaction, which has been shown in pilot studies by the Royal College of Physicians to provide a reliable assessment of a trainee’s performance. It can be easily implemented in any setting by supervisors or others who feel comfortable to act as assessors.

The focus is on the core skills that trainees specialising in occupational medicine need to acquire and demonstrate in patient encounters – e.g. skills in medical interviewing (including relevant occupational aspects of the case), in clinical examination (where appropriate), in communication, judgement and decision-making, effective use of time and resources, and in ethical, legal and professional behaviour. (Not all elements need be assessed on each occasion.)

This tool is designed to cover the following areas of the curriculum of higher specialist training in occupational medicine, which are themselves mapped to *Good Medical Practice*.

**How does the process work?**

The process is ‘trainee led’ – i.e. the onus is on the trainee to organize each mini-CEX with their assessor, to ensure the paperwork gets completed and that the minimum target number of mini-CEX assessments are done for each year of training. The educational supervisor should help the trainee to select a range of relevant consultations across the breadth of the training syllabus, suitable to the training needs.

At least **4** Mini-CEX assessments must be performed annually with the clinical supervisor/trainer as assessor. This is a lower limit. We encourage additional formative assessments to support reflective learning. More assessments may be appropriate where difficulties are identified. The assessor will most often be the trainer, but the tool lends itself to assessment by another consultant, or a fellow but more experienced trainee. Thus several parties can perform these extra Mini-CEX assessments and from the trainee’s viewpoint sampling a number of different assessors is advantageous to be encouraged. The assessor need not know the trainee or the case beforehand.

The contact should be in an environment that reflects the normal clinical practice of the training organization or training programme (e.g. outpatient clinic). The patient should be aware that the Mini-CEX is being carried out. The assessor ‘sits in’ on the encounter and scores the trainee on a 9-point scale against a number of pre-defined criteria using a standard form and following standard written guidelines.

The benchmark is the performance that can reasonably be expected **at the trainee’s stage of training and level of experience** (the guidance notes provide written descriptors). An unsatisfactory score must be supported by a written explanation/example to be valid.

The assessor should give feedback immediately after the assessment, especially where problems have been identified.

Both trainee and assessor sign the form at the end of the process and two copies are kept - one by the trainee (for their logbook) and one by the educational supervisor.

**How does this feed back into learning and annual assessment?**

The purpose of this tool is mainly educational – to enable feedback that supports and promotes high standards of medical consulting. The trainee should receive immediate feedback from the assessor.

The supervisor will collate the mini-CEX forms, summarise them at intervals throughout the training year on a form, and discuss them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

At first there may be things that need some attention, and there is an expectation that scores will improve over time, reflecting the development of new competencies and the refinement of established ones. Thus, no judgment rests on a single Mini-CEX. Instead, the educational supervisor will collect the mini-CEX forms that relate to performance over several clinical encounters, summarise them on a specially provided form, and discuss them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

**Notes for Assessors on conducting and recording the assessment:**

1. Please ensure that the patient is aware that the Mini-CEX is being carried out.

2. Directly observe the trainee in an environment that reflects the normal clinical practice of the training organization or training programme (e.g. outpatient clinic).

3. **Score the trainee on a 9-point scale from 1 (extremely poor) to 9 (extremely good). A score of 1-3 is below expectations, 4-6 satisfactory and 7-9 would be considered above that expected, for a trainee at the same stage of training and level of experience. You must justify each score of 1-3 with at least one explanation/example in the comments box, failure to do so will invalidate the assessment. Please note that your scoring should reflect the performance of the trainee against that which you would reasonably expect *at their stage of training and level of experience*.**

4. The assessor must give feedback to the trainee immediately after the assessment and especially where deficiencies have been identified.

5. Both trainee and assessor should sign the form at the end of the assessment.

6. After completing the form, give a copy to trainee for their logbook. A photocopy of the form should go to the educational supervisor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Descriptors of a satisfactory trainee: What to look for**

**Medical interviewing skills:** Facilitates patient’s telling of story; effectively uses questions to obtain accurate and adequate information; responds appropriately to verbal and non-verbal cues; elicits the occupationally-relevant aspects of the case.

**Physical examination skills:** Follows efficient, logical sequence; examination appropriate to clinical problem; sensitive to patient’s comfort and modesty.

