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Basic competency testing to meet Clinical Negligence Scheme for Trusts standards

AIMS AND METHOD
In order to meet revised (2005) Clinical Negligence Scheme for Trusts standards, tests of competency in key clinical skills were set for psychiatric senior house officers (SHOs) at the start of their posts.

RESULTS
The assessment of basic competencies demonstrated that 9 out of 14 SHOs met the required standards in tests of key clinical skills (overall competency rate of 64%). Senior house officers were generally in agreement with the principles behind the assessments.

CLINICAL IMPLICATIONS
Competency testing is becoming important at all stages of training and within all medical specialties. The recommended methods combine assessment of both knowledge-based competencies and clinical performance in the workplace.

There is an increasing requirement for competency testing of doctors during training within the UK, with most doctors becoming involved either as assessors or trainees. High-profile medical incidents have raised public concern about the quality of clinical care and focused attention on the assessment of competence and the maintenance of standards (Carr, 2004). Medical students and doctors entering the new foundation year programmes will be accustomed to ongoing assessments of competency. Other doctors will become increasingly familiar with competency assessments, with the move away from examination- and time-based accreditation towards assessment of skills.

The Clinical Negligence Scheme for Trusts (CNST) is administered by the National Health Service (NHS) Litigation Authority, a special health authority which was established in 1995. The scheme was established to provide a means for NHS trusts to fund the cost of clinical negligence litigation. Through the scheme, the authority seeks to support the effective reporting and management of claims, together with the promotion of its standards and the implementation of risk management procedures and policies aimed at minimising risk. Membership of CNST is voluntary and open to all trusts, including primary care trusts, in England. Trusts receive a discount on their contributions when they can demonstrate adherence to CNST standards.

There are a total of eight CNST standards for mental health and learning disability trusts. These standards were produced in 2005 (Mynors-Wallis, 2005). Standard 5 is concerned with induction and staff procedures and requires trusts to establish a process whereby medical staff in training are assessed against identified competencies. These competencies should be determined at the start of a placement to ensure that doctors can fulfil their role. Examples provided are history-taking, physical assessment, risk assessment and risk management (NHS Litigation Authority, 2005).

Dorset Healthcare NHS Trust (a specialist mental health and learning disability trust) undertook a pilot CNST assessment which identified the need to establish and test junior doctors for key competencies prior to their starting work. Competency tests were developed to assess key areas in which senior house officers (SHOs) need to have basic skills to fulfil their role. In August 2005 we undertook assessments of competency for those SHOs who had not obtained MRCPsych part I.

Method

We determined that the following basic competencies are essential for a trainee in psychiatry, prior to commencing a psychiatric SHO post:

- history-taking and mental state examination
- suicide risk assessment
- therapeutic management of violence, including rapid tranquillisation
- basic knowledge of the Mental Health Act 1983
- basic life support skills
- electroconvulsive therapy (ECT) for trainees giving ECT or obtaining consent.

Training

All SHOs in the trust attend a 2-day induction programme prior to starting clinical duties. The programme was modified to ensure that the key competency skills were taught or reinforced. The training was in line with the relevant trust risk policies, which were also provided to the SHOs at the time of induction.

Assessments

The competencies are assessed in different ways. Competency in history-taking and mental state examination is assessed by the consultant psychiatrist. Basic life support is assessed by the life support trainer following supervised practice using a dummy model. Knowledge of ECT theory and practice is assessed by the ECT lead consultant during direct supervision of practice.

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Knowledge of suicide risk assessment, the therapeutic management of violence and the Mental Health Act 1983 is assessed by a written short-answer examination. Model answers were directly linked to the relevant sections in trust policy and guidelines. The competencies were assessed by written tests and workplace assessment for SHOs in August 2005.

Feedback

The SHOs completed a questionnaire to determine their views about the competency assessments and their general views regarding basic competency testing at the beginning of their employment. The information provided during training, together with the questions used in the tests and specified pass marks, have been modified for future assessments, in light of the experience and feedback provided.

Results

The results of the written and workplace assessments of SHOs in August 2005 are shown in Table 1. Out of 14 SHOs, 9 met the required standards in tests of key clinical skills (overall competency rate 64%).

Feedback from the SHO questionnaires was incomplete (8 out of 14 completed). In general, SHOs agreed that basic competency should be tested before starting a post; however 1 felt that it was a doctor's own responsibility to ensure that they practise within competency levels, and another disagreed with the principle of pre-job competency testing, stating that 'it is the essence of the job to come and learn'.

