Medical Deans
AUSTRALIA AND NEW ZEALAND

Harmonisation of Clinical Assessment Tools Project

Final Report

July 2013

HealthWorkforce AUSTRALIA

An Australian Government Initiative

Report prepared on behalf of Medical Deans Australia and New Zealand Inc by:

Professor Annemarie Hennessy
Dean, School of Medicine
University of Western Sydney

University of Western Sydney
School of Medicine
Locked Bag 1797
Penrith NSW 2751

Tel: 02 4620 3618
Fax: 02 4620 3890
Email:
an.hennessy@uws.edu.au

Ms Monique Hourn
Project Manager, Medical Education
Medical Deans Australia and New Zealand Inc

Level 6
173 – 175 Philip Street,
Sydney NSW 2000

Tel: 02 9114 1680
Fax: 02 9114 1722
Email:
mhourn@medicaldeans.org.au

Ms Tracey Piccoli
Project Officer
Medical Deans Australia and New Zealand Inc

University Centre for Rural Health
61 Uralba Street
Lismore NSW 2480

Tel: 02 6620 7212
Fax: 02 6620 7270
Email:
tpiccoli@medicaldeans.org.au

Contents

Executive Summary

In 2011, Health Workforce Australia (HWA) provided funding to Medical Deans Australia and New Zealand (Inc) (Medical Deans) to conduct the Harmonisation of Clinical Assessment Tools Project at the University Centre for Rural Health (UCRH), Lismore. The aim of the project was to develop, pilot and evaluate a harmonised assessment tool, at a site where multiple medical schools share the same clinical training environment and clinician assessors.

Three medical schools participated in the project; the University of Sydney (USyd), the University of Western Sydney (UWS) and the University of Wollongong (UoW). Students from these medical schools, in the latter phase of their programs and undertaking longitudinal placements at the UCRH, were recruited.

A comprehensive review of the curricula of the three participating schools was undertaken to ensure that a harmonised assessment process was developed based on the commonalities which exist between the curricula of medical schools. Medical schools, medical students, UCRH academic staff and clinicians were consulted to develop a suite of harmonised formative assessment tools. A single formative assessment tool was selected for the pilot based on the suitability of the tool to be implemented across the three medical school curricula. The harmonised tool was a Formative Assessment of Student Performance in Clinical Attachment (FASPCA) tool which measured core clinical competencies and aspects of professionalism, common to a number of medical disciplines. A key innovation of the FASPCA was the incorporation of a visual analogue scale for clinicians to measure a student's overall readiness for internship.

The harmonised tool was trialled across multiple high priority attachments to evaluate the effects of streamlining assessment processes across disciplines and medical schools; and examine the applicability of core clinical competencies in medicine across different disciplines. The attachments selected were General Medicine, Emergency, Mental Health and General Surgery and involved students from all three schools.

An independent evaluation was undertaken analysing data from a number of sources including student performance scores, student surveys, clinician surveys, clinician interviews and interviews with Medical Deans project staff. The results indicate that the FASPCA tool is a robust, efficient and effective tool for the clinical assessment of medical students at UCRH Lismore and Ballina. Trend analysis of the surveys has provided useful findings and recommendations relating to the validity, feasibility, authenticity, effectiveness and efficiency of the Harmonised Assessment Tool and its implementation.

The project results have been pleasing with the Harmonised Tool being viewed by clinicians and students as an effective tool for streamlining assessment processes for clinicians assessing multiple medical students. Interestingly, the results also indicate that the harmonised assessment tool has also been effective across disciplines; however any tool requires adaption to the assessment criteria and modification to suit the context of relevant attachments.

A key lesson from this project has been the level of consultation, collaboration and negotiation required around a practical issue of importance to the three participating medical schools and the UCRH Lismore. All stakeholders have worked together to achieve the project deliverables and an outcome of this collaboration has been the development of collegial relationships which will promote collaboration and further work between the schools. The valuable outcomes from this project have not just been a Harmonised Assessment Tool, but a case study documenting how medical schools can work together in rural sites.

The findings from this project could be applied at other similar teaching and training sites, particularly rural sites where there are multiple medical schools sharing the same clinical site and supervisors. The processes required for future implementations of this project at other sites would be similar in regards to the level of participant/stakeholder buy in required at the pilot site and between participating medical schools to achieve the project deliverables.

Section 1: Introduction and Background

Introduction

Medical Deans received funding in August 2011 from HWA to conduct the Harmonisation of Clinical Assessment Tools Project at the University Centre for Rural Health, Lismore.

The aims of the project were to:

1. Develop harmonised clinical assessment tools for assessment of medical students in the second half of their medical program.

2. Undertake a pilot of these harmonised clinical assessment tool(s) at a site where multiple medical schools share the clinical environment for teaching and assessment – the Northern Rivers Regional Hospital site.

3. Evaluate and document the outcomes from the pilot project to inform broader implementation of the harmonised clinical assessment tool(s) and relate pilot project findings to other medical education projects involved in the benchmarking of standards and common assessment in medical education.

The project deliverables were executed in two phases:

Phase 1 – development and piloting of the harmonised tool;
Phase 2 – evaluation and reporting

<u>Phase 1</u>

1. Review of the curriculum structure of the participating medical schools - Sydney Medical School, University of Western Sydney and University of Wollongong Medical School to understand the differences and synergies in the curricula at each school.

2. Establishment of a Project Reference Group chaired by Medical Deans, to consult with stakeholders and reach agreement on the selection of criteria for assessing current and proposed clinical assessment tools for medical students.
   Stakeholders included: Medical Deans, Medical Schools, Pilot Sites and Clinicians, Medical Students, Program Manager CSSP, Australian Medical Council and representatives involved in the Pilot Site.

3. Develop harmonised clinical assessment tool(s) at the pilot site including obtaining relevant specific site/hospital committee approvals to enable the harmonised clinical assessment tool to be trialled at the pilot site.

4. Trial the harmonised clinical assessment tool during one rotation of medical students in consultation with clinicians, stakeholders and the Reference Group

<u>Phase 2: Evaluation and development of a Final Report</u>

1. Evaluation of the harmonised clinical assessment tool(s) at the pilot site

2. The development of a Final Report which, includes statistical analysis, key learnings and recommendations for broader implementation to other sites nationally where there are multiple medical schools sharing the same sites.

This Report provides a comprehensive account of the project's achievements.

Background
Late in 2010, discussions were held between HWA and Medical Deans regarding the benefits of a project which would aim to streamline assessment processes where there are multiple medical schools sharing the same clinical training site. These discussions were based on feedback from clinical supervisors that assessment processes for medical students sharing clinical education facilities could be streamlined by the introduction of a single assessment tool. Such an innovation would be predicated on the outcome of recognition of the qualities of the competent medical graduate.

An expression of interest was sought through the Deans of medical schools inviting participation in such a project and the nomination of suitable pilot sites. Two potential pilot sites were identified:

1. University Centre for Rural Health, Lismore
   Medical Schools involved:
   - University of Sydney
   - University of Western Sydney
   - University of Wollongong

2. Wesley Private Hospital, Auchenflower, Brisbane
   Medical Schools involved:
   - Bond University
   - Griffith University
   - University of Queensland

A series of workshops were conducted with the potential pilot sites to design the project, identify key activities, deliverables and timelines. An important outcome from these workshops was the decision to focus on developing a harmonised assessment tool for those medical students in the latter phase of their medical programs. Such an assessment tool used across three medical schools would measure the desired outcome of identifying the qualities of the competent medical graduate ready for internship. The workshops also highlighted the need to conduct the pilot at a site where there were multiple medical schools immersing students full time in clinical attachments in order to achieve optimal results for the pilot.

An initial proposal was submitted to HWA involving the two pilots sites identified, UCRH Lismore and the Wesley Private Hospital, Brisbane. The proposal was scaled back due to funding constraints and a decision was made to proceed only with the UCRH as the pilot site. Major factors influencing this decision were;

- A rural site could benefit greatly from the results of this project given that rural sites may not have the resources to develop a similar project in the immediate future;
- Rural teaching sites are being increasingly used for clinical placement allocation and;
- Being distant from main campuses, rural sites have a greater difficulty in managing multiple assessment processes.

The UCRH was chosen as the pilot site with the intention that the project results could inform other potential pilot sites such as the Wesley Private Hospital.

Early on in the project period, an additional pilot site was added at Ballina Hospital to include Emergency Medicine attachments. The inclusion of Ballina Emergency Medicine in the pilot ensured that all three medical schools had equal numbers of student participation in the pilot.

The project was funded in August 2011. Early project activities included the recruitment of a Project Officer to be located at the UCRH, and the establishment of a Project Committee to provide governance and strategic advice on the project activities. The Project Officer was recruited in December 2011. Throughout the project, close supervision and mentoring of the Project Officer, as well as overall coordination of the project was provided by the Medical Deans' Project Manager, Medical Education.

The Harmonisation Project Committee membership included the three medical schools involved in the project and local stakeholders, including clinicians, University Centre for Rural Health's Medical Education Team and medical student representatives at the pilot site. The Project Committee was chaired by Professor Annemarie Hennessy, Dean, School of Medicine, UWS, representing Medical Deans. Full Project Committee membership was not complete until early 2012. HWA and the Australian Medical Council (AMC) do not have direct representation on the Project Committee however they were kept informed through regular communications.

A complete list of Project Committee Membership is included as Appendix A.

The Project Committee Terms of Reference (TOR) are included as Appendix B.

In terms of broader Medical Deans' activity and interactions with partnership organisations in medical education, regular reports are provided to the Medical Deans' Executive, HWA, Confederation of Post Graduate Medical Education Council's (CPMEC) and the Committee of Presidents of Medical Colleges (CPMC). These reports provide updates to our partnership organisations regarding the progress of Medical Deans' projects.