**Professionalism:** Shows respect, compassion, empathy, establishes trust; attends to patient’s needs of comfort, respect, confidentiality of information; shows awareness of his/her limitations; observes relevant legal frameworks.

**Ethical behaviour:** Behaves in an ethical manner; explains role and secures consent to proceed; explains clearly, and negotiates any reports/communications to third parties (e.g. managers).

**Clinical judgment in the occupational setting:** Makes appropriate diagnoses; formulates a suitable management plan that considers the occupational context; selectively orders/performs appropriate diagnostic tests; selectively refers; considers risks and benefits.

**Communication skills:** Explores patient’s perspective; communicates in a jargon-free, clear, open, honest and empathetic way; agrees the management plan with patient; educates and counsels as appropriate.

**Organisation/Efficiency:** Prioritises; is timely and succinct; makes appropriate use of resources.

**Overall clinical and occupational health competence:** Demonstrates satisfactory clinical and occupational health judgment; elicits and syntheses the relevant information; is caring, professional, ethical, effective and efficient.

NB Not all elements may be relevant in every assessment and there is the option to score “not observed or applicable” as well as “don’t know”. Sections on professionalism and overall competence are likely to be relevant to most assessments. Specific comments to justify scores in the unsatisfactory category should b added, including details of errors requiring remedial learning.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Some specific points:**

*Assessor Training* is helpful in any assessment process. Ensure that the entire form and accompanying guidance has been read. The assessor should also record the number of Mini-CEX assessments done previously with any trainee and any additional training in Mini-CEXs.

*Complexity of case:* Score the complexity of the case for the trainee’s present level of training; remembering to score the trainee’s performance against the level which should reasonably be expected *at their stage of training and level of experience.*

*Using the scale:* Don’t be afraid to use the full range of the rating scale if it seems warranted.

*Feedback:* In order to maximise the educational impact of Mini-CEX, the assessor and the trainee need to identify agreed strengths, areas for development and an action plan. This should be done sensitively and in a suitable environment.

## 

## **DOPS**

**General Guidance**

Direct observation of procedural skills (DOPS) is a form of workplace-based assessment in which common everyday procedures are observed and assessed by a third party. In foundation Training these may include taking blood or performing an ECG. The Faculty is developing a series of DOPS with relevance to occupational physicians. This guidance relates to one version of the tool we feel will be of special value to trainees – workplace visiting.

Trainees regularly undertake workplace visits and trainers will often accompany them, especially early on in their training, to ensure that all is going well and to impart their experience, advice and hints for better practice. The **DOPS1** is a tool that formalises this process, enabling the trainer’s assessment to be written down systematically and with structured feedback.

The focus is on the skills that trainees specialising in occupational medicine need to acquire and demonstrate in conducting workplace visits. Observation and discussion will typically cover the relationship between the workplace circumstances and hazards relevant to the clinical situation, assessment of the working environment advice on the management of health risks from and the control of hazardous exposures, Information gathering, interpretation and analysis, professionalism, communication skills, recommendations, preventive advice and time management.

It allows trainees to discuss what needs to be done and why. It allows sampling of a range of competencies across the curriculum for higher specialist training in occupational medicine which can themselves be mapped to *Good Medical Practice*.   
(Not all of these aspects will arise in every case).

**How does the process work?**

The process is ‘trainee led’ – i.e. the onus is on the trainee to organize each DOPS with their assessor, and to ensure the paperwork gets completed and the minimum target number of DOPS assessments are done for each year of training.

The educational supervisor should help the trainee to select a range of relevant workplace visit scenarios across the breadth of the training syllabus, suitable to the training needs. The Faculty will issue educational supervisors with planning guidance, but some possible examples include: a visit to assess the work capabilities and possible adjustments for a patient, an occupational health needs assessment, the assessment of occupational exposures and the likely consequences, an ergonomic evaluation, investigation of a suspected disease cluster, compliance with an occupational health / health and safety policy, a situation raising issues relevant to health surveillance. (These are for illustrative purposes only.)

At least **4** DOPS assessments should be performed annually. This is a lower limit and additional formative assessments are encouraged to support reflective learning. More assessments may be appropriate where difficulties are identified.

