

## **START (Specialty Trainee Assessment of Readiness for Tenure)**

### **The beginning of the end or the end of the beginning**

The START assessment is **not** an exam and shouldn't be seen as one. It is tool to highlight areas requiring focus for the last leg of your specialist training. It should be seen as such and an opportunity to practice potential consultant interview scenario questions. It is not something you can pass or fail so don't put too much pressure on yourself and who knows; you might even enjoy it!

### **Application**

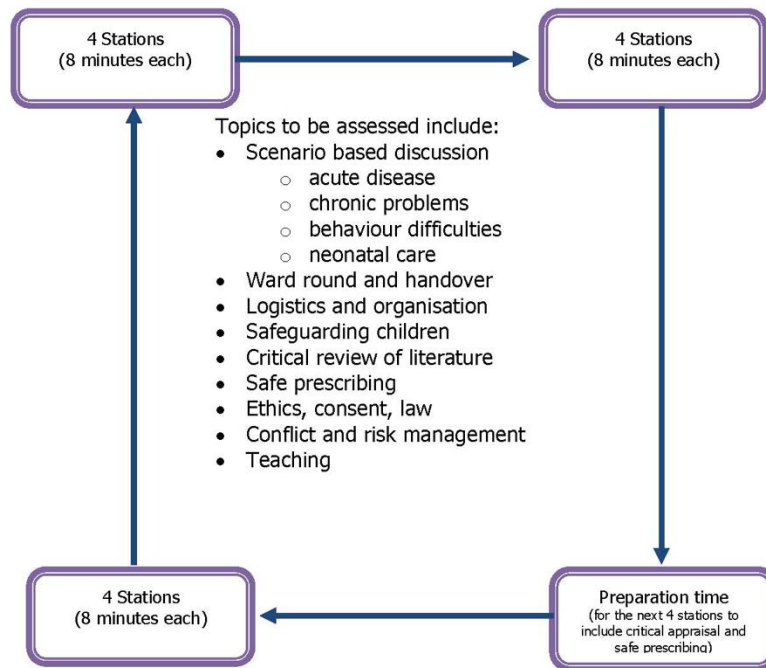
- START assessments run twice a year and the application process is via the RCPCH website
  - The online application guide is available via the following link;  
[http://www.rcpch.ac.uk/system/files/protected/page/START%20ONLINE%20APPLICATION%20USER%20GUIDE%20FOR%20TRAINEES\\_1.pdf](http://www.rcpch.ac.uk/system/files/protected/page/START%20ONLINE%20APPLICATION%20USER%20GUIDE%20FOR%20TRAINEES_1.pdf)
- You can apply for START from ST6 but it is expected that most trainees will complete START during their ST7 year allowing enough training time to address highlighted learning requirements
  - Evidence to date suggests that those completing START at an earlier stage (ST6) perform worse than their slightly senior peers
- Priority is given to applicants nearer the end of training (ST8>ST7>ST6)
- The cost is £250 to paediatric trainees (£850 to non paediatric trainees)
- You will receive email confirmation 1-2 working weeks after closure of the application period and a letter confirming the details which you are required to bring on the day itself

### **Structure & Tips**

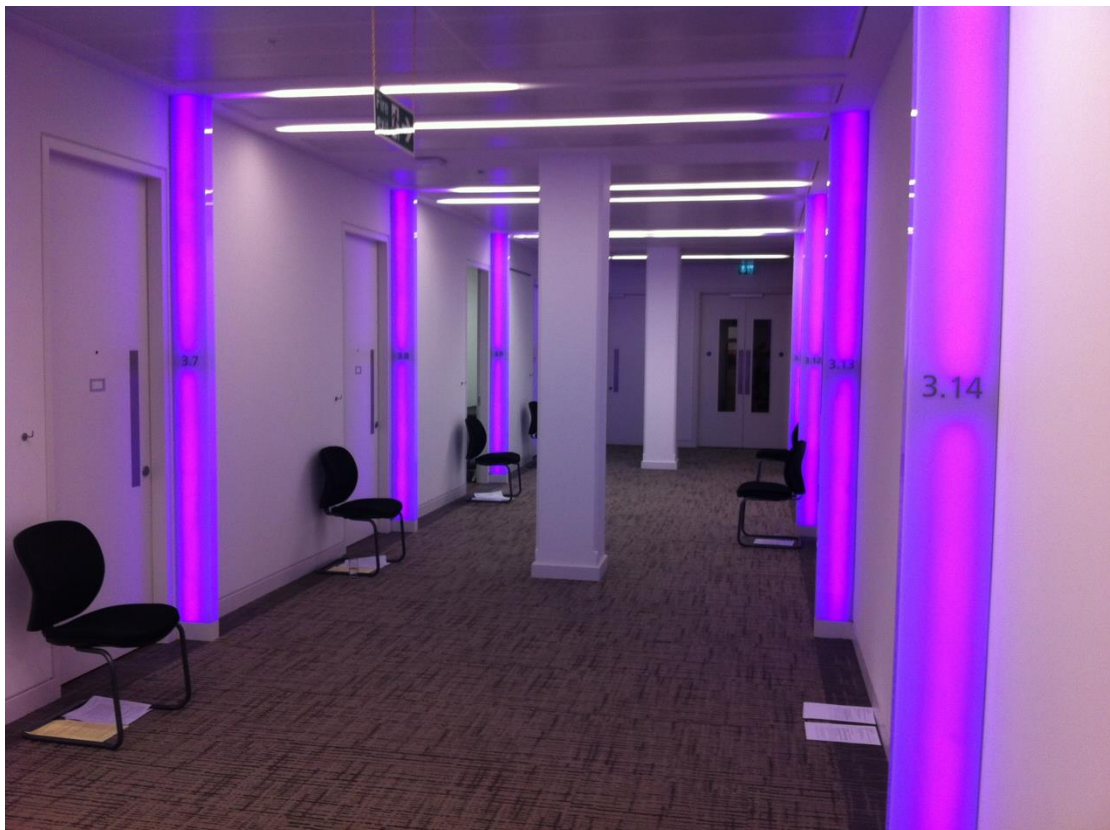
- You will be told to arrive 45 minutes before and will be briefed with information hopefully similar to that below
  - Expect a joke or 2 about this being an assessment and not an exam
  - You will be told to smile. If you are smiling already, they will tell your neighbour to smile
  - They will tell you other people may be present – the assessors of assessors and the other nosy colleges who apparently all think START is the best thing ever and want to follow suit
- Consists of 12 stations which you will move around in groups of 4
  - Half (6) of the stations will be general paediatrics and the other half will be your sub-specialty
  - If a general paediatric trainee, all 12 will be relating to general paediatrics
  - The stations have the scenario sheets under the chairs and you pick a coloured sheet if you a sub-specialty trainee and a white sheet if a general paediatric trainee.