In May 2012, the project suffered a significant delay due to the resignation of the Project Officer due to unforeseen circumstances. The pilot was delayed and all project activity suspended pending the appointment of a suitable Project Officer. UCRH kindly nominated an existing staff member for the Harmonisation Project Officer role and the new Project Officer assumed the role in June 2012.

Section 2: Methodology

Part 1. Pilot Implementation

There were a number of key activities which were integral to the implementation of the pilot at UCRH. The significant pilot activities can be summarised as pilot implementation activities, ongoing pilot activities and evaluation plan activities.

Pilot implementation activities included curriculum structure and review, regular Project Committee meetings including a Project Committee workshop, ethics approval processes, identification of attachments, students and clinicians involved in the pilot, consenting processes and promotion of the pilot to key stakeholders.

Ongoing pilot activities included stakeholder liaison with students, clinicians, UCRH Medical Education Team, introduction of Ballina to the pilot and additional strategies to improve assessment tool completion rates.

Building relationships across programs and educators before, during and after the pilot has been essential to the success of the project and a key lesson regarding the methodology of this project.

Implementation activities

Curriculum structure and review

An early significant activity involved examining the structure and content of the three participating medical school's curricula to gain an understanding of the commonalities which may exist and to identify where in the curriculum/program a harmonised assessment tool could be implemented.

Early in the project period, the Project Committee decided that the most efficient and effective way to undertake this work was to engage an experienced educational consultant. The educational consultant would then provide a rigorous and objective review to assist the Project Committee with its deliberations in the development of the Harmonised Assessment Tool and the most effective evaluation process. Funding to support the engagement of the educator was found from within the project budget by redistributing the funds initially allocated to engage a statistician for the evaluation plan.

Following a targeted expression of interest process, a suitably qualified educational consultant was recruited in November 2011 to conduct the curriculum structure review, propose a harmonised clinical assessment tool/s based on the findings of the curriculum review and develop an evaluation plan. The Education Consultant recruited to undertake these activities was Dr Christine Tom.

The findings from the curriculum structure review focused on the commonalities, differences and priorities and existing assessment tools of the curriculum of the three participating medical schools. The review included a comparative analysis of the curricula in general.

The curricula structure review was an integral early activity to ensure that the assessment tool developed and subsequently piloted was formed on a sound educational basis and that the assessment tool measured the expected content requirements of the three medical school's curriculum.

Regular Project Committee Meetings including the convening of a Project Committee Workshop

Regular Project Committee Meetings

A significant contributing factor to the success of the implementation of the pilot has been the regular meetings of the Project Committee to provide strategic advice and direction for the project. The Project Committee included key individuals at UCRH, the three participating medical schools and Medical Deans. The committee met monthly from August, 2011.

This frequency of meetings indicates the level of input and commitment required from the Project Committee, particularly UCRH members to help guide and drive the project.

Project Committee Workshop

In February 2012 a full day, face to face workshop was held to discuss the outcomes from the review of the curricula structure, content and to decide on a tool to pilot from the three proposed harmonised clinical assessment tool (s). All members of the Project Committee, including the Education Consultant Dr Christine Tom attended at UCRH to discuss the findings from the curriculum review and to reach consensus on the type of tool to be piloted and which attachments to pilot the tool.

The Project Committee Workshop was significant - it produced important outcomes that shaped the direction of the project. Bringing together the Project Committee members was central to reaching consensus on how, when and where the Harmonisation Assessment Tool should be piloted. Importantly, the workshop ensured that all Project Committee members were consulted and that the participating medical schools had an opportunity to provide input on the development of the assessment tool and the implementation of the pilot.

There were a number of key outcomes from the Project Committee Workshop, including:

i. The decision to develop the harmonised tool as a formative assessment tool to be used in addition to existing assessment processes
ii. Harmonised clinical assessment tool selected: Formative Assessment of Student Performance in Clinical Attachment (FASPCA)
iii. Pilot the harmonised tool across multiple attachments, not just one standard rotation as per the contract, thus going above and beyond the contractual requirements
iv. Identification of high priority attachments

i. Developing the harmonised tool as a formative assessment tool in addition to existing assessment processes

One of the significant outcomes from the Project Committee Workshop was the decision to develop and pilot a harmonised assessment tool as a formative assessment tool. The Project Committee recognised that this was the least disruptive way of implementing a new assessment tool without causing interruption to well established assessment processes within medical schools. It was agreed that the assessment tool chosen for the pilot would be trialled in parallel to existing formative and summative assessment processes without impacting on a student's overall final grade.

ii. Harmonised Clinical Assessment Tool selected: Formative Assessment of Student Performance in Clinical Attachment (FASPCA)

The curricula review report recommended three different types of assessment tool which could be suitable for the pilot. The Project Committee selected the Formative Assessment of Student Performance in Clinical Attachment (FASPCA) tool as the preferred tool for the pilot. This tool was selected as it measures the student's overall performance in a clinical attachment including aspects of professionalism which are traditionally more challenging to measure.

The Project Committee made suggested changes to the FASPCA in accordance with each of their medical school's requirements. A significant inclusion to the FASPCA was the visual analogue scale which requests clinicians to make a judgement about a student's readiness for internship using a horizontal scale.

The piloted harmonised clinical assessment tool, the Formative Assessment of Student Performance in Clinical Attachment (FASPCA) is attached as Appendix C.

iii. Pilot the harmonised tool across multiple attachments, not just one standard rotation as per the contract, thus going above and beyond the contractual requirements

A further outcome from the Project Committee workshop was the decision to use the harmonised assessment tool across multiple attachments not just the one standard rotation as per the original proposal. It was felt that the tool developed could be modified to pilot across multiple attachments and thus provide data examining the role of core clinical competencies across multiple

disciplines. This was an exciting development for the project as the piloted tool would be implemented with a dual purpose: examining the role of core clinical competencies across disciplines in addition to the primary objective of the project which was to streamline assessment processes for clinicians.

iv. Identification of high priority attachments

Following on from the decision to pilot the harmonised assessment tool across multiple attachments, UCRH Project Committee members identified areas of their clinical placement program for medicine which were deemed high priority areas that could benefit from a more streamlined assessment processes - Mental Health, General Medicine and Surgery. These attachments are at saturation point and the clinicians involved have a heavy teaching/supervisor load. Thus it was agreed that the Harmonised Tool should be piloted across these attachments to determine if a single assessment tool could streamline assessment processes for the clinicians who have a supervision role in these attachments.

Despite initial enthusiasm, the General Practice (GP) attachment was deemed as unsuitable to pilot the Harmonised Tool. This was due to fundamental differences in the curricula between the role of the GP supervisor and GP attachment. Thus commonalities in outcomes as well as the critical role of the assessor/supervisor are both important in determining the feasibility of harmonisation of assessment processes.

Ethics approvals

As the project involved conducting research on medical students' assessment results and survey response data, it was necessary to gain appropriate ethics approvals to ensure that the project followed a scholarly and rigorous approach and to ensure that the research was conducted in a safe and ethical manner.

A lead ethics application was submitted to Sydney University Human Research Ethics Committee (HREC) in early 2012 with final approval being granted in March 2012. Ethics approvals were also required for the other participating medical schools, University of Western Sydney and University of Wollongong. The University of Western Sydney ratified the ethics application based on the Sydney University HREC approval; however the University of Wollongong required a separate application and approval process.

As the pilot was being conducted at an area health service site, a Northern New South Wales Local Health District, ethics approval was also required from Richmond/Clarence Area, NSW Health.

All ethics application activities commenced in early 2012 with final approval being granted from all medical schools and the local area health service by June 2012. The Project Committee were involved in the ethics application activities and assisted with applications at their University HREC or the local area health service.

Identification of attachments, students and clinicians gathered in the pilot

The identification of the potential pilot attachments including students and clinicians involved required extensive consultation between the Project Officer and the Director of Medical Education, UCRH, the Ballina Emergency Department staff and the student coordinators for the University of Sydney, University of Western Sydney and University of Wollongong. The Project Officer required information from all of the aforementioned individuals to ensure that the pilot attachment data remained current as the timetable, students and clinicians involved were subject to constant change.

A detailed timeline of activities was developed prior to the pilot commencing to serve as a guide to structure activities including highlighting the commencement of attachments, completed assessment tools due dates and identification of students and clinicians involved in the pilot at any given time.

This "work plan" extensively detailed pilot activities and was necessary to ensure that the project progressed smoothly. The work plan enabled the Project Officer to accurately monitor the return

of assessment tools, student surveys and clinician surveys and was a valuable tool used to implement the pilot.

The project was delayed in May 2012 due to the resignation of the original Project Officer, and as a result the project timelines were extended out until the end of October. This allowed for an appropriate timeframe to promote the project to clinicians, students, academics and members of the Medical Education Team. This altered the attachments, students and clinicians involved in the pilot as outlined in the progress report to HWA in January 2012.

A summary of the revised pilot attachments is included as Appendix D.

Key stakeholder engagement
Key stakeholders were identified as clinicians, students and members of the UCRH Medical Education Team.

a) Clinician engagement
Earlier in the project period, a clinician information session was held at UCRH, for those clinicians identified as being involved in the pilot. The aim of the session was to provide clinicians with an overview of the project, outline the upcoming pilot activities, identify the attachments involved, and explain the anticipated contributions required should clinicians be willing to participate. The clinician information session was a good opportunity to initially engage clinicians and to request assistance from discipline leads to champion the project amongst their peers.

A follow up introductory email was sent by the Director of Medical Education, UCRH and the Clinical Sub Dean to clinicians requesting their involvement in the pilot. The Director of Medical Education's role and status amongst peers was utilised to promote the project as it was felt that having a locally established doctor inviting clinician participation, would encourage clinician involvement. It also provided clinicians with a liaison person who was 'one of their own' should any concerns arise during the pilot.