The assessor will most often be the trainer, but the tool lends itself to assessment by another consultant, or a fellow, but more experienced trainee. It is also reasonable for other colleagues such as Health and Safety Advisers, Senior Occupational Health Nurses or Occupational Hygienists to act as assessors provided that they familiarise themselves with these guidelines and appreciate the purpose of the exercise. Thus several parties can perform these extra DOPS assessments, and from the trainee’s viewpoint sampling a number of different assessors and a broad range of workplace scenarios is advantageous and we encourage it. The assessor need not know the trainee or the workplace beforehand.

Typically in a given DOPS1, the trainee, with advice from the educational supervisor, will identify a situation where a workplace visit would be useful. Discussion and observation will often start from the reasons for the workplace visit and the objectives, it should go on to explore a variety of aspects such as: relationship between the workplace circumstances and hazards to the clinical situation, assessment of the working environment, advice on the management of health risks from and the control of hazardous exposures, information gathering, interpretation and analysis, professionalism, and communication. The latter is a key skill and encompasses - the ability to handle people, extract relevant information from them, secure their co-operation, reach shared understanding, draw up clear recommendations and negotiate appropriate follow-on actions.

The assessor scores the trainee’s performance on a 9-point scale against pre-defined criteria using a standard form and following standard written guidelines. The benchmark is the performance that can reasonably be expected *at the trainee’s stage of training and level of experience* (the guidance notes provide written descriptors). An unsatisfactory score must be supported by a written explanation/example.

The whole session should take no longer than 20-30 minutes, including feedback and completion of the assessment form. However in the case of workplace visits this may be determined by the location and activity being observed.

**What is the purpose of the tool?**

The purpose of this tool is primarily educational – to enable feedback that supports and promotes high standards of medical consulting.

**How does this feed back into learning and annual assessment?**

The trainee should receive immediate feedback from the assessor after the assessment, especially where problems have been identified. Both trainee and assessor sign the form at the end of the process and two copies are kept - one by the trainee (for their logbook) and one by the educational supervisor.

The supervisor should collate the DOPS1 forms, summarise them at intervals throughout the training year on a form, and discuss them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

**Notes on conducting and recording the assessment:**

1. The trainee should ask the assessor to accompany them on a workplace visit.

2. Discussion and observation should start from the reasons for the workplace visit and the objectives, it should go on to explore a variety of aspects such as: relationship between the workplace circumstances and hazards to the clinical situation, assessment of the working environment advice on the management of health risks from and the control of hazardous exposures, Information gathering, interpretation and analysis, professionalism, communication skills and recommendations (details and descriptors of expected performance are given below).

3. **The trainee is scored on a 9-point scale from 1 (extremely poor) to 9 (extremely good). A score of 1-3 is below expected, 4-6 satisfactory and 7-9 would be considered above that expected, for a trainee at the same stage of training and level of experience. Each score of 1-3 must be justified with at least one explanation/example in the comments box, failure to do so will invalidate the assessment. Please note that the scoring should reflect the performance of the trainee against that which would reasonably be expected *at their stage of training and level of experience*.**

4. The assessor should give feedback to the trainee immediately after the assessment and especially where deficiencies have been identified.

5. Both trainee and assessor should sign the form at the end of the assessment.

6. After completing the assessment form, a copy should be given to the trainee for their logbook. A photocopy of the form should go to the educational supervisor.

**Descriptors of trainee performance: What to look for**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

As a guide, descriptors of performance are given below for each assessed competence, in 3 broad categories:

* Below expected – scores of 1 to 3
* Satisfactory – scores of 4 to 6 (given in **bold italics**)
* Above expected – scores of 7 to 9

# 1 Approach to the problem

# No adequate reason with no objectives for a workplace visit

# *Appropriate reasons and some structured objectives for a workplace visit*

# Clear reasons with focussed objectives for a workplace visit

**2 Clinical judgement**

* Fails to relate workplace circumstances and hazards to the clinical situation.
* **Relates workplace circumstances and hazards to the clinical situation.**
* Undertakes a thorough assessment of the relationship between the workplace circumstances and hazards to the clinical situation.

**3 Risk assessment**

* Fails to undertake an adequate assessment of working environment. A lack of awareness and advice on the management of health risks from, and the control of hazardous exposures.
* ***Undertakes a good assessment of working environment. Recognises and advises on the management of health risks from, and the control of hazardous exposures.***
* An excellent assessment of working environment. Recognises, quantifies (to the extent practicable) and advises on the management of health risks from (if appropriate, including alternative options), and the control of hazardous exposures.