## START Guide for Wessex – Seb Gray

- You will be given a unique circuit map telling you your order of circuits – everyone in a circuit will have a different order



- It is currently held at the RCGP assessment centre which is high tech (see picture below) and very easy to see where you are going (there are also numerous people present with fingers capable of pointing)



- You are given 4 minutes to read each scenario before entering the station
  - You are allowed to make notes on the sheet and bring it in with you to refer to in the station
- You are then given 8 minutes with the assessor to discuss the scenario
  - The only station currently where you are not supposed to engage solely with the assessor is the teaching station in which you should engage directly with the student(s) – unless you are using a new novel teaching approach that I am not aware of!
  - You get a knock on the door when you have 2 minutes left to remind you to squeeze in the last couple of things you wanted to say
  - There is another knock or buzz when the 8 minutes is up at which point you should leave and find your next station
- Some stations will feel like an 8 minute monologue and others like a 2-way conversation with a colleague
  - This will vary based on the station and also the assessors personality (and yours)
- You will have a 44 minute preparation station preceding your block of 4 that includes the critical appraisal and prescribing stations
  - You will be sitting on a table (which hopefully will be less wobbly now) in your group of 4
  - There is no separation in the preparation station so you have to divide your time appropriately
  - Prescribing should take slightly less time so is probably worth doing first
  - You can hear all sorts of buzzers and knocks during this station but try to ignore it and focus on the clock in the room instead
  - Prescribe as you would normally (because we all put our GMC number on every prescription always!) and use the BNF and calculator provided
  - Make sure you have had a flick through the latest version of the BNF as things can move around and it saves a bit of stress on the day
  - The drug chart isn't completely weird but is made from paper specifically for START and has a page for fluid prescription
  - Do the obvious like writing in black, in capitals and clearly with no brand names
  - Do the stuff that is handy in real life also – write in dose per kg and when levels are required, etc
  - Don't be thrown off if “as per local protocol” is seriously odd
  - Try to think of what you will be asked based on what you have been prescribed
    - For example, side effects, drug peak and trough levels, interactions, monitoring and if you are feeling extra geeky, mechanisms of action
  - For critical appraisal, have a clear structure (see further down) and I'm sure a highlighter would have been magical also
    - You are provided with additional paper and can make notes to your hearts content
    - You can also bring the paper and notes with you to the station
    - Make sure you relate it to the clinical scenario - don't just critically appraise the paper
- Your preparation station may not precede the prescribing or critical appraisal stations directly but will comprise 2 of the next 4 stations

- You get the 4 minutes preparation time prior to the actual station to remind yourself what is going on (without BNF and calculator)
- The preparation station can be at any point during the assessment (other than the end obviously)
- Ensure you always read the question/ scenario very carefully
- If anything is unclear from the scenario, clarify this with the assessor and try not to fall in the trap of making assumptions
- Go to the toilet just before – over 3 hours is a long time and 4 minutes preparation is not a long time
- There is water on request but you can also bring your own if you like

For official trainee guidance, click on the following link:

<http://www.rcpch.ac.uk/system/files/protected/page/START%20Trainee%20Guidance%20-%20April%202016.pdf>

Benchmarking standards used in assessing are available here:

<http://www.rcpch.ac.uk/system/files/protected/page/START%20Benchmarking%20Standards.pdf>

An example of the assessor feedback form is available here:

<http://www.rcpch.ac.uk/system/files/protected/page/START%20Assessment%20feedback%20form%202015.pdf>

As already mentioned, it is not necessary to prepare for START. However, there are trainees that would feel much more comfortable having done some preparation. There are therefore some areas in retrospect that would be useful to cover:

- Critical appraisal
  - See “Critical appraisal in 10 points” below for a quick and easy template retrieved from my medical student notes
  - Practice critically appraising papers and presenting in journal clubs asking for feedback (and double up by using these as case based discussions)
- Handover
  - Read the paper by Klaber et al from ADC (2009) entitled “Maximising learning opportunities in handover”
  - Do a HAT both as an assessment for you and assessing your peer or junior
- Prescribing
  - Update yourself with the latest BNFc
  - Prescribing modules are available on the RCPCH compass website – safe prescribing tool
  - Perform a mini audit reviewing drug charts with your local pharmacist
- Ethics
  - Try to attend local ethics meetings/ debates
  - Online modules are available again on the RCPCH compass website including:
    - Healthy child programme (module 2: record keeping)
    - Adolescent health programme (module 3: legal framework, confidentiality, consent, ethics)
  - Other courses are also useful relating to this:

- Introduction to good clinical practice
- Consent in paediatrics (Medicines for children research network)
- Safeguarding
  - Attend a level 3 safeguarding course
  - Get involved in strategy meetings, CAF meetings, report writing
  - Perform safeguarding CBD

The remaining areas are difficult to specifically prepare for in terms of management of acute and chronic conditions, teaching methods and techniques and more generalised communication skills. The best planning for these is to do your job and seize every opportunity to experience the most you can. Meeting with friends or senior colleagues who have done START can be really useful to talk through possible scenarios and I have summarised my START assessment from October 2015 for some examples (after critical appraisal section).

### **Critical appraisal in 10 points**

#### **1. PURPOSE**

- Was the trial well justified?
- Has the research tackled an important problem?
- Was the purpose/ hypothesis clearly stated?

#### **2. METHODS & SAMPLE**

- What methods have the authors used?
- Was the overall study design appropriate for achieving the objectives?
- **Sample**
  - How was the sample selected? – look at CONSORT diagram
  - Were there lots of exclusions?
  - Was there selection bias? – inclusion & exclusion criteria
  - Was the sample tightly defined (*homogeneous*)? – More likely to show effect, less universally useful
  - Was it loosely defined (*heterogeneous*)? – Less likely to show effect, more universally useful
  - Are the basic characteristics of the sample described?
  - Was the sample size justified? – Large enough to give an accurate picture
  - A formal size/ power calculation should be performed & details should be in the methods section

#### **3. RANDOMISATION**

- Randomisation has the advantage of balancing unknown confounders
- How were the patients randomised?
- Did randomisation work?
  - Look at baseline characteristics table – are the groups similar?