As the pilot commencement date drew nearer, clinicians were sent information via clinician packs. The packs included: Participant Information Statement, Clinicians Instructions, Formative Assessment of Student Performance in Clinical Attachment (FASPCA) form and a Clinician Survey. Clinician packs were delivered in person to clinicians or their Practice Managers / Secretaries by the Director of Medical Education and the Project Officer, thus enabling an additional opportunity to promote the project in person.

b) Student engagement
Students involved in the pilot were identified according to their allocation to the high priority attachments occurring within the pilot timeframes. An introductory email was sent to these students outlining the project, expected student contributions and requesting participation.

Where possible, members of the Project Committee briefed students from their medical school about the Harmonisation Pilot Project before they undertook their longitudinal rural placement at Lismore. This was a helpful promotion activity as students were already informed about the upcoming pilot and their potential involvement before they arrived at UCRH.

The Harmonisation Project Officer provided a presentation to the new incoming medical students at UCRH on their orientation day. This session gave students an opportunity to ask questions regarding the contributions required from them if they elected to participate in the pilot. The Project Officer followed up with the students later in the same week, in person to obtain formal consent.

Similar to the clinician promotion strategy, student packs were developed and provided to each participating student at their orientation session. The packs included; Participant Information Statement, Instructions for Students, Formative Assessment of Student Performance in Clinical Attachment (FASPCA) and a Student Survey.

The pilot was promoted to the students as an opportunity to have additional contact with their supervisors including a structured opportunity to discuss their progression towards internship within a formative assessment framework.

c) Medical Education Team and UCRH staff engagement
The pilot was promoted to relevant UCRH staff such as the student coordination team, UCRH general staff and the Executive Officer, to ensure that staff were aware of the activities being undertaken and to encourage assistance in promoting the project to the medical students and clinicians involved where appropriate. The promotion of the project to UCRH staff and hospital staff was important in a small close knit environment to ensure the successful implementation of the pilot.

Participant Consent
All participants, students and clinicians gave written informed consent before the pilot commenced. Consenting activities were used as an additional opportunity to promote the project to participants in person.

Overall, there were a number of implementation activities which were essential to the success of the pilot. A number of these activities focussed on the Project Officer actively promoting the project to a range of different stakeholders and using a variety of forms of communication. The Director of Medical Education and the Clinical Sub Dean were utilised to promote the project amongst their peers and to encourage clinician involvement.

Pilot activities

Participant liaison was integral to the success of the pilot. Activities included ongoing liaison with students, clinicians and the Medical Education Team, and further liaison with the UCRH Medical Education Team to develop strategies to improve return rates of formative assessment forms. With the introduction of Ballina to the pilot, assistance was required to promote and roll out the project at that site.

Ongoing Student Liaison
The Project Officer attended Problem Based Learning (PBL), Case Based Learning (CBL), Regional Academic Days (RAD), weekly tutorials and Clinical Skills Sessions to gain access to students participating in the pilot. By attending these sessions the Project Officer was able to discuss the project with a large group of students at the one time. This provided regular student contact to discuss and solve issues regarding the completion of the assessment forms including identifying who might be the best supervisor to complete the tool.

Promotion of the project was initially advertised to students via email. Emailing initially provided the quickest way to contact students regarding the project. It also enabled continuous promotion during the pilot and advising of due dates for completed assessment tools. However, once the pilot had commenced it became evident that students did not check their emails on a regular basis therefore it became imperative that the Project Officer met with the students regularly to reinforce the completion of the Harmonised Assessment Tool.

Ongoing Clinician Liaison
The Director of Medical Education and the Clinical Sub Dean, UCRH, promoted the project to the clinicians involved in the pilot. This occurred at regular clinician meetings with informal follow up also undertaken on overdue assessment tools or surveys when they met with their colleagues.

The Director of Medical Education also attended Hospital Physicians and Surgeons meetings to encourage clinician involvement. At these meetings the Director was able to reinforce the value of the project to key clinician groups and advise of upcoming due dates for completed assessment tools. Clinicians involved in the pilot required continuous liaison throughout the project, particularly once the pilot was underway. The championing of the project by these two members of the Project Committee was crucial to the implementation of the pilot.

Medical Education Team Liaison

The UCRH Medical Education Team was key to facilitating the implementation of the pilot. The Project Officer met weekly with the Program Manager, Clinical Education and the Student Coordination team to provide both parties with an overview of the pilot activities. The Medical Education Team provided support during the pilot particularly in engaging students to encourage the return of completed assessment tools. The Project Officer's ability to liaise with the Medical Education Team improved the return rate of completed assessment tools and student surveys.

The Project Officer promoted the project at the UCRH Medical Educators meetings, which are attended by UCRH academic leads, medical educators and the Medical Education Team. These meetings were a good opportunity to discuss the project to a large group of key stakeholders and provided a forum to update clinicians and academics on the progress of the project.

Strategies to Improve return of Completed Assessment Tools

A number of strategies were implemented by the Project Committee to address the initial poor participation rate by students in the process.

The Program Manager, Clinical Education and Student Coordinators reinforced with the students that the pilot provided an additional opportunity for students to have structured feedback with their supervisors whilst completing the Harmonised Assessment Tool; and the valuable formative feedback they could receive about their overall progression towards internship.

This strategy saw an immediate increase in students undertaking the assessment tool with their supervisors.

A meeting was held with UCRH Project Committee members to address the poor return rate of completed Harmonised Assessment Tools. This meeting was a turning point for the pilot as it not only highlighted the challenges of getting students to complete formative assessment exercises but the outcomes from this meeting improved the return rates of the formative assessment tool immediately.

The Director of Medical Education and the Clinical Sub Dean followed up with the clinicians involved in the pilot to encourage the completion of the assessment tool on students they supervised. A further letter was sent to clinicians from the Director of Medical Education and the Clinical Sub Dean identifying individual students via photos and encouraging clinicians to complete the assessment tool on the student identified. This strategy instantly improved return rates of the completed assessment tools as the student were identified by name, attachment and university to the clinicians.

Introduction of Ballina to the pilot

The Ballina Emergency Department (ED) attachment was introduced to the pilot at a later stage to ensure an even distribution of student participant numbers across all three Universities. Without the inclusion of Ballina ED in the pilot, the University of Wollongong students, of which a significant number were undertaking their Emergency attachments at Ballina, would have been under represented in the pilot. An altered site specific ethics application was required to include Ballina ED in the pilot, and final approval was granted from Far North Coast Area Health Service in June 2012.

The Ballina ED attachment is located 30 minutes away from the main pilot site in Lismore. Discussions were held with UCRH Harmonisation Project Committee members to determine how to conduct the pilot at Ballina ED including how to identify and obtain clinician consent at Ballina. This was a challenge for the project as there was not the same level of familiarity with the Ballina ED clinicians. Personal approaches were used to facilitate the introduction of the pilot to Ballina ED.

The Ballina ED Nurse Unit Manager (NUM) consented clinicians involved in the pilot and became an important contact person for the project. The assistance provided by the NUM was a key factor in the implementation of the pilot at a site located away from the main pilot site at UCRH.

Part 2. EVALUATION

Phase two of the project focused on the evaluation of the project. Activities included administering and analysing student and clinician surveys, and conducting semi – structured interviews with clinicians and Harmonisation Project Committee members. The evaluation plan was developed and conducted by the Education Consultant, Dr Christine Tom and was endorsed by the Project Committee.

Evaluation activities required the same liaison strategies used during the pilot to ensure that student and clinician surveys were completed and returned. Once again, the Project Officer was required to make a personal approach to students and clinicians to encourage the completion of surveys for the evaluation plan. Similarly, the UCRH Medical Education team were involved in ensuring that the student and clinician survey completion rates were high.

The Education Consultant conducted semi structured interviews and analysed the data from the surveys. The evaluation results will be covered later in this report.

A copy of the student survey is attached as Appendix E.

A copy of the clinician survey is attached as Appendix F.

A copy of the semi structured interview questions is attached as Appendix G.

Section 3: Results

At the conclusion of the pilot data from the Formative Assessment Tool, Student Survey and Clinician Survey was collated and analysed by the Education Consultant.

The results from the Evaluation Report are outlined below, together with selected tables from the Report, under the following;

1. Evaluation Framework
2. Results: Student Performance as assessed using the Formative Assessment Tool
   Table 2: Scores of Student Performance using Formative Assessment Tool
3. Survey of Clinical Supervisors
   Table 3: Results of Survey of Supervising Clinicians
4. Survey of Students
   Table 4: Results of Survey of Students in Clinical Attachment
5. Comparative analysis of Supervisors and Student survey responses
6. Semi structured interviews with Clinicians
   Table 6: Semi Structured Interview Questions – Clinicians from range and disciplines.
7. Table 7: Alignment of Clinician Interview Questions to Evaluation framework

1. Evaluation Framework

The Evaluation Report was formulated to address the appropriateness, effectiveness and efficiency of the Formative Assessment tool and was approved by the Harmonisation Project Committee.

2. Results: Student Performance as assessed using the Formative Assessment Tool

A total of 35 student performances were assessed by clinical supervisors using the Formative Assessment of Student Performance in Clinical Attachment. The tool covered 13 criterion and the students were assessed against each criterion on a 5 point marking scale, together with a Not Assessed option:

NA = Not Assessed	rating	= 0
NS = Not Satisfactory Performance		= 1
BP = Borderline Performance		= 2
SP = Satisfactory Performance		= 3
GP = Good Performance		= 4
EP = Excellent Performance		= 5

Students generally performed well on the 13 criteria, with an overall mean score equalling 3.63 out of 5 with S.E.M = ± 0.2850.