**4 Information gathering**

* Fails to obtain preparatory information or to request workplace information contemporaneously.
* ***Actively seeks preparatory and contemporaneous workplace information.***
* Makes full and appropriate efforts to prepare for and obtain information during and after the workplace visit.

**5 Interpretation and analysis of information**

* Inability to utilise, interpret and analyse workplace information e.g. MSDS, packaging and labelling, risk assessments, policies and procedures
* ***Uses, interprets and analyses workplace information e.g. MSDS, packaging and labelling, risk assessments, policies and procedures***
* Demonstrates insightful interpretation and analysis of workplace information e.g. MSDS, packaging and labelling, risk assessments, policies and procedures

**6 Professionalism**

* Evidence of a lack of professional standards in any aspect of the case.
* ***Appropriate professional standards demonstrated in all aspects of the case.***
* Evidence of the highest professional standards throughout the case – a role model for others to learn from.

**7 Communication**

* A lack of clarity in language, content and intentions. Fails to recognise that other relevant colleagues or external agencies may have a useful role e.g. Health and Safety Advisers, Health and Safety Executive.
* ***Communicates using language appropriate to the audience, clear, open and honest. Considers the involvement of other relevant colleagues or external agencies e.g. Health and Safety Advisers, Health and Safety Executive.***
* A model of clarity and transparency in communication. Diligently considers and explains the useful role and involvement of other relevant colleagues or external agencies e.g. Health and Safety Advisers, Health and Safety Executive.

**8 Advice and Recommendations**

* Inadequate advice and recommendations to relevant parties (patient and/or managers).
* **Satisfactory advice and recommendations to the relevant parties, recorded and communicated.**
* Excellent and highly appropriate advice and recommendations to all relevant parties, with proper documentation and communication.

**9 Opportunities for prevention**

* Overlooks the preventive opportunities of the case.
* **An adequate consideration of preventive opportunities, with no major omissions.**
* Excellent consideration of prevention, thoroughly pro-active and opportunistic, a leader in preventive initiatives.

**10 Organisation/Efficiency**

* Fails to address priorities, poor time keeping, superfluous discussion, distracted from the task in hand, wasteful of resources.
* **Prioritises; is timely and succinct; makes appropriate use of resources.**
* A model of efficiency, economy and focussed discussion and comment.

**11 Overall occupational management (i.e. covering assessment, communication, case management, decision-making, professionalism, ethical behaviour and any opportunities for team working and prevention):**

* Concern over the standard of occupational management demonstrated in this case.
* **Occupational management of the required high standard, though possibly allowing a few minor shortcomings.**
* Evidence of excellent occupational management in all aspects of the case – a role model.

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**Some specific points:**

*Assessor Training* is helpful in any assessment process. Ensure that the entire form and accompanying guidance has been read. The assessor should also record the number of DOPS assessments done previously with any trainee and any additional training in DOPs.

*Complexity of case:* Score the complexity of the case for the trainee’s present level of training; remembering to score the trainee’s performance against the level which should reasonably be expected *at their stage of training and level of experience.*

*Using the scale:* Don’t be afraid to use the full range of the rating scale if it seems warranted.

*Feedback:* In order to maximise the educational impact of DOPs, the assessor and the trainee need to identify agreed strengths, areas for development and an action plan. This should be done sensitively and in a suitable environment.

At first there may be things that need some attention, and there is an expectation that scores will improve over time, reflecting the development of new competencies and the refinement of established ones. Thus, no judgment of the trainee rests on a single DOPS. Instead, the educational supervisor will collect the DOPS forms over several encounters, summarising them on a specially provided form, and discussing them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

**MSF**

**General Guidance**

MSF, otherwise known as 360-degree assessment, is the systematic collection and feedback of performance data on an individual from a number of stakeholders or ‘raters’. These are people with whom the doctor being assessed works and interacts. MSF aims to assess general skills such as: communication, leadership, team working, attitudes, punctuality and reliability, rather than knowledge or practical skills.

The assessment method is in widespread use in medicine in the USA, Canada and Australia. Pilot work by the Royal College of Physicians suggests that 15-20 ‘raters’, in equal proportions from four groups (allied health professionals, doctors, nurses and clerical/secretarial staff) provide a reliable assessment of a specialty registrar. The tool is also widely used in industry.