- If unequal, did authors account for confounders? (i.e. including variables in analysis, such as regression models)

#### **4. INTERVENTION**

- Was the choice and description of intervention appropriate?
  - It should be described in sufficient detail to replicate it, e.g. staff training, resource requirement
- Was the choice of control group appropriate?
- Apart from the intervention were the groups treated equally?

#### **5. OUTCOMES**

- Were all clinically important outcomes included and measured properly?
- Are these the outcomes that are most important for patients?
  - Harms and benefits including quality of life assessments
- Was the outcome assessment valid? (previous validation or validation of new outcome)
- Was outcome assessment unbiased?
  - The same in intervention and control
  - Blinded where possible (single/ double)

#### **6. FOLLOW-UP**

- Were all patients accounted for and was there a high loss to follow-up?
  - Look at CONSORT diagram
  - Substantial amounts of missing data gives ample opportunity for bias to intrude
  - Less than 20% loss to follow-up is acceptable
- Was there a response bias?
  - More people lost to follow-up in control of intervention group?
- If bias is present, what are the implications for the results?
  - If there was a very high loss to follow-up could the authors account for it? (e.g. assume those not followed up have not changed from the baseline if a stable condition)

#### **7. STATISTICS: CHANCE & POWER**

- Were all statistical methods described, referenced and justified?
- Were statistical analyses appropriate?
  - Large numbers of statistical tests increase the likelihood of spurious significant results
- Do the statistical analyses show evidence of chance or low power?
  - Look at p value – if  $<0.05$  = statistically significant,  $>0.05$  = not statistically significant
  - **Chance** (type 1 error) = false positive results
    - Could a significant result be by chance?
    - If  $p<0.05$ , probability of chance outcome is 5%/ 1 in 20

- **Low power** (type 2 error) = false negative results
  - Was the study big enough to demonstrate an important effect?

### **8. ESTIMATES: PRECISION (CONFIDENCE INTERVAL; CI) & INTENTION TO TREAT (ITT)**

- Are the estimates precise (**confidence interval**)?
  - 95% CI = range within which we are 95% certain the true value lies within
  - Allows estimate of how large or small true effect may be
  - If CI overlaps with null (no effect),  $p > 0.05$
- Do the estimates come from an **intention to treat** analysis?
  - Patients analysed no matter whether they complied with treatment or not
    - Estimates therefore reflect realistic patient decisions
  - *Per protocol* (analysis of patients who complied)
    - Not as accurate but can still be used to tell patients that this will happen if they comply

### **9. RESULTS**

- Are the results clinically important?
  - Numbers needed to treat (NNT) – 100 divided by difference in percentage between the groups

### **10. DRAWING TOGETHER THE EVIDENCE**

- Were limitations acknowledged?
- Were appropriate conclusions drawn?
- Were the study results related to other evidence?
  - How does it compare with previous studies?
- Was cost-effectiveness compared to the main alternatives?
  - Opportunity costs – what else could be done with the same resources?

### **APPLYING THE EVIDENCE**

- Divide into pros and cons; reasons why you would and wouldn't advise
- Was it a good or poor study?
  - Internal validity (randomisation, bias, ITT, follow-up, etc)
  - External validity – does it apply to my local population?
- Do you want to do it?
  - Is there other supporting or contradicting evidence?
  - Is it cost effective?
- Can you do it?
  - Availability of resources
- Will this study change your management?

## Sample Circuit (October 2015)

Station	General Paeds	Allergy	IID	Neonates	Emergency	Nephrology	Metabolic
1	GEN 299: Combined ibuprofen and paracetamol for fever						
2	GEN 0135: 30 day old baby admitted to Paediatric Ward with Sepsis						
3	GEN 001: Jade 13 year old with OD and safeguarding concerns	PAIID 0203: Childhood eczema	PAIID 0209: Failure to attend clinic with Eczema, Failure to Thrive and on restricted diet	NEO 0300: Difficult Neonatal Death – Referral to the Coroner Necessary	GEN 477: Suspected maltreatment in a 3 month old with parents working as professionals.	PNEP 0183: Renal cysts familial disease	PIMM 0244: Poorly controlled homocystinuria
4	GEN 0017: You are the attending consultant at the morning handover on the children's ward from the overnight ST3 and FY2.	PAIID 561: Handover of patient who has had an anaphylactic reaction	PAIID 561: Handover of patient who has had an anaphylactic reaction	NEO 0313: Handover List: to Discuss and Prioritise Tasks and Assign as Required	PEM 616: F1 not coping Friday on call	PNEP 456: Handover of on call	PIMM 0245: Handover of a list of inpatients to the on-call team
5	GEN 0042: Deteriorating surgical patient - surgeons unavailable. Conflict	PAIID 0204: Rhinitis as part of a 'united airway'	PAIID 0204: Rhinitis as part of a 'united airway'	NEO 529: Congenital Diaphragmatic Hernia	PEM 0166: Time critical head injury	PNEP 0173: 20 weeks pregnant lady with large echo-bright kidneys	PIMM 0252: Familial Hypercholesterolaemia treatment

6	GEN 0101: 14 month old girl, Sophie, has been in hospital since birth. she was born at 24 weeks gestation and has not been able to be discharged because of multiple problems relating to her prematurity.	PAIID 0207: Setting up a new paediatric allergy service	PAIID 663: Setting up a new paediatric Outpatient antibiotic therapy (OPAT) service	NEO 0305: Communication - congenital anomaly	PEM 0165: Multiple Trauma Management	PNEP 0174: 1 year old boy with failure to thrive	PIMM 0254: Non-compliance with PKU
7	GEN 0023: Friday afternoon admission for 15 year old with anorexia	PAIID 0130: Safeguarding management of presumed multiple food allergies in child with eczema	PAIID 0130: Safeguarding management of presumed multiple food allergies in child with eczema	NEO 531: Management of neonatal death	PEM 167: Hospital at Home	PNEP 0176: New presentation of ESRF	PIMM 0243: Acute neonatal hyperammonaemia
8	GEN 594: Issue of a stillbirth/neonatal death certificate	PAIID 0213: 6 year old with severe eczema and recurrent staphylococcal skin infections	PAIID 0213: 6 year old with severe eczema and recurrent staphylococcal skin infections	NEO 533: Survivor with severe HIE: preparation for discharge	PEM 446: 4 Hour wait breach report	PNEP 0194: HUS SLE challenging	PIMM 0247: Galactosaemia School meeting
9	GEN 0139: Failure to follow DKA guideline						
10	GEN 540: Planned absence of a consultant colleague						
11	GEN 657: Teaching medical students – trainee selects topic						
12	GEN 545: A missed fracture						