Students scored highly on criterion 1 & 11
1 - Depth, breadth and application of knowledge and understanding of disease mechanisms
11 - Interpersonal relationships and teamwork on ward

Clinicians rated students well on criteria 4, 12 & 8
4 - Problem formulation skills: e.g. synthesis of biological, psychological and social aspects and their interaction
12 - Prioritising, punctuality, preparedness
(Demonstrates ability to set priorities and meet deadlines including punctual attendance, adequate preparedness and intellectual contribution to learning and teaching sessions)
8 - Communication skills e.g. with patients and their relatives, colleagues and teams

The mean score for overall progress assessed by a Global rating was 4.02; S.E.M = ± 0.0960, indicating that students were considered to be performing well in relation to *'Readiness to practise safely and well'*.

One student's comment on the survey indicated that a positive of the criteria was:

> "*The tool covers aspects not previously recognised in other assessment criteria e.g. interpersonal relationships, teamwork and patient safety."*

The data indicates that there were two criteria where clinicians judged that students did not achieve well. These were criterion 10 & 7
10 – Patient safety requirements e.g. Record keeping, Discharge letters, medication charting and prescriptions
7 – Performance of technical and practical procedures

Some of the clinicians' comments recorded on the survey and from those interviewed explained that for some disciplines, for example, Mental Health, Rehabilitation, and Haematology, these two criteria were not relevant or appropriate for assessing student performance in those specific clinical attachments, as students do not have the opportunity to engage in those activities when placed in those attachments.

As well, criterion 8 – *Communication skills e.g. with patients and their relatives, colleagues and teams* was considered not relevant for '*the patient and their relatives'* aspect in the Mental Health attachment, as students are not expected to practise these skills in this attachment, but it was acknowledged that *Communication skills with colleagues and teams* was extremely important, and so should remain as a criterion for Mental Health and all other disciplines. All other criteria were deemed to be relevant and pertinent for assessment purposes for the disciplines trialled.

All other criteria on the Formative Assessment Tool reflected satisfactory performance or better by the students, that is, each criterion reflected a mean score > 3.5, as evidenced in Table 2.

Clinicians and students provided positive support for the 5 point rating scale and for the Global rating scale which provides a visual image for students to see where they are at this stage of their medical program.

One clinician at interview supported the 5 point rating scale with the comment that:

> *"The 5 point rating scale is preferable to the usual 4 point scale because it allows me to reward performance with Good Performance, or on rare occasions, Excellent Performance rather than being limited by the range of Satisfactory Performance and Excellent Performance. I also think that the Not Assessed option is very important and should be retained".*

Table 2: Scores of Student Performance using Formative Assessment Tool.

CRITERIA		Mean Score N = 35	S.E.M
1.	Depth, breadth and application of knowledge and understanding of disease mechanisms	4.00	± 0.0819
2.	Patient History taking skills	3.74	± 0.1707
3.	Examination skills -– including discipline specific skills e.g. Mental state examination	3.62	± 0.1837
4.	Problem formulation skills: e.g. synthesis of biological, psychological and social aspects and their interaction	3.88	± 0.1628
5	Prioritization skills: e.g. urgency, risk assessment	3.57	± 0.1757
6.	Treatment planning and patient management skills — including discipline specific skills e.g. psychological intervention skills	3.54	± 0.1755
7.	Performance of technical and practical procedures	2.74	± 0.3288
8.	Communication skills e.g. with patients and their relatives, colleagues and teams	3.91	± 0.2105
9.	Respect towards patients and their families *(Demonstrates sensitivity, responsibility, respect and discretion with patients from all demographic backgrounds)*	3.74	± 0.2571
10.	Patient safety requirements - e.g. Record keeping, Discharge letters, medication charting and prescriptions	2.45	± 0.3486
11.	Interpersonal relationships and teamwork on ward	4.00	± 0.1639
12.	Prioritising, punctuality, preparedness *(Demonstrates ability to set priorities and meet deadlines including punctual attendance, adequate preparedness and intellectual contribution to learning and teaching sessions)*	3.94	± 0.1080
13.	Strategic in learning and teaching *(Demonstrates ability to plan and achieve goals in timely manner. Evaluates performance against expected outcomes)*	3.71	± 0.1947
MEAN Score for criteria 1 – 13 = 3.63		S.E.M for criteria 1 – 13 =± 0.1260	
OVERALL PROGRESS at this stage of the medical program. **On the continuum in the right hand box, please indicate where the student's performance is in relation to – READINESS TO PRACTISE SAFELY AND WELL.**		**MEAN Score for Global Rating = 4.02 S.E.M = ±0.0960**	
Overall mean Score = 3.42; S.E.M. = ± 0.1260			

Appendix K, Table 2. Report prepared by Christine Tom

3. Survey of Clinical Supervisors

Supervising clinicians were generally positive in their level of agreement with the survey statements. These statements were aligned to the evaluation of the appropriateness, effectiveness and efficiency of the Formative Assessment tool, as demonstrated in Table 3.

The scoring of the responses was recorded on a 4 point, forced-choice Likert scale as:

Strongly Disagree	= 1	Disagree	= 2
Agree	= 3	Strongly Agree	= 4

The three areas that received greatest support from the clinicians surveyed were statements 1, 5 & 14

1 - The criteria of the Harmonisation Assessment tool reflect the outcomes expected of students at the end of attachment

5 - The Harmonisation Assessment tool provides opportunity for the student to share self-evaluation comments with me
14 - The Harmonisation Assessment tool requires minimal resources to implement

Three of the survey statements received less positive support from the clinicians responding, with only one negative, that being Statement 10.
10 - The criteria provide information on the standard of student learning at end of attachment

Clinicians at interview corroborated this finding, indicating that the criteria alone cannot provide in depth descriptions of the standard of performance expected of the students by each of the Universities at end of attachment. The clinicians requested more curriculum and syllabus information relating to standards required of students at different stages in their medical program on each attachment. As seen from responses to statement 1 above, the clinicians appreciated that the criteria reflected the outcomes expected of the students but not the standard expected for the different stages of experience of the students.

Less positive responses were recorded for Statement 3 & 7
3 - I could identify how the specific skills required of my discipline aligned to the criteria
7- The Harmonisation Assessment tool is useful for formative assessment purposes

The clinicians agreed that there were areas where the criteria did not address the specific skills of some disciplines, especially Mental Health, Rehabilitation and Haematology. The clinicians interviewed were far more positive about the Formative Assessment tool being useful for formative assessment purposes, but with the proviso that, if possible, it should not be used as a 'stand alone' formative assessment tool used only once. It was also noted that the clinicians considered that the tool should be used at the mid-term point of the attachment and could be beneficial if used more than on one occasion to provide feedback to the student progressively throughout the attachment.

Table 3: Results of Survey of Supervising Clinicians.

Survey of Supervising Clinicians – Survey Statements and Mean Scores				
Focus	**Survey 1 – Assessors/ Supervisors** Quantitative data	**SURVEY STATEMENTS**	Results from 10 responses	
Appropriateness of the assessment tool:		**Levels of Agreement – Strongly Disagree = 1 Disagree = 2 Agree = 3 Strongly Agree = 4**	**MEAN Score**	**S.E.M**
Content Validity – measure of curriculum stated outcomes	√	1. The criteria of the Harmonisation Assessment tool reflect the outcomes expected of students at the end of attachment	3.10	± 0.1000
Construct validity - measure of specific discipline	√	2. The criteria accommodate the discipline specific skills required of the student at end of attachment	2.30	± 0.1707
Construct validity – Achieves the results for which it was designed	√	3. I could identify how the specific skills required of my discipline aligned to the criteria 4. The Harmonisation Assessment form assists me in making decisions about a student's performance in this attachment 5. The Harmonisation Assessment tool provides opportunity for the student to share self-evaluation comments with me	2.10 2.90 3.20	± 0.3785 ± 0.1795 ± 0.1333

Feasibility – The assessment tool is acceptable and workable to users	√	6. The Harmonisation Assessment tool works well as an assessment tool for providing feedback on the student's performance in this attachment 7. The Harmonisation Assessment tool is useful for formative assessment purposes 8. The criteria reflect the expected performance required of the student at end of attachment	2.40 2.10 2.70	± 0.3055 ± 0.3785 ± 0.1527
Authenticity – work-based experiences and problems	√	9. The criteria address the 'work-based', clinical experiences required of this attachment	2.60	± 0.3055
The assessment measures student learning	√	10. The criteria provide information on the standard of student learning at end of attachment	1.70	± 0.3958
Provides information on the impact of the curriculum on student performance	√	11. The essential clinical learning experiences are assessable against the criteria	2.40	± 0.4268
Allows students to demonstrate level of knowledge – factual, conceptual, procedural an metacognitive	√	12. The 5 point rating scale provides comprehensive feedback to the students	2.70	± 0.2603
Efficiency of the assessment tool:				
Time – The time used to complete the assessment is appropriate	√	13. The assessment can be completed in a timely manner	2.60	± 0.3399
Material resources - The assessment tool requires minimal resources to implement	√	14. The Harmonisation Assessment tool requires minimal resources to implement	3.00	± 0.3651
Human resources – The assessment tool requires input from the appropriate people	√	15. The Harmonisation Assessment tool allows for input from the relevant clinical personnel involved in the attachment 16. The Harmonisation Assessment tool is more effective if the Supervisor consults with others to rate the student at end of attachment	2.20 2.30	± 0.3266 ± 0.3000
Space/venue – Implementing the assessment requires space/venue	√	17. The Harmonisation Assessment tool does not require a specialised venue/space for its completion at end of attachment	2.60	± 0.3399
Effectiveness of assessment tool:				
Curriculum coverage – The assessment tool	√	18. The Harmonisation Assessment tool focuses on the most important aspects of the discipline of the	2.40	± 0.3399

focuses on the most important aspects of the discipline		attachment		
Rating Scale/Global Rating The rating scale allows students to demonstrate their level of performance against the criteria	√	19. The Harmonisation Assessment tool 5 point rating scale allows students to clearly demonstrate their level of performance against the criteria 20. The Global rating is appropriate in that it allows the Supervisor/Assessor to record the student's readiness for practice as an Intern, at the end of attachment	2.60 2.40	± 0.3399 ± 0.3399

Appendix K, Table 3 Report prepared by Christine Tom

While none of the remaining survey statements rated a mean score < 2.10, the majority of the statements were > 2.40. The overall mean score for the survey responses of clinicians on 20 statements was 2.51; S.E.M. = ± 0.0818. The number of clinician responses = 10.