**How does the process work?**

One MSF assessment must be performed annually.

In occupational medicine the process is normally organised by the clinical supervisor, who identifies 15-20 potential raters. In addition to doctors, nurses, secretaries, clerical staff, and allied health professionals, these would typically include managers, and personnel and safety officers. The trainee can also be invited to offer a self-assessment to aid discussion. The data from at least 10 respondents (other than the trainee) are put together to provide the doctor with structured feedback on their performance.

Each rater is sent a set of instructions, a recording form and a pre-addressed envelope. The rater is asked to score the trainee on a 9-point scale for:

* **attitudes to staff** and how much the trainee respects and values contributions of other team members
* **attitude to patients** and how much the trainee respects the rights, choices, beliefs and confidentiality of patients
* **reliability and punctuality**
* **communication skills** and how much the trainee communicates effectively with patients, families, and healthcare professionals
* **honesty and integrity**
* **team player/leadership skills** and how much the trainee supports other team members, accepts appropriate responsibility, and is approachable.

The benchmark is the performance that can reasonably be expected *at the trainee’s stage of training and level of experience*. An unsatisfactory score must be supported by a written explanation/example to be valid.

The completed form is **mailed back to the supervisor** (not the trainee).

Ordinarily the trainee will not see individual responses.[[2]](#footnote-2) Instead, to encourage honest and open reporting, the educational supervisor will collate the information onto a single summary form, as the basis for sensitive and constructive feedback.

**How does this feed back into learning and annual assessment?**

The purpose of this tool is mainly educational – to enable feedback that supports and promotes high standards of medical consulting.

The educational supervisor will collate the information and give feedback to the trainee in an educational appraisal meeting (to chart areas of strength, developmental needs, and plan educational objectives). The form records any points of concern and any actions planned or taken as a result of discussions between trainee and supervisor.

The trainee should keep a copy of the MSF summary form for their logbook. The supervisor will send a copy the Chair of the Deanery STC, to inform the ARCP.

**CBD**

**General Guidance**

Trainees regularly present and discuss their cases with more experienced colleagues, though rarely are those conversations documented. The aim of **Case-based Discussion (CBD)** is to formalise this process and to enable an assessor to make a systematic assessment of performance and offer structured feedback. The whole session should take no longer than 20-30 minutes, including feedback and completion of the assessment form.

In a CBD, discussion will typically cover the application of knowledge in the assessment and management of clients seen by the trainee in the occupational health department, as well as the ethical and legal framework of practice. It allows trainees to discuss why they acted as they did. It allows sampling of a range of competencies across the curriculum for higher specialist training in occupational medicine which can themselves be mapped to *Good Medical Practice*, though clearly not all of these aspects will arise in every case.

**How does the process work?**

The process is ‘trainee led’ – i.e. the onus is on the trainee to organize each CBD with their assessor, and to ensure the paperwork gets completed and the minimum target number of CBD assessments are done for each year of training.

The educational supervisor should help the trainee to select a range of relevant case scenarios across the breadth of the training syllabus, suitable to the training needs. The Faculty will issue educational supervisors with planning guidance, but some possible examples include: a patient with long-term sickness absence; a case considered for ill-health retirement; a case with suspected work-induced illness; a mental health case; a musculoskeletal case; a case relevant to the application of the Disability Discrimination Act; a case raising issues relevant to health surveillance or screening policy. (These are for illustrative purposes only.)

At least **8** CBD assessments should be performed annually with the clinical supervisor (trainer) as assessor. This is a lower limit. Additional formative assessments are encouraged to support reflective learning. More assessments may be appropriate where difficulties are identified.

The assessor will most often be the trainer, but the tool lends itself to assessment by another consultant, or a fellow, but more experienced trainee. Thus several parties can perform these extra CBD assessments, and from the trainee’s viewpoint sampling a number of different assessors is advantageous and is encouraged. The assessor need not know the trainee or the case beforehand.

**Notes on conducting and recording the assessment:**

1. In a given CBD, following the format proposed for Foundation Training[[3]](#footnote-3), the trainee will select two case records from patients they have recently seen and in whose notes they have made an entry. The assessor will select one of these for the CBD session.