### 1. Critical appraisal

- 2006 paper from ADC by a certain Dr Lajeunesse during his time at Bristol – comparing the use of combined paracetamol and ibuprofen versus single agent – combined use brought temp down more than single paracetamol (statistically significant) but by less than 0.5 degrees and therefore not clinically significant
- Task: Critically appraise the paper and relate it to a 3 year-old boy who has had a febrile convulsion and has a temp above 38. What would you advise in this situation based on the paper?
- Station: presented my structured critical appraisal to assessor and then related it back to the case. Seemed pleased that I'd considered potential bias (bring temp down faster in ED setting) but negated by objective measure (temp). Seemed excited by every critical appraisal buzz word – selection bias,



homogenous sample, confounders all made her smile. Didn't know what one of the statistical tests was but explained I would look it up. I then started chatting about related evidence in terms of temp (special thanks to Dr Roe!) and she had reached the end of her checklist so sent me out a couple of mins early. I was a bit confused by this as had expected much more of a 2-way conversation; it felt very exam-like.

- Feedback:

#### 1. Critical Appraisal

You communicated very well and critically evaluated the paper, looking at impact of the selection process, bias, power of study, exclusion and inclusion criteria and wide age range and temperature at one hour and the clinical significance of it. You said that it will not change your management, which I agree with, and you talked about the safety and you had a professional approach to it. You stated your limitation in what ANOVA means and would benefit by studying or learning about methods of comparing groups in study design and its impact. You would benefit by consolidating your appraisal skills in attending journal club but overall well done.

- Plan:
  - Check what ANOVA statistical test is
  - Continue to attend journal clubs and critically appraise papers

#### 2. Prescribing

- Scenario: 30-day old 4.5kg baby presents with a 12 hours history of bilious vomiting, off feeds, pyrexia (39.7). Observations given suggesting he is cardiovascularly stable and a full septic screen has been performed.
- Task: Please prescribe gentamicin and flucloxacillin as per the local protocol and appropriate IV fluids
- Station: reviewed drug chart and asked to speak through my prescription in detail from dosing to timings to the box that I'd drawn for levels. Discussed side effects of both antibiotics. Told that 1<sup>st</sup> pre dose level was 3 and what I would do about it. Discussed patient safety first (stopping gent) and then reviewing why. Checking renal function, review dosing and drug chart as well as administration. Discussed follow up – audiology. Asked what I would say to the family – talked about duty of candour and explanation of side effects and long term effects. Realised when sitting outside station that I'd prescribed neonatal fluids (10% dextrose with additives) but explained that I would review fluid status regularly and may adjust to non neonatal fluids and may need further fluid resuscitation. Asked what fluid requirements are for the first 10kg after the neonatal period so guessing that's what they were looking for but seemed happy that I had considered options.
- Feedback:

#### 2. Safe Prescribing

Correct prescription writing though started with maintenance fluid of 120 mls/kg though corrected it to 100mls/kg on prompting. Good explanation to parents about all side effects and confident about how to manage the high Gent level. Good management of shock and change to Ceftriaxone high dose. Came across as confident.

- Plan:
  - Continue to prescribe and stay up-to-date with changes to BNFC

#### 3. Ethics

- Scenario: 13 year-old presented with an overdose of her mums fluoxetine and admitted overnight. Observations given suggesting she was medically stable. She disclosed to night nurse that she thought she may be pregnant and had a 20 year old boyfriend. She was adamant she didn't want her Mum

to know. It wasn't clear from the vignette whether mum knew she was admitted already or not.

- Task: discuss how you would handle this situation
- Station: started by making sure she was medically fit and checking TOXBASE to ensure no further management or investigations required in terms of the overdose. Then explained would need to see CAMHS before going on to talk about the main concern. Explained that this was illegal and would need escalation in terms of safeguarding and would need to discuss with social services and the police. Further discussion about what agencies would be involved and consent. Explained about risks, benefit and trust and the challenges but that this would need escalation even if she didn't consent. When nearly finished she asked a couple of times what other agencies might need to be involved. Having mentioned quite a few already I finally got to GUM and contraception +/- obstetricians which got the assessor nodding and scribbling happily.
- Feedback:

3.

A very competent approach to this complex case. You broke down the scenario into different areas which you managed appropriately. You knew this was a legal case of underage sexual activity with an older man and knew that the safeguarding issues over-rode the consent of Jade. However you also knew that gaining her trust and confidence was the best way forward. Look up Fraser and Gillick competencies.

- Plan:
  - Revise differences between Fraser and Gillick competencies

4. Handover

- Scenario: given a patient list of 8 patients with some clinical details on including:
  - A child with CP who had been fitting for 4 hours and parents wanted full escalation of care
  - A child with sickle cell on IV Abx, oxygen and a Hb of 3.2 with parents who are Jehovah's witnesses
  - A bronchiolitic in air and feeding with very anxious parents
  - A travelling family with a child with a positive urine dip from a pad - ?UTI ?follow-up
  - A child with abdo pain – surgical r/v non-surgical, nurses concerned
  - A nephrotic who sounded stable
  - A child with LRTI still spiking temps 3 days in to antibiotics
  - Another child (can't remember problem but not too sick sounding) with doctor parents
- Task: Told you have just finished handover of the following patients and have a team of a ST4, FY2, senior nurse and nurse practitioner – discuss how you would organise your team. Oh and you only have nursing staff for 7 beds.
- Station: I was completely thrown by seeing one of my old neonatal registrars as the assessors. Spoke about patient safety as priority and would see the sickest children myself. Explained that I would be able to judge who is the sickest from the verbal handover but on paper it looked like the child in status needed intubation and ventilation and PICU involvement so I would do that. Described how I would delegate the rest of the tasks and who would see

who but after a couple of minutes was told the child with the sickle crisis had collapsed and how could I have presented that. Explained that I would have hoped the verbal handover would guide me on how sick the children were and that written handover is not enough. Factors such as how quickly his Hb had dropped and what he was like clinically could have made him a higher priority. Explained that if he had sounded that sick then I would have sent my ST4 to liaise with PICU and ITU. Briefly started chatting about the ethics and legalities of treating a child with sickle cell and Jehovah's Witness parents when in extremis. For me, this was a poor station. I think it is difficult to assess handover in START. With 4 minutes preparation and no verbal handover you are solely relying on a piece of paper with snippets of information. It was clear from how the station went that I had gone down a different path to what their crib sheet wanted and in retrospect should have clarified or explored some of the clinical information further to more appropriately prioritising and delegating.