Most SHOs felt inadequately prepared for the assessments, some criticised the time limits for the assessment or misunderstood its purpose. Most SHOs felt happy with the format of the competency assessment. One suggested that the questions might be related more to clinical scenarios to put things into context.

Discussion

This paper sets out our experience in developing competency tests for basic psychiatric skills. Although there is an increasing body of information about competency assessments in general, we were unable to find any specific literature relating to tests of psychiatric competency.

The main impetus towards developing competency tests was the CNST standards. The Postgraduate Medical Education and Training Board (PMETB, 2005) identified the need for a combination of examinations to test knowledge and workplace assessment of clinical skills, attitudes and behaviour (Southgate & Grant, 2004). All assessment systems must meet the nine principles laid out by the PMETB (Southgate & Grant, 2004) and our competency assessments were designed with these principles in mind. Moreover, the CNST supports the Senate of Surgery in that 'there should be no learning curve as far as patient safety is concerned'.

We determined two broad areas of required competence for our psychiatric trainees:

- the ability to assess a patient and obtain the relevant information to undertake a diagnostic and risk formulation; the management of such patients would be undertaken under the direct supervision of a more senior colleague
- to undertake the role of an on-call junior doctor which requires competence in:
  - management of behavioural disturbance
  - life support skills
  - use of Mental Health Act 1983.

The initial assessment of patients and involvement in medical emergencies are tasks that junior doctors undertake without other doctors necessarily being present. The competency requirement was therefore to be able to undertake these tasks in such a situation. Of course, access to advice from senior colleagues must be readily available.

The written assessment of knowledge was not time-consuming. Consultant assessment of clinical practice does take time and was incorporated into the educational supervision. The assessment of ECT competence is in the job description of the lead consultant for ECT and is remunerated separately.

The emphasis at the early stage of SHO psychiatric training leans towards testing competence as opposed to performance (performance being what the doctor demonstrates in a real clinical setting). In psychiatry, the gap between competence and performance may be wider than in those specialties whose practice is based more on procedures and protocols. In psychiatry it is harder to assume that competency will predict later

Table 1. Competency assessment of 14 senior house officer trainees in August 2005[1]

	Written tests			Workplace assessment			
	Management of violence (pass mark 60%)	Management of suicide risk (pass mark 60%)	Mental Health Act 1983 (pass mark 60%)	ECT	Basic life support	History-taking and mental state examination[2]	Total
Passes, *n*/*N* (%)	11/14 (79)	9/14 (64)	13/14 (93)	14/14 (100)	14/14 (100)	2/2 (100)	9/14 (64)

1. This cohort included some that were new to both psychiatry and the trust, others that had previous psychiatric experience, and 1 general practitioner trainee.

2. Only assessed for senior house officers doing first psychiatry attachment.

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excellence in performance. The College remarks on this distinction between competence, 'can do', and states that it is not sufficient for identified performance, 'does do' (Royal College of Psychiatrists, 2005).

Future developments

We propose for future cohorts of trainees to introduce some basic workplace-based assessments of general clinical skills and attitudes in a 'real-world' setting. We will continue to use consultant observation for the examination of basic history-taking and mental state examination. However, in the future this assessment will be aligned to the mini-CEX (clinical evaluation exercise) assessment that is included as part of foundation training.

For future cohorts of trainees we also plan to use a case-based discussion for examination of the use of section 5(2) of the Mental Health Act 1983 and the use of rapid tranquilisation and assessment of suicide risk. The trainee will be expected to identify their first involvement in a relevant clinical scenario and discuss this with their educational or clinical supervisor. This will be undertaken during educational supervision.

A final question is to consider the consequences of SHOs failing to display competence. We plan to restrict the work of such SHOs to directly supervised assessments until retesting, but this would have significant repercussions on the supervising teams and on the provision of the SHO on-call service.

Other future considerations involve differences in past experience of our SHOs. Some SHOs join following UK foundation training, some as general practitioner trainees and some with at least some prior experience in psychiatry (UK or overseas). In this study we included all SHOs already in training within our trust (pre-MRCPsych part I). We will need to consider the validity of our testing in all of these circumstances.

Conclusion

We hope that this paper will generate debate and the sharing of information among those from other centres seeking to develop basic competency skills in psychiatry for the purposes of meeting CNST standards and delivering safe psychiatric care. We believe competency standards should be uniform and developed nationally rather than on an ad hoc basis within individual trusts. The development of these standards and assessments will need to link to the competencies within the run-through training grade in psychiatry.

Declaration of interest

None.

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