2. Discussion should start from and be centred on the trainee’s record in the notes, and explore a variety of aspects such as: clinical and risk assessment, management and advice, decision-making, awareness of professional, ethical and legal boundaries, record keeping, and opportunities for team working, leadership and prevention (details and descriptors of expected performance are given below).

3. **The trainee is scored on a 9-point scale from 1 (extremely poor) to 9 (extremely good). A score of 1-3 is below expected, 4-6 satisfactory and 7-9 would be considered above that expected, for a trainee at the same stage of training and level of experience. Each score of 1-3 must be justified with at least one explanation/example in the comments box, failure to do so will invalidate the assessment. Please note that the scoring should reflect the performance of the trainee against that which would be reasonably expected *at their stage of training and level of experience*.**

4. The assessor must give feedback to the trainee immediately after the assessment and especially where deficiencies have been identified.

5. Both trainee and assessor should sign the form at the end of the assessment.

6. After completing the form, a copy should be given to trainee for their logbook. A photocopy of the form should go to the educational supervisor.

**Descriptors of trainee performance: what to look for**

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As a guide, descriptors of performance are given below for each assessed competence, in 3 broad categories:

* Below expected – scores of 1 to 3
* Satisfactory – scores of 4 to 6 (given in **bold italics**)
* Above expected – scores of 7 to 9

**1 Clinical record keeping**

* Poor, incomplete records. Might be unsystematic, illegible, not comprehensible, unsigned, undated, missing important detail.
* **Structured, signed and dated; legible, clear and comprehensible with no important omissions.**
* Excellent records with few or no flaws at all.

**2 Occupational assessment (including diagnostic skills)**

* Fails to obtain or interpret evidence correctly; omissions in assessment and the differential diagnoses considered; neglects the occupational context and occupational aspects of the case
* **A good occupational assessment showing satisfactory diagnostic skills based on appropriate evidence from, for example, history, examination and investigations. Appropriate diagnosis and spread of suggestions in the differential diagnosis. Assessment integrates the important occupational aspects of the case.**
* A thorough, accurate, and appropriately focussed occupational assessment and diagnosis demonstrating excellent assessment and diagnostic skills.

**3 Risk assessment and management**

* Fails to assess risk to the patient, or others.
* **An adequate risk assessment leading to an appropriate management plan, including consideration of risks to the patient and others.**
* A very thorough and appropriate risk assessment, excellently documented, with a very good management strategy (if appropriate, including alternative options) properly communicated to all the appropriate individuals.

**4 Investigation and referral/clinical liaison**

* Although indicated, little or no proper investigation; referral/clinical liaison not made, or made inappropriately.
* **Adequate investigation and appropriate referral. Investigation includes talking to managers, safety officers and any other appropriate third parties.**
* Excellent selection and implementation of investigations and interpretation of findings; best available referral/clinical liaison option chosen and appropriately made.

**5 Advice and recommendations**

* Inadequate advice and recommendations to relevant parties (patient and/or managers) – unacceptable performance.
* **Satisfactory advice and recommendations to the relevant parties, recorded and communicated.**
* Excellent and highly appropriate advice and recommendations to all relevant parties, with proper documentation and communication.

**6 Opportunities for prevention**

* Overlooks the preventive opportunities of the case.
* **An adequate consideration of preventive opportunities, with no major omissions.**
* Excellent consideration of prevention, thoroughly pro-active and opportunistic, a leader in preventive initiatives.

**7 Professionalism**

* Evidence of an unacceptable lack of professional standards in any aspect of the case.
* **Appropriate professional standards demonstrated in all aspects of the case.**
* Evidence of the highest professional standards throughout the case – a role model for others to learn from.

**8 Ethical and/or legal considerations**

* Inadequate consideration important ethical and/or legal issues of the case
* **An adequate consideration of the ethical and/or legal issues of the case, leading to appropriate actions (e.g. consent) and/or advice and covering the important concerns.**
* A thorough and appropriate handling of the ethical and/or legal issues, excellently documented, and an exemplar of good communication and sound ethical practice.

**9 Team working**

* Inadequate consideration of the role of other team members and team working; might be seen as a weak team player.
* **An adequate consideration of the role of other team members, leading to effective team working; (from year 3: able to lead when necessary).**
* Excellent team working skills and appreciation of the team’s role; a model in communication and team involvement; (from year 3) able to lead effectively.