- Feedback:

4.

You had a rational approach to a busy paediatric ward and prioritising urgent situations/tasks. You did send your junior team to sort out a few things, but they could be used better to sort out urgent stuff: ST4 could speak to PICU/anaesthetics etc. and sort out transfer for the seizing child. You needed prompting with regards to identifying the sicker child with a potential sickle cell crisis who probably needs a consultant to review and sort things. That child may also need to be discussed with seniors and legal team's input before clinical deterioration. Sick patients need urgent input but not necessarily always by the consultant.

- Plan:
  - Continue to gain experience prioritising and delegating tasks
  - Ensure my own handover style is appropriate through further handover assessment tool (HAT's)

#### 5. Communication with colleagues

- Scenario: you are called from home by the nursing staff on the paediatric ward. A 3 year-old child was admitted from ED by the surgical team 4 hours ago and they are concerned about him. He is vomiting bile and becoming increasingly tachycardic. He has not had any investigations or treatment since admission. They have tried bleeping the surgical ST2 and ST5 on 3 occasions but they are both scrubbed in theatre for a surgical emergency. The locum paediatric registrar has refused to see the child as she does not feel confident managing surgical problems.
- Task: discuss how you would manage this situation.
- Station: I explained that as a new consultant in this situation I would want to come in. I would ask to speak to the locum registrar and ask her to get IV access and give a 20ml/kg fluid bolus whilst awaiting my arrival. The assessor obviously thought I had got over excited as asked me if I would not want further clinical information first. I explained that I would ideally but there was enough information to tell me that this child was deteriorating and needed escalation in treatment or at least some treatment. As a new consultant with a registrar who wasn't confident, I wouldn't feel comfortable managing it from the end of a phone. I explained that I would want to assess the child myself clinically and resuscitate appropriately and would then contact the surgical consultant on call. He then got me to do a roll play of this and smiled

when I explained I would use the SBAR approach and gave a 30 second monologue. I felt good during the scenario but will be intrigued by the feedback.

- Feedback:

5.

You showed sound knowledge of medical management of such cases and your approach to all agencies involved was sensible. You offered to come to the hospital and review the child yourself and using SBAR method when talking with the consultant surgeon colleague was good.

- Plan:
  - Continue to use SBAR as a communication aid, especially in challenging conversations

#### 6. MDT Discharge planning

- Scenario: an ex-prem who is now 14 months old is about to be discharged. They are gastrostomy fed, have epilepsy and developmental delay.
- Task: discuss how you would plan a discharge planning meeting
- Station: spoke about planning in advance and involving the MDT. Listed off as many professionals who I thought could be involved as possible. Spoke about a lead nurse who should have been allocated and named social worker. Discussed about chairing the meeting and involving parents, setting targets and assigning action points. Timescales discussed and potential need for second meeting and setting target discharge date. Seemed quite wishy washy so difficult to judge if I'd missed anything pertinent.
- Feedback:

6.

Excellent structured approach. Considered open access arrangements. Good objectives with action plan for various team members. Ensure dissemination of the report to all and consider having secretarial support at the meeting to minute, type up and disseminate plan.

- Plan:
  - Continue to get involved in MDT discharge planning meetings

#### 7. Decision making – ward/ bed management

- Scenario: You are phoned by the psychiatric consultant as the consultant on call on Friday afternoon who wants to admit a teenage girl with known anorexia nervosa. She had deteriorated over the last week and has refused everything. The psychiatrist thinks she needs NG feeding but the girl doesn't want it and her mother doesn't think we should do anything against her will. You know from the nurse in charge that you are down on nursing staff for the weekend.
- Task: Discuss how you would deal with this situation.
- Station: Discussed a bit about the medical requirement and what she would need when she was admitted. Talked about getting involvement from dieticians asap as would be leaving work shortly and would be good to have a plan and contingency plan in place. Mentioned complete bed rest, ECG monitoring and risk of re feeding. Discussed necessity of getting her admitted and spoke about communication with girl and parents. Suggested a behaviour contract initially with the proviso that would escalate to NG

feeding if not upheld. Discussed staffing and liaising with psychiatric team to provide staff or nurse in charge to request a locum. Went on to talk a bit about what I would do if she needed a NG tube and was still refusing. Spoke about consent and focussed on communicating and getting parents on side and trying to avoid having to use mental health act or prevent it becoming a safeguarding issue.

- Feedback:

7.

Overall borderline performance. Would discuss with psychiatrist of need for admission, plan of action, getting psych nurse help etc. However, need to discuss with ward sister, involving legal team, social services etc. for EPO, should it be necessary - did not come spontaneously and needed to be eked out. Looking at Security issues also needed prompting, however very safe and knowledgeable about clinical management. Suggest refresh regarding NICE and local guidelines re management of anorexia nervosa.

- Plan:
  - Review NICE & local guidelines regarding management of anorexia nervosa
  - Continue to try to avoid need for involving security and EPO's by communicating directly with families and the MDT

#### 8. Colleague issues & Probity

- Scenario: your colleague, an associate specialist, was covering your on call shift last night so you could go to the theatre. You are approached by a midwife who was also on call with him. A Mum had delivered at 22+4 weeks who was a friend of this doctor and he had been in attendance. The midwife says that she heard a heartbeat initially and that this therefore needed a birth and death certificate. The doctor had dismissed this and just issued a death certificate. He had examined the baby only at 20 minutes and said it was stillborn. The family were planning a funeral the following day and reissuing new certificates would delay this.
- Task: discuss what the issues are and how you would handle the situation.
- Station: went in and was very honest about the fact I'd never been involved with stillbirths at this gestation and would want to further explore why a paediatrician was present. Discussed about conflict of interest and communication problems. Explained how I would want to speak to all parties involved to find out what happened. I said I would want to clarify the legalities of birth and death certification with the MDU as would want to be clear what would be required. We then came on to probity and who governs this with associate specialists. Spoke about the GMC but needed prompting to mention other hospitals who had employed them. Got side tracked a bit by the fact that I see associate specialists as at least consultant equivalent (due to only limited exposure to one fantastic associate specialist) when asked how I would help them and advise them. Then started suggesting courses and closer supervision. Given my complete lack of experience of this situation and not knowing the legal paperwork requirements for stillbirth paperwork at pre viable gestations, this wasn't my best station and felt like I needed a fair chunk of prompting.
- Feedback:

8.