4. Survey of Students

The data collated from the Student Surveys provide support for the appropriateness, effectiveness and efficiency of the Formative Assessment tool.

The scoring of the responses was recorded on a 4 point, forced-choice Likert scale as:

Strongly Disagree = 1 Disagree = 2 Agree = 3 Strongly Agree = 4

The three areas that received greatest support from the 30 students surveyed were statements 1, 3 & 7
1 - The criteria of the Harmonisation Assessment tool reflect the outcomes expected of me at the end of this attachment
3 - The criteria reflect the expected performance required of me at end of attachment
7- The Harmonisation tool is relevant in providing feedback on my performance in attachment

Comments from students on the survey form (8 of 21 comments) reiterated their support for the tool in providing useful feedback on their performance.

Two of the survey statements received less positive ratings from the students responding, but no statement received a negative response – that is, mean score = or < 2 - from the students. The first of the less positive statements was Statement 2 - *The Harmonisation Assessment criteria accommodate the discipline specific skills required of me at end of attachment.* This response from the students reflected the perceptions of the clinicians surveyed and interviewed, with many identifying disciplines that were not accommodated by some of the criteria.

One student's comment aligned with those of some clinicians, which stated that:

> *"The criteria need to fit better with Psychiatry. Wasn't all that good a fit for our assessment".*

The second less positive response from students was to Statement 13 - *The Harmonisation Assessment tool does not require a specialised space/venue for completion*. As Statement 13 is presented in a negative form, it can be interpreted that the students consider it necessary to have a specialised space/venue for completion. This perception was addressed by the clinicians at interview who acknowledged that it was important to have a private space to discuss and give feedback on their ratings of the student and to plan for improvement. The

clinician's, however said that this was not inconvenient as they had access to such spaces/venues.

None of the remaining statements rated a mean score < 2.50, the majority of statements were > 2.63. The overall mean score for the survey responses of students on 15 statements was 2.62; S.E.M. = ± 0.0413. The number of student responses = 30.

Table 4: Results of Survey of Students in Clinical Attachment.

Focus	**Survey Students** Quantitative data **2/**	**SURVEY STATEMENTS**	**Results from 30 responses**	
Appropriateness of the assessment tool:		**Levels of Agreement – Strongly Disagree =1 Disagree = 2 Agree = 3 Strongly Agree = 4**	**MEAN Score**	**S.E.M**
Content Validity – measure of curriculum stated outcomes	√	1. The criteria of the Harmonisation Assessment tool reflect the outcomes expected of me at the end of this attachment	2.80	± 0.1138
Construct validity - measure of specific discipline	√	2. The Harmonisation Assessment criteria accommodate the discipline specific skills required of me at end of attachment 3. The criteria reflect the expected performance required of me at end of attachment 4. The criteria assess the 'work-based', clinical experiences required by this discipline	2.43 2.86 2.63	± 0.2072 ± 0.1333 ± 0.1824
Construct validity – Achieves the results for which it was designed	√	5. The Harmonisation Assessment form assists me in making judgments about my performance in this attachment 6. The Harmonisation Assessment tool provides opportunity for me to share my self-evaluation with my supervisor	2.53 2.66	± 0.1570 ± 0.1996
Consequential validity – students find the assessment tool relevant, challenging, engaging, encouraging worthwhile learning	√	7. The Harmonisation tool is relevant in providing feedback on my performance in attachment 8. The Harmonisation Assessment tool provides information that encourages me to progress my learning 9. The Harmonisation Assessment tool is useful for formative assessment purposes	2.80 2.50 2.60	± 0.1546 ± 0.1841 ± 0.1953
Authenticity – work-based experiences and problems	√	10. The assessment tool allows me to identify my strengths demonstrated in this attachment 11. The assessment tool allows me to note the areas I need to further develop in this discipline	2.73 2.70	± 0.1262 ± 0.1189
Efficiency of the assessment tool:				
Time – The time used to complete the assessment is	√	12. The assessment can be completed in a timely way	2.66	± 0.1464

appropriate				
Space/venue – Implementing the assessment requires an appropriate space/venue	√	13. The Harmonisation Assessment tool does not require a specialised space/venue for completion	2.66	± 0.1464
Effectiveness of the assessment tool:				
Rating Scale/Global Rating The rating scale allows students to demonstrate their level of performance against the criteria	√	14. The Harmonisation Assessment tool's 5 point rating scale allows me to understand my level of performance against each criterion 15. The Global rating is appropriate in that it allows the Supervisor/Assessor to record my readiness for practice as an Intern at the end of attachment	2.56 2.63	± 0.1837 ± 0.2372

Appendix K, Table 4 Report prepared by Christine Tom

5. Comparative analysis of Supervisors and Student Survey responses.

The similarities and differences between the survey responses of supervisors and students when viewing validity, feasibility, authenticity, efficiency (time, material and human resources, space) and effectiveness of the assessment tool as collated in Table 5 is useful as it reflects the level of agreement with the statements as they link to the evaluation framework.

Table 5: Comparative analysis of Supervisors and Students survey responses.

Evaluation focus	COMMON SURVEY STATEMENTS	Supervisor Mean Score /4 (Overall)	Student Mean Score/4 (Overall)
Validity	The criteria of the Harmonisation Assessment tool reflect the outcomes expected. The Harmonisation Assessment criteria accommodate the discipline specific skills required of at end of attachment The criteria reflect the expected performance required at end of attachment. The criteria assess the 'work-based', clinical experiences required by this discipline. The Harmonisation Assessment form assists in making judgments about my performance in this attachment	**2.72**	**2.65**
Feasibility	The Harmonisation Assessment tool provides opportunity to share self-evaluation The Harmonisation tool is relevant in providing feedback on performance in attachment The Harmonisation Assessment tool provides information that encourages progress learning	**2.40**	**2.65**
Authenticity	The Harmonisation Assessment tool is useful for formative assessment purposes The assessment tool allows me to identify my strengths demonstrated in this attachment The assessment tool allows me to note the areas I need to further develop in this discipline	**2.35**	**2.67**

Efficiency – Time, Space	The assessment can be completed in a timely way The Harmonisation Assessment tool does not require a specialised space/venue for completion	**2.54**	**2.44**
Effectiveness	The Harmonisation Assessment tool's 5 point rating scale allows me to understand my level of performance against each criterion The Global rating is appropriate in that it allows the Supervisor/Assessor to record my readiness for practice as an Intern at the end of attachment	**2.46**	**2.59**

Appendix K, Table 5 Report prepared by Christine Tom

6. Semi Structured Interviews with Clinicians

Semi-structured interviews with clinicians were undertaken by the Education Consultant. These interviews provided further support for the appropriateness, effectiveness and efficiency of the Formative Assessment tool. A set of questions were developed and individual responses from clinicians recorded via telephone with interviews lasting approximately 20 minutes per person.

Of a total of 20 participating clinicians, ten clinicians were interviewed. The majority of clinicians who were not interviewed were on leave during the two week interview period, or did not respond after three contact attempts. Only one clinician refused to be interviewed.

The clinicians strongly agreed that the Formative Assessment tool achieves the purpose of the Harmonisation Project, which was to provide an instrument that allows for a consistent approach to assessment of student performance in attachment, across all medical schools.

The clinicians found no significant differences between the students from the three different Universities in regards to curriculum, performance, or participation, however, a recurring statement was:

> "*We need to be provided with more details from the Universities or Education Unit regarding the student – what prior experience they have had in clinical attachments; identify year in medical school, for example, Year 3 of 4; term duration; expected outcomes linked to the University's curriculum."*

The clinicians all valued the tool as a formative assessment of students, and agreed that it provided them with an opportunity to interact with students and to provide feedback.

The general consensus was that the time taken to complete the tool was no longer than 15 minutes and they considered this to be feasible. None of the clinicians found it necessary to access additional resources to complete the assessment tool, with three of the clinicians saying, "*I tapped into my normal resources, for example, my admin assistant organised the appointments."*

To obtain an overall view of the student for assessment, clinicians also consulted with other colleagues which included CMO, Registrars, nursing staff and other specialists who had observed the student in a range of contexts and from differing perspectives. Some clinicians considered that this was necessary as they had limited contact with the student and wanted to present honest feedback to the student. However, the students were not informed of the extent of the consultation and some felt that they were assessed by a clinician who had only seen them briefly.

One student commented that:

> *"It is difficult for the consultant to access the student most times if you don't spend much time with them. There are multiple consultants acting as supervisors. I find we spend much more time with the intern or registrar and they should be responsible for marking our progress. It shouldn't just be the consultant but the doctor you spend the most time with."*

The clinicians found the 5 point rating scale together with the Not Assessed option to be effective and were supportive of the Global rating as a visual image for students. From the clinicians interviewed it was found the 'Readiness to practise safely and well' effective but most commented on the need for further explanation of the standard required – that of Intern or that appropriate to the experience/time in medical program of the student being assessed.

While most of the interviewees found page 2 of the tool to be very important in providing specific feedback to the student, some were disappointed that many students had not completed their self evaluation prior to their meeting with their supervisor. Some students provided superficial and 'glib' statements and had poor skills in reflecting on their own performances and self-evaluating against the expected outcomes.