**10 Clinical reasoning (including decision making)**

* Limited evidence of appropriate clinical reasoning; inadequate decision making – unsafe.
* **Good, logical clinical reasoning and appropriate decision making.**
* Excellent clinical reasoning, taking proper account of all the relevant factors leading to decisions that support a high or very high standard of care.

**11 Overall occupational management (i.e. covering assessment, communication, case management, decision-making, professionalism, ethical behaviour and any opportunities for team working and prevention):**

* Concern over the standard of occupational management demonstrated in this case – unsafe and maybe unfit for practise.
* **Occupational management of the required high standard, though possibly allowing a few minor shortcomings.**
* Evidence of excellent occupational management in all aspects of the case – a role model.

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**Some specific points:**

*Assessor Training* is helpful in any assessment process so please read the entire form, trainee guidance and this written training carefully. The number of CBD assessments that the assessor has done previously with any trainee should be recorded and along with any additional training received in CBDs.

*Complexity of case:* The complexity of the case must be scored for the trainee’s present level of training. Score the trainee’s performance against that which would be reasonably expected *at their stage of training and level of experience.*

*Using the scale:* Don’t be afraid to use the full range of the rating scale if it seems warranted.

Feedback: The purpose of this tool is mainly educational – to enable feedback that supports and promotes high standards of medical consulting. The trainee should receive immediate feedback from the assessor. In order to maximise the educational impact of CBD, the assessor and the trainee need to identify agreed strengths, areas for development and an action plan. This should be done sensitively and in a suitable environment.

The supervisor should collate the CBD forms over clinical encounters, summarise them at intervals throughout the training year on a form, and discuss them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

At first there may be things that need some attention, and there is an expectation that scores will improve over time, reflecting the development of new competencies and the refinement of established ones. Thus, no judgment of the trainee rests on a single CBD. Instead, the educational supervisor will collect the CBD forms that relate to the trainee’s performance over encounters, summarise them on a specially provided form, and discuss them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

**SAIL(OH).**

**General guidance**

**What is SAIL? What does it assess?**

**SAIL** is a tool for assessing the quality of a trainee’s letters. The original instrument, which was developed from a consensus framework, focused on routine letters between primary and secondary care. It was found to be adequate in terms of validity, feasibility, reliability (reproducibility and discrimination), and potential educational impact among panels of paediatric registrars[[4]](#footnote-4) and other hospital practitioners[[5]](#footnote-5).

The authors of the tool have encouraged trainers to “adapt and modify the checklist to record the presence or otherwise of components deemed important in communicating by letter”[[6]](#footnote-6) and a Steering Group of the Faculty of Occupational Medicine has since refined the tool to match occupational health practice.

The model used in trainee assessment in occupational medicine, **SAIL(OH)**, currently exists in two versions covering different common scenarios in occupational medicine:

1. **SAIL(OH)1** – the trainee doctor’s first letter in response to a manager’s referral (of a clinically related case), and
2. **SAIL(OH)2** – the trainee doctor’s primary referral letter to another doctor or health care professional – e.g. for an opinion, investigation, or treatment.

(Please be sure to use the appropriate form.)

These assessment tools focus on clarity of communication, ability to capture the essential issues (including the occupationally-relevant aspects) of the case, team working with managers and health professionals, and observation of ethical, contractual and legal boundaries. They assess the following areas of the curriculum of higher specialist training in occupational medicine, which are themselves mapped to *Good Medical Practice*.

N.B. Current versions of SAIL(OH) do not cover every kind of letter a trainee is likely to write. Further developmental work is envisaged, covering other common reports of specialists in occupational medicine.

At least **4** SAIL(OH) assessments should be conducted in each training year by the **clinical supervisor** (2 for each type of letter). This is a lower limit. Trainees are encouraged to complete additional formative assessments to support reflective learning. More assessments may be appropriate where difficulties are identified.

The assessor will most often be the trainer, but the tool lends itself to assessment by another consultant, or a fellow, but more experienced trainee. It can even be self-completed. Thus several parties can perform these extra SAIL assessments, and from the trainee’s viewpoint sampling a number of different assessors is advantageous and we encourage it. The assessor need not know the trainee or the case beforehand.