You were able to tackle this scenario very well. I think you needed prompting about whether what Dr Pavos did was right or wrong. You really needed to mention the word probity. You asked Jean why she did not challenge Dr Pavos at the time and this is excellent. I think this is a very serious matter and I did get the feeling that you were able to bring this out. It should be a critical incident and also for discussion in his appraisal. The WHO has guidelines on live birth and the GMC on how to behave with poorly performing colleagues. You could use this as a prompt to educate the team.

- Plan:
  - Review WHO guidelines on live birth and GMC guidance on how to behave with poorly performing colleagues

9. Dealing with mis-management by junior

- Scenario: A child was admitted overnight in DKA. Your ST4 overnight gave them 3 fluid boluses of 20ml/kg each and then maintenance + correction for dehydration not excluding the initial boluses. They remain acidotic on their most recent gases. The nurses had shown the trainee the DKA protocol but this had been dismissed. You have not been contacted about this until your arrival this morning.
- Task: discuss how you would manage this situation.
- Station: I started by saying there were a number of issues but my initial priority was patient safety. I would go and review the patient clinically and stop the current fluid regime, recalculating to include the aggressive initial fluid resuscitation. Again duty of candour got mentioned and I explained that I would discuss with the family what had happened and that we would continue to monitor the child very closely. I think at this point the assessor tried to catch me out by asking if it was really necessary to tell the family if no harm had come to the patient. I stuck to my guns and think that is the right thing to do. I spoke about the high risk of cerebral oedema and ensuring appropriate medications were available and that the nurses knew what they were looking for. Once the patient had been reviewed and fluids adjusted I explained I would then move on to the other 2 issues – the trainee and the lack of escalation from the nurses. We discussed the challenges of addressing a mistake by an individual without humiliating them. I explained that I would ideally like to speak to the trainee before hand and discuss what happened but would need to be clear in handover that over-aggressive fluid administration in DKA is dangerous and what we will need to do today to monitor the situation. The balance of protecting the trainee from feeling embarrassed is outweighed by the need to ensure the other trainees do the right thing in the future. In terms of addressing educational needs, I mentioned coming back to do a case based discussion about it and producing a one minute wonder poster on the management of DKA. Also mentioned that the trainee would need to reflect upon this in their e-portfolio. Then moved on to discuss communication with nursing staff and the need for escalation if unhappy with current management. Explained that I would discuss with nurses involved and explore reasons why not escalated and would then arrange multi-disciplinary simulations for the management of DKA.
- Feedback:



9.

Excellent performance. You thought about all the issues in question and managed brilliantly. Well done!

- Plan:
  - Continue to work closely with trainees and the MDT

#### 10. Workforce planning

- Scenario: you are working in a DGH in a 12 consultant rota. The consultant who shares your specialist interest is due to take planned sick leave for 3 months in the near future. You are meeting with the clinical director.
- Task: discuss how you would manage this situation
- Station: discussed various options during the station. Started by saying that a locum consultant for 3 months could be an option but may be too short notice. Then went on to discuss how the workload could be distributed between the 11 remaining consultants and the need for a proper handover and then hand back. I discussed that pre-planning would be useful to limit the number of outpatient appointments during the absence and potentially timing tertiary reviews to fall during this time. I explained that as the other specialist interest consultant it is most likely that I would take on those additional clinics and that the remainder of the general clinics could be distributed between my colleagues. Depending on the amount of interest clinics, there may require redistribution of some of my general clinics to balance things out. Discussed pros and cons of doing more specialist clinics versus general. We then spoke about trainees and how to manage educational supervision and SPIN trainees.
- Feedback:

10.

You clearly articulated the operational remedies of the situation discussed. You had solutions that were practical and pragmatic. Patient safety was discussed by you and discussion about the use of all available resources was adequate. Your communication style was clear.

- Plan:
  - Continue to work as part of a team trouble-shooting potential problems as they arise and planning ahead to avoid further issues

#### 11. Teaching

- Scenario: you have just finished a ward round with 2 medical students.
- Task: do a micro-teaching session in 8 minutes on a topic of your choice.
- Station: 2 genuine medical students were there with the examiner hidden in the corner. I chose bronchiolitis because I thought I could cover it easily in 8 minutes. The medical students were actually pretty good and knew a decent amount. Seemed to have a decent rapport with the students but ran out of time as would have ideally liked to have summarised and tested key learning points.
- Feedback:

11.

You chose an appropriate topic and had a good interactive discussion about the assessment of the child with bronchiolitis. There wasn't enough time then to cover management or summarise so you might have been better to decide to concentrate on this one aspect. You started well by checking the students' prior knowledge. You have a good calm approach but with authority reflecting your knowledge and experience.

- Plan:
  - Continue to teach at every opportunity using different formats and methods

## 12. Duty of candour

- Scenario: you are seeing a teenage boy in asthma clinic in a district general hospital. He mentions that his hand is still swollen and painful. He was seen in ED 1 week before and told by the junior doctor that there was no fracture on the X-ray. You can see on the computer system that the X-Ray has subsequently been reported as having a fracture.
- Task: discuss how you manage the situation.
- Station: Explained that I had a duty of candour and would apologise and then focus on patient safety ensuring his hand was managed appropriately. She asked if I would do anything first before discussing with orthopaedics/ fracture clinic prompting me to mention examining the hand (not that it would add much in reality unless massively neuro-vascularly compromised!). We then moved on to discuss about incident reporting and the PALS system. I started to then talk about speaking to the junior doctor and addressing shortfalls identified. I mentioned lack of experience, education and supervision and suggested ways they could be addressed. I was asked whether I would contact the trainee directly or whether there would be a better way leading to further discussions about educational supervisors and then blame culture. She then brought me back to the scenario and asked if there was anything else I'd like to do considering we were in asthma clinic. So I reviewed the asthma management and mentioned that the only associated link between asthma and fractures is high dose steroids and osteoporosis. I don't think that is what she was getting at as hinted near the end to get me talking about mechanism of injury and whether there were safeguarding issues. In retrospect I may have been a bit too dismissive of that by mentioning teenage boys fracture bones all the time but we will see.
- Feedback:

12.