The majority of clinicians agreed that the Harmonised Assessment tool should not be used at the end of the attachment (more like a summative assessment) as this is too late for providing useful and constructive feedback to students who can then act on this to improve. If possible, the tool should be implemented mid-term of the attachment.

While the Attendance aspect of the form was not for formal assessment, it was considered an important aspect and clinicians considered that students should know that attendance is important and will be recorded.

Overall the interviews with the 10 clinicians provided insight into those aspects of the tool that worked well and those that need further development. Many of the interview responses correlate with those of the supervisors who were surveyed.

Section 4: Discussion

The results from the evaluation of the Harmonised Assessment Tool and the pilot have been positive. The statistical analysis of the evaluation data indicates that the Harmonised Tool was feasible, valid and an authentic assessment tool for use across the three medical schools.

Clinician and student feedback regarding the appropriateness, effectiveness and efficiency of the Harmonised Tool has revealed strong support for a consistent approach to assessment across the three universities using the Formative Assessment of Student Performance at end of Clinical Attachment (FASPCA) tool.

Overall the tool produced valid results across medical disciplines and across the three medical schools.

The statistical analysis from the student performance results from the Harmonised Tool concludes that the tool is feasible, valid and authentic for the purposes of a common assessment tool across the three medical schools.

The Harmonised Tool comprehensively covers the curriculum for all three universities and the global rating scale was valued by clinicians and students as a useful way to generate discussions within a formative framework about a student's overall readiness for internship.

The Harmonised Tool measured discipline specific criteria but was not appropriate for some aspects of the Mental Health attachment. Future pilots would require the revision of the criteria for specific disciplines; however the overall tool is a good starting point and could be customised for each discipline.

The students found the tool challenging, engaging, encouraging and worthwhile learning. Overall students responded positively to the assertion that the tool is relevant in helping them to identify their strengths and weaknesses.

The clinicians responded positively to a consistent approach for assessment across the three universities with findings from the implementation of a Harmonised Tool creating an increased level of engagement between the clinical supervisors and the UCRH Medical Education Team.

The evaluation findings indicate that the Harmonised Assessment Tool and the pilot have been positive for the clinicians and students at UCRH.

<u>Key findings</u>
The key findings from the project to inform broader implementation of the harmonised clinical assessment tool are as follows:

(i) The Harmonised Tool, the FASPCA, and the other two assessment tools developed as part of the curriculum review could be used as a template for other medical schools sharing clinical training sites to develop a harmonised approach to clinical assessment. The tool itself has been found to be robust and could be modified by other medical schools to suit their site and discipline specific requirements.

(ii) Although beyond the scope of the project, it is recommended that the Harmonised Tool be validated against standardised tools from each medical school to allow for a comparison of student results and to corroborate the effectiveness of the tool within their own curriculum. If this process was undertaken and the results found positive, it would further improve the validity and feasibility of the tool being adopted by the participating medical schools as a component of their assessment program.

(iii)To implement the Harmonised Tool at another rural training site where there are multiple medical schools sharing the same site, the processes need to draw upon the experiences from this pilot including:

- formation of a Project Committee with high level educational representation from all stakeholders;
- recruiting a 'local' Project Officer who is familiar with the pilot site and key stakeholders;
- conducting a curriculum review of the participating medical schools;
- developing a Harmonised Tool in consultation with pilot site participants;
- convening a Project Committee Workshop face to face to encourage collaboration throughout the project, and to reach consensus on a Harmonised Tool, pilot attachments, project processes and evaluation activities;
- submitting appropriate ethics applications to medical schools and area health services;
- engagement of pilot participants;
- commencing the pilot in identified attachments for set period of time;
- conducting evaluation activities to document the validity, appropriateness and effectiveness of the tool and the pilot;
- documenting results and provide feedback to pilot participants
- disseminating results via report, publication

(iv) In any future project of this type, stakeholders need to consider that in order to achieve a long term goal the pilot itself creates a short term increase in workload for the pilot site - particularly a Medical Education Team and those staff involved in curriculum delivery at the pilot site. However, a key positive finding from this project has been the level of consultation and resultant increased clinician engagement the Harmonisation Project has produced. This has been viewed as a positive outcome by UCRH. A further positive outcome of this increased collaboration has been the generation of discussions with clinicians regarding university curriculum and associated assessment.

(v) There was a high level of engagement required from senior educational academic staff from the participating medical schools and the pilot site to conduct this project. This is an important aspect for future implementations of the pilot as this ensured that all stakeholders had high level representation on the Project Committee to encourage collaboration and to ensure that stakeholder needs were met. This high level engagement helped to produce a feasible product, the Harmonised Assessment Tool and tangible outcomes for the project.

Overall, the results from the project have been positive with all stakeholders welcoming a consistent approach to clinical assessment for multiple medical schools and those students in the latter half of their medical program.

Section 5: Lessons Learnt

Throughout the pilot many lessons have been learnt and these have been summarised below:

Strengths

i) Harmonisation Project Committee support
The support from the Harmonisation Project Committee members has been exceptional and integral to the success of the pilot. With the exemplary leadership of the Chair, committee members have participated above and beyond expectations and have demonstrated their dedication in working towards achieving the project deliverables. The Project Committee provided assistance with ethics applications, assistance at the pilot site with activities to improve return rates and overall guidance regarding the strategic direction of the project.

ii) UCRH Director, Medical Education Team and staff support
The support from the UCRH Director, Medical Education Team and staff has ensured the success of project. The academic staff from the Medical Education Team and the Student Coordinators assisted extensively during the pilot phase of the project to ensure the return of completed Harmonised Assessment Tools, student surveys and clinician surveys. The support from the staff at the UCRH has been a key element to the success of the project.

iii) Project Officer be recruited from within local networks
As the project progressed it became apparent that it was essential that the Project Officer had an understanding of the UCRH and the key stakeholders for the project. This local knowledge from the Project Officer was a strength for the project. The Project Officer utilised knowledge of local networks, contacts, the UCRH medical education program and local clinicians to achieve the project deliverables. The execution of this project would have been challenging without the Project Officer having a good understanding of the pilot site and the UCRH medical education program, and existing networks at the site.

iv) Personal Approach
All aspects of the Harmonisation Project have required a personal approach. As the project progressed, it became clear that the key to achieving project deliverables was to communicate with all participants in person. By approaching participants and key stakeholders personally the project has been able to meet its deliverables efficiently and effectively.

Areas for Improvement

Upon reflection there were areas of the project that had room for improvement. These included repeated contact with the students, increasing the length of time for the pilot, having a pilot site medical academic championing the project, short term attachment challenges, inclusion of medical academic leads on the Project Committee, use of conjoint supervisors and the feasibility of using mental health attachments for the project.

i) Increased follow ups with students to promote the project
The project could have benefited from increased follow ups with medical students involved in the pilot. The Project Officer presented an overview of the project and the anticipated student requirements at student orientation sessions. It became apparent once the pilot had commenced that repeated forms of communication and follow ups were required to reinforce the value of the project and what was required from the students. It appeared that the importance of the project was lost on the students at the orientation session. For any future projects, it is recommended that there are repeated follow ups with students using a variety of forms of communication as well as utilising the orientation session to promote the project to the students.

ii) Increasing the length of time for the pilot
Unfortunately due to time and funding constraints the Harmonised Tool was only piloted for a period of nine weeks. It is suggested that future pilots be conducted over a longer timeframe to enable additional promotion to key stakeholders and to gather more data regarding the Harmonised Assessment Tool. Furthermore, during the pilot period the UCRH medical education team was understaffed which proved challenging whilst implementing a pilot in a medical

education program. The pilot required extensive involvement of a senior medical staff member and having key figures of the Medical Education Team unavailable, made contact with the key hospital clinicians difficult.

iii) Pilot site medical academic championing the project
During the project there were challenges with gaining access to the Director of Medical Education and the Clinical Sub Dean due to their fractional appointments and high clinic load. For any future project to be successful it is recommended that the project has an onsite medical academic lead willing to champion the project throughout all stages; and for this person to have regular, structured contact with the Project Officer to provide guidance and assistance particularly with engaging clinicians at the pilot site.

iv) Short Term Attachment challenges
The inclusion of short term two week attachments into this pilot was difficult to manage. The short term attachments required student briefings before attachments commenced which was difficult due to students being immersed in other attachments. The consenting of students was also required before the attachment commenced and gaining access to students for consenting purposes was challenging as students were immersed in other attachments.