For each SAIL that is not self-assessed, the trainee will select two letters fitting one of the two broad generic types (response to manager’s referral/first letter to another health care professional) for patients on whom they have recently corresponded. The assessor will select one of these for the SAIL evaluation.

**Instructions for completion** are on the forms. For SAIL(OH)1 it will be necessary for the assessor to also see the manager’s original note of referral.

The benchmark for assessment is the performance that can reasonably be expected *at the trainee’s stage of training and level of experience*. The assessor should give feedback immediately after the assessment, especially where problems have been identified. Both trainee and assessor sign the form at the end of the process and two copies are kept - one by the trainee (for their logbook) and one by the educational supervisor.

**How does this feed back into learning and annual assessment?**

The purpose of this tool is mainly educational – to enable feedback that supports and promotes high standards of medical consulting.

The supervisor will collate the SAIL forms, summarise them at intervals throughout the training year on a form, and discuss them with the trainee at regular educational appraisal meetings (to chart progress, areas of strength, developmental needs, and plan educational objectives).

## **WBA Forms**

WBA Assessment Forms for trainees and Summary Forms for supervisors for Mini-CEX, DOPs, MSF, CBD and SAIL(OH) are available from the [Faculty website](http://www.fom.ac.uk/education/speciality-training/work-based-assessments/forms-support-materials-assessor-training).

**Once a year, in time for the trainee’s ARCP, a copy of the annual summary forms (Mini-CEX, DOPS, CDB and SAIL) must be sent to the Chair of the Deanery STC. A copy will be retained by the trainee for their logbook. The form records any points of concern and any actions planned or taken as a result of discussions between trainee and supervisor.**

**References**

1. PMETB. *Workplace Based Assessment. A paper from the PMETB Workplace Based Assessment Subcommittee, January 2005*.
2. PMETB. *Developing and maintaining an assessment system - a PMETB guide to good practice* (2007), Box 1, p9. (<http://www.gmc-uk.org/Assessment_good_practice_v0207.pdf_31385949.pdf>)
3. Crossley JGM et al. Sheffield Assessment Instrument for Letters (SAIL: performance assessment using outpatient letters. Medical Education 2001; 35: 1115-1124.
4. Fox AT et al. Improving the quality of outpatient clinic letters using the Sheffield Assessment Instrument for Letters (SAIL). Medical Education 2004; 38: 857-858.

**Section F – CONTINUING PROFESSIONAL DEVELOPMENT (CPD)**

This section should include details of all CPD activity including:

* training courses attended
* conferences attended
* meetings (e.g. SOM, FOM, local trainees group etc.)
* publications
* teaching activities undertaken (e.g. undergraduate, postgraduate, managers, nursing staff etc)
* clinical attachments

Guidance on how to complete the CPD forms is given in Appendix 1 of this Section.

A summary of CPD activity (Form CPD6) must be made available to the ARCP review panel.

Note:

**Part-time training.**  Doctors training ‘flexibly’ may find it difficult to achieve the targets set out in this guidance. The responsibility for assessing whether the trainee’s CPD is sufficient will rest with the trainee’s educational supervisor, who will take account of the learning needs of the individual under the circumstances of his or her practice.

**Long-term illness and maternity leave, or other out-of-programme activity.**  Any difficulties or imbalance in any one CPD year arising these circumstances can be redressed over the 5-year period. An ARCP review panel will need to be made aware of the circumstances in relation to the CCT date.

1. \* 1 is a requirement of *Good Medical Practice*; 2 is a requirement of the model training agreement. [↑](#footnote-ref-1)
2. *Trainees will not normally see any individual forms or scores; however, if the trainee requests it, or in the unlikely event of a formal complaint by a trainee, such forms will be released to the trainee concerned.* [↑](#footnote-ref-2)
3. <http://www.mmc.nhs.uk/pdf/CbD-Rater-written-training.pdf> [↑](#footnote-ref-3)
4. Crossley JGM et al. Sheffield Assessment Instrument for Letters (SAIL: performance assessment using outpatient letters. Medical Education 2001; 35: 1115-1124. [↑](#footnote-ref-4)
5. Fox AT et al. Improving the quality of outpatient clinic letters using the Sheffield Assessment Instrument for Letters (SAIL). Medical Education 2004; 38: 857-858. [↑](#footnote-ref-5)
6. <http://www.gp-training.net/training/tools/sail.htm> [↑](#footnote-ref-6)