You have good understanding of all the issues in this scenario, including duty of candour, need to prioritise and facilitate patient care. You have good understanding of critical incidence reporting and PALS. You understand the training needs of junior doctors in this situation. You needed a few prompts to help discuss and demonstrate your clinical knowledge and understanding of clinical governance issues. Well done overall.

- Plan:
  - Continue to practice with a duty of candour

Further specimen questions are available on the college website here:

<http://www.rcpch.ac.uk/training-examinations-professional-development/assessment-and-examinations/start/start-structure-and>



## START Guide for Wessex – Seb Gray

This is the station set up for the second day of the October 2015 START:

Station	General	PICM	CCH	Neurodisability	Neurology
1	GEN 0021: Critical Appraisal: Goldman et al. Validation of the Clinical Dehydration Scale for Children With Acute Gastroenteritis. Paediatrics 2008; 122: 545–549.				
2	GEN 0133: Intravenous Salbutamol bolus prescription in asthmatic - chart review				
3	GEN 0070: Pregnant teenager with older boyfriend requesting termination	PICM 0281: 1 year old boy with severe Epidermolysis Bullosa with DNR notes	CCH 1111: Child with Probable Fetal Alcohol Syndrome up for Adoption	PNED 618: Lack of central venous access in a child with severe disability and frequent chest infections	PNEU 610: Management of child with severe life-limiting illness (Ethics)
4	GEN 256: Handover of patient to DGH from PICU (5yr old CP septic)	PICM 0279: Management of a child with meningococcal septicaemia	CCH 0125: Child protection concerns-obstructive response from social services	PNED 312: Co-ordinate the discharge planning process for a child post acquired brain injury	PNEU 609: Managing handover list
5	GEN 554: Prolonged seizure in an adolescent	PICM 0278: Management of acute respiratory distress syndrome	CCH 0110: Child with visual impairment and short stature	PNED 0255: 4 year old boy who has a social communication disorder	PNEU 0153: 7 year old with epilepsy and regression
6	GEN 593: Headaches in a 10 year-old girl	PICM 0286: Guillain-Barre syndrome and treatment	CCH 0111: Looked after child with 'autistic' behaviour	PNED 0161: 4 year old boy with bilateral cerebral palsy (GMFCS V) who is failing to thrive	PNEU 0159: 13 year old girl with acute stroke
7	GEN 0027: 5 year old boy with 'seizures' and normal EEG. Possible Factitious illness.	PICM 0282: Bronchiolitis referral for retrieval	CCH 0240: Reducing melatonin costs	PNED 310: Baby with concerns about vision	PNEU 0155: Long history of different types of paroxysmal events- complex motor and vocal tics
8	GEN 0072: Discharge Planning in Chronic Lung Disease	PICM 0280: 15 year old boy with lethargy and vomiting.	CCH 474: Frequent school absences	PNED 309: 5 year old girl with cerebral palsy. Parents concerned about poor progress with speech and are preparing an official complaint about inadequate speech therapy	PNEU 515: Guillain-Barre in a 7 year old
9	GEN 546: Response to a complaint letter				
10	GEN 547: Prioritisation of tasks				
11	GEN 658: Teaching medical students – trainee selects topic				
12	GEN 550: Child with developmental delay, epilepsy & bruising				

## Feedback

Feedback is given 6 weeks after completion of START and is available to view on eportfolio. You are presented with a table that looks like this:

Station	Consultant Skills Domains						Performance
	Decision making and prioritising	Knowledge	Management of complexity	Professional Approach	Safety and Risk Management	Communication	
1. Critical Appraisal	✓	✓	✓	✓	✓	✓	Meets competence
2. Safe Prescribing	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	Above competence
3.	✓✓	✓	✓✓	✓✓	✓✓	✓✓	Above competence
4.	●	✓	✓	✓	✓	✓	Development needed to achieve competence
5.	✓	✓	✓	✓	✓	✓	Meets competence
6.	✓	✓✓	✓✓	✓✓	✓✓	✓	Above competence
7.	✓	✓	●	✓	●	●	Development needed to achieve competence
8.	✓✓	✓	✓	✓	✓	✓✓	Meets competence
9.	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓	Above competence
10.	✓	✓	✓✓	✓	✓	✓	Meets competence
11.	✓	✓✓	✓✓	✓	✓	✓	Meets competence
12.	✓	✓	✓	✓	✓	✓	Meets competence