All completed assessment forms and student surveys were due within a two week time frame. This proved challenging and it became apparent as the pilot continued that perhaps these short term attachments were not ideal due to the fast turnaround required to complete assessment tools. The piloting of the Harmonised Assessment Tool in short term attachments raises a further difficulty regarding the reliability of assessors given that students may not have had the same supervisor throughout attachment. This creates challenges for a supervisor to make a valid judgement about a student's performance in a short term attachment if they have not had repeated exposure to the student. The inclusion of short attachments needs to be carefully considered for future pilots.

v) Inclusion of clinical academic leads on the Project Committee
For any future pilots undertaken, a recommendation would be that the clinical academic leads from all participating medical schools are included on the Project Committee. Once the project was in the pilot phase at UCRH, the clinical leads from the universities were called upon to provide additional support. The inclusion of clinical leads located at the pilot site on the Project Committee from the outset of the project would have provided additional access to clinicians which would have been beneficial.

vi) Conjoint supervisors
Supervisors who have conjoint appointments with the UCRH are familiar with the UCRH assessment processes. Those supervisors who did not have conjoint appointments with the UCRH found completing the assessment tool difficult at times as they were unsure of what was required from them and also of what the universities required from their students. The Project Officer, the Director of Medical Education and the Clinical Sub Dean provided repeated overviews of the project and the requirements to clinicians who were unsure of the UCRH assessment processes for medicine. Although in the short term this created an increased workload, this should be viewed as a positive outcome as the project facilitated an increased dialogue between supervisors and the Medical Education Team.

vii) Mental Health Attachment
At the conclusion of the pilot it was noted that the Mental Health attachment required a different set of skills that were not captured by the criteria on the Harmonised Tool. The Mental Health attachment lacks many practical skills such as cannulation, checking blood, and ordering tests. There are also no brief consultations with the patients, writing progressive notes or prescriptions and little to no clerking. Further consideration is required regarding the inclusion of the Mental Health attachments for the purposes of harmonising assessment processes.

viii) Additional clinician workshops
As a result of the resignation of the Harmonisation Project Officer in May 2012, the project suffered a delay and the pilot timeframes were revised. The revised pilot dates left little time to promote the project to clinicians and students. The time lag from the initial clinician workshop

(April 2012) to the commencement of the pilot (July 2012) proved challenging when re-engaging the clinicians. Future pilots could ensure that additional clinician workshops are scheduled closer to the commencement of the pilot and also during the pilot to ensure that clinicians understand how to use the Harmonised Tool and also have additional information about the universities curriculum.

ix) Process improvements

Additional information gathered during clinician consent

A process improvement regarding consent could be to obtain additional information on the Consent Form such as clinician contact numbers, email addresses and postal addresses. If this information could be obtained at the time of consent it would have made for better time management toward the end of the project when it came time to interviewing the clinicians. All of the information would have been at hand rather than having to have been sourced during a stage of the project when there were multiple conflicting deadlines to be met.

Additional forms of communication use to engage students and clinicians

Initially, email was used with students and clinicians as it was an effective and quick way to distribute information about the project. Once the pilot had commenced students and clinicians did not regularly respond to or read emails regarding the project; therefore email was not an effective communication tool. A recommendation would be to consider the use of other forms of mass communication for other trials of this project such as SMS, virtual noticeboards or perhaps the use of Facebook with regular updates/wall postings.

Section 6: Recommendations

The evaluation of the pilot and the Harmonised Assessment Tool has resulted in a number of recommendations relating to the Harmonised Assessment Tool and the processes required to implement the pilot.

In considering these recommendations, it is of vital importance that the engagement of clinicians, staff and students involved in this project is viewed as a key activity for the success of the project. The implementation of a harmonised tool without the engagement of key participants would be of little value.

The recommendations are as follows:

Recommendations: Harmonised Assessment Tool

1. The Formative Assessment of Student Performance in Clinical Attachment (FASPCA) tool be recognised as an appropriate, effective and efficient instrument for assessing medical students from different medical schools in the Lismore and Ballina area.
2. The FASPCA tool be used mid-term in the attachment rather than at the end of attachment, where possible, to provide relevant and timely feedback to students for improvement in performance.
3. For any changes made to the FASPCA Tool, the Report of Curriculum Review (Tom, 2011) be used as a guide to development so that the changes can link to the common curriculum priorities of the three universities. Criteria 7 and 10 of the FASPCA tool be revised for Psychiatry/Mental Health, to closer align to the skills and experiences required of students in attachment to that discipline. Suggested criteria to be considered could come from the previously Recommended Structure 2 for Assessment of Student Performance at Clinical Attachment – Mental Health/Psychiatry, which include:

• Patient Mental Health history taking skills
• Mental state examination skills
• Differential diagnosis skills
• Risk assessment skills
• Patient management skills
• Psychological interventions skills

4. An additional box be placed on page 2 of the tool for Supervisors to record the extent of their consultation with others (e.g. Registrar) to develop relevant feedback for the student, so as to give students confidence in the accuracy and comprehensiveness of the feedback from the supervisor if they have had limited contact with that supervisor.
5. Additional information is provided to clinicians regarding at what point in a medical program a medical student is currently at, prior to the completion of the Harmonised Assessment Tool. Clinicians would benefit from more information provided to them regarding where the medical student is in a medical program (year 3, 4,5) and what are the expectations regarding student performance at this level.

Recommendations: Broader implementations/future projects

1. The FASPCA tool is a legitimate assessment instrument that could apply to clinical attachments in other settings where multiple Universities feed into the same clinical settings
2. The FASPCA tool be retested with a larger sample of students, taking into consideration that UCRH has already conducted a pilot, to allow for stronger statistical analysis of the results and examines the reliability of the instrument.
3. Student and clinician workshops are held before, during and after the project to highlight the purpose of the project, how to use the Harmonised Assessment Tool, disseminate results and to facilitate improved engagement with Medical Education Teams or staff responsible for the delivery of curriculum.

4. The FASPCA can be used as template to guide common assessment and modified according to a pilot sites context and discipline requirements.
5. Future pilots can adopt the steps outlined in the methodology for implementing the project at additional sites.
6. More flexible “just in time” guides or support for clinicians should be developed to assist with providing information to clinicians about curriculum in order to guide clinical assessment. All universities send detailed information to clinicians about their curriculum, however it has become apparent through this project, that at the point of implementation or of teaching, this information is not recalled or readily accessible.
7. The UCRH pilot has only just begun to cement the relationships formed between the three medical schools, clinicians and the UCRH Medical Education Team. Relationship building was key to the success of the pilot, with development of the tool being a mechanism to achieve this end. The recommendation would be for another iteration of the pilot to be conducted to demonstrate the strength of these collaborations and incorporating the feedback and improvements suggested by participants so that they feel valued and continue to be engaged.

Section 7: Conclusion

Overall the Harmonisation of Clinical Assessment Tools Pilot Project has achieved its aim which was to streamline assessment processes at the UCRH. In developing and piloting a Harmonised Clinical Assessment Tool, strong collaborations have been formed between the three participating medical schools and the UCRH Medical Education Team.

The pilot has increased the engagement of clinicians and students with the UCRH Medical Education Team to ensure that the project deliverables were met. The project has created an increased dialogue regarding clinical assessment and the delivery of a medical education program between medical schools, UCRH Medical Education Team, UCRH clinicians and medical students. A positive and most important lesson learnt from this project has been examining the level of collaboration required amongst stakeholders in medical education to work towards a common goal.

This project would not have been possible without the support of HWA's Clinical Supervision Support Section. Medical Deans appreciates the support and looks forward to working with HWA on future collaborations.

List of Appendices

Harmonisation of Clinical Assessment Tools Project
Project Committee Membership

Member	Representing
Professor Annemarie Hennessy (Chair)	Medical Deans University of Western Sydney
Professor Lesley Barclay	University Centre for Rural Health
Professor John Bushnell (Deputy Chair)	University of Wollongong
Associate Professor David Garne	University of Wollongong
Professor Wendy Hu	University of Western Sydney
Ms Imogene Rothnie	University of Sydney
Dr Narelle Shadbolt (Deputy Chair)	University of Sydney
Dr John Graham	University Centre for Rural Health
Ms Frances Barraclough	University Centre for Rural Health
Dr Austin Curtin	University Centre for Rural Health
Mr Hudson Birden	University Centre for Rural Health
Ms Hannah Walker	Student representative (UOW) – Northern Rivers
Ms Lara Gallur	Student representative (UWS) – Northern Rivers
Ms Harshil Sangha	Student representative (UWS) – Northern Rivers
Ms Tracey Piccoli	Medical Deans
Ms Monique Hourn	Medical Deans
Ms Catriona Wilson	Medical Deans

- Education Consultant recruited for curriculum review and execution of the evaluation plan: Dr Christine Tom

Harmonisation of Clinical Assessment Project Committee
Terms of Reference

Role:

Oversight of the development, implementation and evaluation of a pilot project: Harmonisation of Clinical Assessment Tools being undertaken by Medical Deans Australia and New Zealand (Medical Deans) and funded by Health Workforce Australia (HWA). The pilot project involves medical students from Sydney University, University of Wollongong and University of Western Sydney; it is being conducted at Lismore Base Hospital in conjunction with the University Centre for Rural Health (UCRH), Lismore, NSW.

Responsibilities and Activities:
The Committee will provide strategic advice and support to the project, and ensure the broad action and progress toward meeting the project deliverables is appropriate and timely.

Activities will include, but not necessarily be limited to:

1. Providing advice on the project activities including the development of the clinical assessment tool, guidance on ethics approval processes, timelines and procedures for the pilot and the overall evaluation process.
2. Providing expert advice and opinion to the project team on medical education issues relevant to the project.
3. Providing advice on communication and consultation strategies with stakeholder groups.
4. Advocating for the project through professional channels.

Membership:

• Professor Annemarie Hennessy (Chair)	University of Western Sydney
• Professor Lesley Barclay	University Centre for Rural Health
• Professor John Bushnell	University of Wollongong
• A/Prof David Garne	University of Wollongong
• Professor Wendy Hu	University of Western Sydney
• Ms Imogene Rothnie	Sydney University
• Dr Narelle Shadbolt	Sydney University
• Ms Lara Gallur	Student Representative – University of Western Sydney
• Ms Hashil Sangha	Student Representative – University of Western Sydney
• Ms Hannah Walker	Student Representative – University of Wollongong
• Dr John Graham	University Centre for Rural Health
• Dr Austin Curtin	University Centre for Rural Health
• Ms Frances Barraclough	University Centre for Rural Health
• Ms Monique Hourn	Medical Deans
• Ms Tracey Piccoli (Project Officer)	Medical Deans
• Ms Catriona Wilson (Project Officer)	Medical Deans

Frequency of meetings

The Committee shall meet on a regular basis at monthly intervals, via teleconference for approximately I hour for the duration of the project.

Medical Deans AUSTRALIA AND NEW ZEALAND | University of Western Sydney | UNIVERSITY OF WOLLONGONG | THE UNIVERSITY OF SYDNEY

Formative Assessment of Student Performance in Clinical Attachment

STUDENT ID								

ATTACHMENT e.g. MENTAL HEALTH

STUDENT NAME: ……...