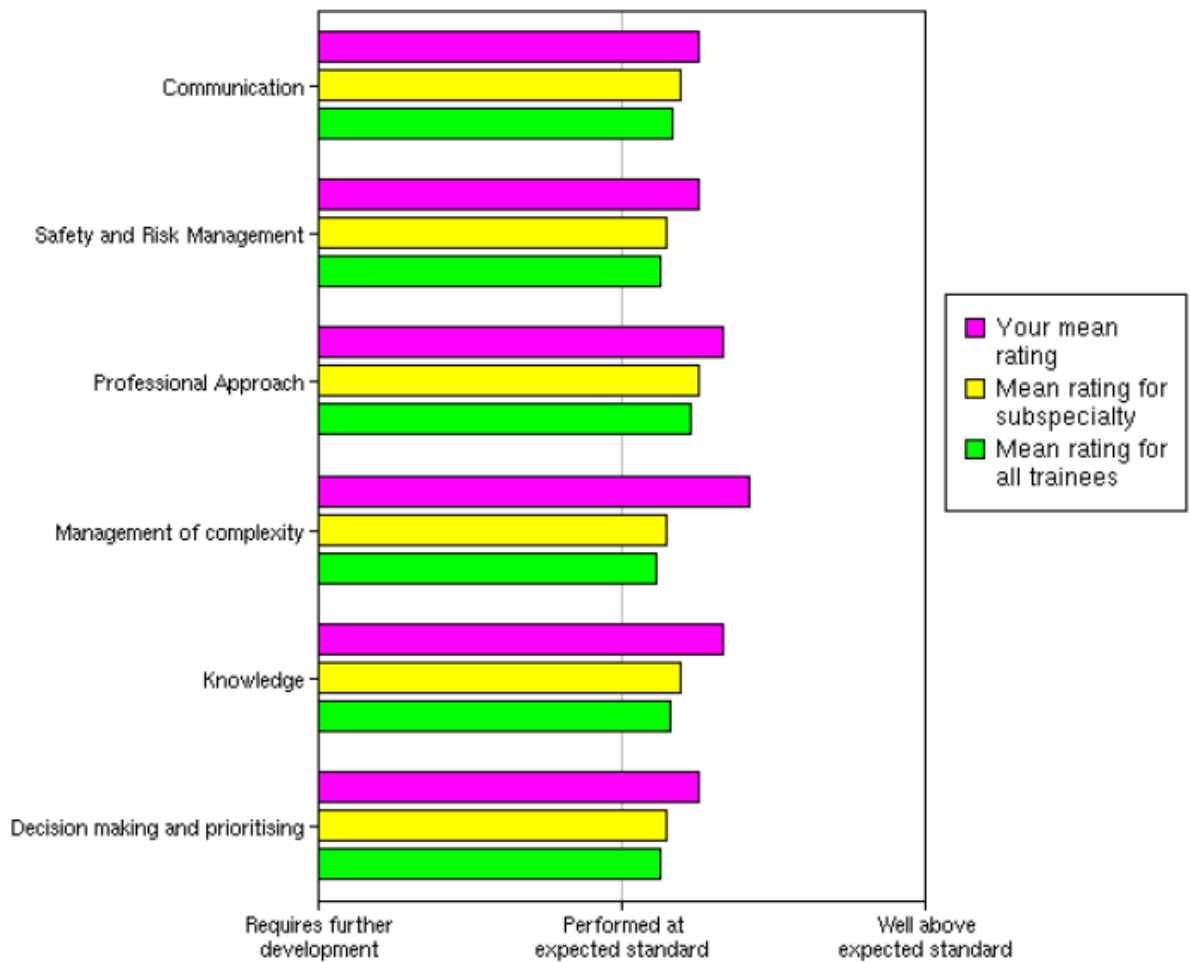
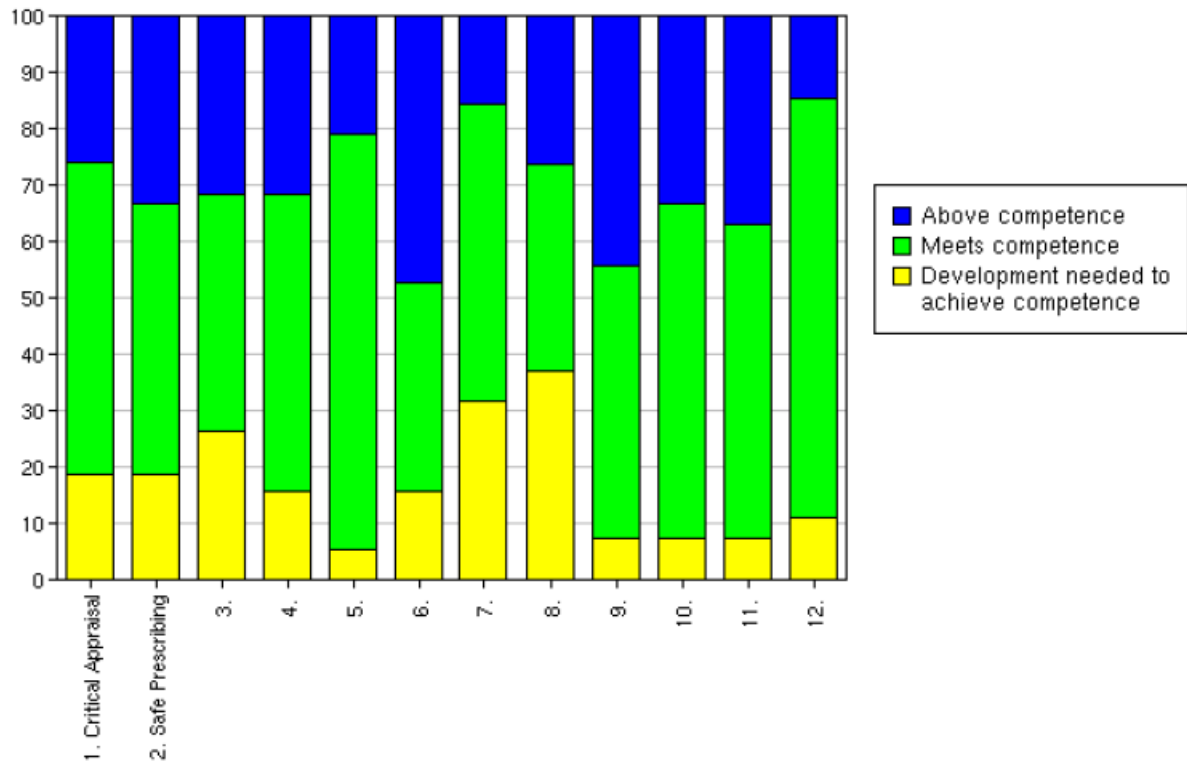
### Legend

- ✓✓ Well above expected standard
- ✓ Performed at expected standard
- Requires further development

Paediatric trainees as a breed are sensitive souls and it easy to get disheartened by the black circles (even if only a small proportion). Try to take this as the constructive advice it is intended. You could even potentially utilise the suggestions to agree future plans that not only address these but could be otherwise beneficial. For example, performing poorly in a clinic-based scenario could empower you to ask the training programme director for a stint in a DGH known to focus more on outpatients than higher intensity acute-orientated rotations. The same applies in the reverse situation and the reflection could be tailored to support requests for your final rotations.

This is followed by comments on each of the stations as shown on previous pages, followed by a couple more graphs with information on “performance rating per station” and “consultant skills rating” which compares you to your peers.

## START Guide for Wessex – Seb Gray



Supervisors are also able to view the feedback and plans to address highlighted issues should be discussed within 4 weeks. Escalation to training programme directors and heads of schools may be needed if broader training needs are required than can be provided at the current placement. The aim of the assessment is to provide constructive feedback on areas of focus not as a list of things you did wrong. Supervisors are provided with written guidance on how to manage issues highlighted from START but if you feel these have not been appropriately addressed, you should discuss with your trainee rep, training programme director or head of school.

The guidelines given to supervisors are freely available here much of which is mentioned in the preparation advice:

[http://www.rcpch.ac.uk/system/files/protected/page/START%20Feedback%20and%20Targeted%20Feedback%20for%20Educational%20Supervisors%20Nov%202014%20updated\\_0.pdf](http://www.rcpch.ac.uk/system/files/protected/page/START%20Feedback%20and%20Targeted%20Feedback%20for%20Educational%20Supervisors%20Nov%202014%20updated_0.pdf)

If you have any further questions, comments or things you'd like to add to assist current and future trainees in relation to START, please email me at [sebastiangray@hotmail.com](mailto:sebastiangray@hotmail.com)

GOOD LUCK!