SUPERVISOR NAME: …….

CLINICAL ATTACHMENT LOCATION: …….

DATES OF ATTACHMENT: ..... to.....

Please **TICK** the **ONE** box that is appropriate to the student's level of performance.

NA = Not Assessed **NS =** Not Satisfactory Performance **BP =** Borderline Performance
SP = Satisfactory Performance **GP =** Good Performance **EP =** Excellent Performance

	FOR DESCRIPTIONS OF CRITERIA SEE HANDBOOK	NA	NS	BP	SP	GP	EP
1.	Depth, breadth and application of knowledge and understanding of disease mechanisms						
2.	Patient History taking skills						
3.	Examination skills -– including discipline specific skills e.g. Mental state examination						
4.	Problem formulation skills: e.g. synthesis of biological, psychological and social aspects and their interaction						
5	Prioritization skills: e.g. urgency, risk assessment						
6.	Treatment planning and patient management skills -– including discipline specific skills e.g. psychological intervention skills						
7.	Performance of technical and practical procedures						
8.	Communication skills e.g. with patients and their relatives, colleagues and teams						
9.	Respect towards patients and their families *(Demonstrates sensitivity, responsibility, respect and discretion with patients from all demographic backgrounds)*						
10.	Patient safety requirements - e.g. Record keeping, Discharge letters, medication charting and prescriptions						
11.	Interpersonal relationships and teamwork on ward						
12.	Prioritising, punctuality, preparedness *(Demonstrates ability to set priorities and meet deadlines including punctual attendance, adequate preparedness and intellectual contribution to learning and teaching sessions)*						
13.	Strategic in learning and teaching *(Demonstrates ability to plan and achieve goals in timely manner. Evaluates performance against expected outcomes)*						

<u>OVERALL PROGRESS</u> at this stage of the medical program. **On the continuum in the right hand box, please indicate where the student's performance is in relation to – READINESS TO PRACTISE SAFELY AND WELL.**	Not Ready ——————————————— Very Ready

ATTENDANCE: **Unsatisfactory O** **Satisfactory O**

Formative Assessment of Student Performance in Clinical Attachment

STUDENT SELF-ASSESSMENT: (Please complete before meeting with your supervisor.)

1. What did you do well on this attachment?

   .....

   .....

   .....

2. What do you need to improve?

   .....

   .....

   .....

3. What strategies will you use to improve in these areas?

   .....

   .....

   .....

SUPERVISOR COMMENTS: (Please complete and discuss with your student.)

1. What did the student do well?

   .....

   .....

   .....

2. Which areas need improving?

   .....

   .....

   .....

3. Suggested strategies for improvement:

   .....

   .....

   .....

SUPERVISOR NAME: **STUDENT SIGNATURE:**

SUPERVISOR SIGNATURE: **SUPERVISOR POSITION:**

DATE:

SUMMARY OF PILOT ATTACHMENTS
16 JULY TO 14 SEPTEMBER, 2012

	Jul	Jul	Jul	Aug	Aug	Aug	Aug	Sep	Sep
Emergency	**16**	**23**	**30**	**6**	**13**	**20**	**27**	**3**	**10**
Ballina	University 1								
	University 1								
Lismore		University 3		University 3		University 3		University 3	
General Medicine Lismore		University 3							
	University 1								
	University 15								
	University 2				University 2				
	University 2								
					University 2				
	University 2				University 2				
						University 3			
Surgery Lismore		University 3		University 3		University 3		University 3	
					University 1				
	University 2								
	University 2								
	University 2								
		University 3							
	University 2								
		University 3		University 3		University 3		University 3	
	University 2								
	University 2					University 3			
Mental Health Lismore		University 3							
		University 3							
		University 3							
		University 3							
	University 2								
	University 2								
	University 2								
	University 2								
	University 1								

Evaluation of the Medical Deans' Harmonisation of Clinical Assessment Tools Project - 2012

SURVEY OF STUDENTS

Instructions: Please indicate the following details:

NAME		ID	
UNIVERSITY		LOCATION	

Your name and ID will be removed from this survey form before analysis so that your responses remain anonymous.

Please place a tick (√) in the relevant box to rate your level of agreement with each of the statements. Your response should best tell how you feel about the Harmonisation Assessment tools.

THESE ARE THE RESPONSE CATEGORIES:

- Strongly Agree
- Agree
- Disagree
- Strongly disagree
- Don't know

Item number	Item statements	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DON'T KNOW
1.	The criteria of the Harmonised Assessment tool reflect the outcomes expected of me at end of this attachment					
2.	The Harmonised Assessment criteria accommodate the discipline specific skills required of the me at end of attachment					
3.	The criteria reflect the expected performance required of the me at end of attachment					
4.	The criteria assess the 'work-based', clinical experiences required by this discipline					
5.	The Harmonised Assessment form assists me in making judgments about my performance on this attachment					
6.	The Harmonised Assessment tool provides opportunity for me to share my self-evaluation with my supervisor					
7.	The Harmonised Assessment tool is relevant in providing feedback on my performance in attachment					

Item number	Item statements	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DON'T KNOW
8.	The Harmonised Assessment tool provides information that encourages me to progress my learning					
9.	The Harmonised Assessment tool is useful for formative assessment purposes					
10.	The Harmonised Assessment tool allows me to identify my strengths demonstrated in this attachment					
11.	The Harmonised Assessment tool allows me to note the areas I need to further develop in this discipline					
12.	The Harmonised Assessment can be completed in a timely way					
13.	The Harmonised Assessment tool requires a specialised space/venue for completion					
14.	The Harmonised Assessment tool's 5 point rating scale allows me to understand my level of performance against each criterion					
15.	The Global rating is appropriate in that it allows the Supervisor/Assessor to record my readiness for practice as an Intern at the end of attachment					

In using the Harmonised Assessment tool, what works well for you?

What areas need improvement to the Harmonised Assessment tool?

Thank You.

Evaluation of the Medical Deans' Harmonisation of Clinical Assessment Tools Project - 2012

SURVEY OF SUPERVISORS/ASSESSORS

Instructions: Please provide the following details:

NAME		LOCATION	
POSITION		ROTATION	

Your name will be removed from this survey form before analysis so that your responses remain anonymous.

Please place a tick (√) in the relevant box to rate your level of agreement with each of the statements. Your response should best tell how you feel about the Harmonisation Assessment tools.

THESE ARE THE RESPONSE CATEGORIES:

- Strongly Agree
- Agree
- Disagree
- Strongly disagree
- Don't know

Item number	Item statements	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DON'T KNOW
1.	The criteria of the Harmonised Assessment tool reflect the outcomes expected of students at the end of attachment					
2.	The criteria accommodate the discipline specific skills required of the student at end of attachment					
3.	I could identify how the specific skills required of my discipline aligned to the criteria					
4.	The Harmonised Assessment form assists me in making decisions about a student's performance in this attachment					
5.	The Harmonised Assessment tool provides opportunity for the student to share self-evaluation comments with me					
6.	The Harmonised Assessment tool works well as an assessment tool for providing feedback on the student's performance in this attachment					

Item number	Item statements	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	DON'T KNOW
7.	The criteria reflect the expected performance required of the student at end of attachment					
8.	The criteria address the 'work-based', clinical experiences required of this attachment					
9.	The criteria provide information on the standard of student learning required at end of attachment					
10.	The essential clinical learning experiences are assessable against the criteria					
11.	The assessment can be completed in a timely manner					
12.	The Harmonised Assessment tool requires minimal resources to implement					
13.	The Harmonised Assessment tool allows for input from the relevant clinical personnel involved in the attachment					
14.	The Harmonised Assessment tool becomes more effective if the Supervisor consults with others to rate the student at end of attachment					
15.	The Harmonised Assessment tool requires a specialised venue/space for its completion at end of attachment					
16.	The Harmonised Assessment tool allows for the most important aspects of the specific discipline to be assessed					
17.	The Harmonised Assessment tool 5 point rating scale allows students to clearly demonstrate their level of performance against the criteria					
18.	The Global rating is appropriate in that it allows the Supervisor/Assessor to record the student's progress towards readiness to practice as an intern					

Please identify areas needed for improvement to the Harmonised Assessment tool:

How can these improvements be made?

Evaluation of Harmonisation Assessment Tools.

Semi - Structured Interview - Clinicians from other Disciplines.

1. The purpose of the Harmonisation Assessment tool is to provide a consistent approach to assessment of student performance at this attachment, across all medical schools. How well does this tool achieve this purpose?
2. Did you trial this tool with students from the three medical schools? Were there any significant differences between the schools that impacted on your judgments?
3. Does the Harmonisation Assessment form focus on the most important aspects of your discipline? Anything missing?
4. How well do the criteria of the Harmonisation Assessment tool assess the outcomes expected of students at the end of attachment?
5. How well do the criteria relate to your specific discipline?
6. How well would the Harmonisation Assessment tool work as a formative assessment of students in your attachment?
7. How well does the tool work in providing you with an opportunity to interact with students for formative feedback and discussion?
8. What aspects of the Harmonisation assessment tool are workable and acceptable to your discipline?
9. How well does the assessment tool report on what the student knows and can do in the attachment?
10. How much time would it take for you to complete the assessment form? Is that feasible?
11. What resources (human, material, time, space) would you require to complete the assessment?
12. Who might you consult with to develop comprehensive and accurate feedback to the student?
13. How effective is the 5 point rating scale for reporting on student performance against criteria? What do you like about this scale? What do you dislike?
14. How well do the descriptors of the standard for each criterion assist you in the assessment process?
15. Is the Global rating as a continuum an effective way to give students an idea of 'where they are at'?
16. Should the continuum be anchored by the 'Readiness to practice safely and well' concept?
17. What works well in the Harmonisation Assessment tool? What areas need improvement?