Educational Supervisor's Report

This is the sine qua non of an ARCP. It is predictable that many Educational Supervisors will go on annual leave in the summer and the lack of a report for this reason is unacceptable. CT2s should ensure that they arrange an appointment for a report with their ES in April, 2017 and CT1s should do so in May, 2017.

If your Educational supervisor is unavailable to issue a report in a timely fashion, you should ask your RCP Tutor for help. Avoidable last minute requests are unlikely to be greeted with favour.

An Educational meeting form or an end of attachment appraisal form contains different information from an ES report form and is inadequate for this purpose. However, educational meetings with ESs should be held every two months to record progress.

If the ES report is left in draft form by the ES, it cannot be seen by the ARCP panel and causes an outcome 5 ARCP.

Trainees should expect a candid ES report. The ARCP panel does not expect to issue unsatisfactory ARCPs to trainees rated as "above" or "well above" expectation by their ES, and MRCP completion should be congruent with the overall ES conclusion i.e. a trainee who has not passed part 1 during CT1 or full MRCP by the end of CT2 should not be rated as "above" or "well above" expectation.

Multiple Consultant Reports (MCRs)

At least four MCRs from different Clinical Supervisors should be commissioned each year. They can be spread throughout the year but must be on the e-portfolio by one month before the ARCP.

Insufficient MCRs cause an outcome 5 ARCP.

MRCP

Please upload your certificates to the examination section of the curriculum page, so that they can be ratified by your ES.

They are now automatically loaded to the RCP examination section of the profile section. The targets are clearly shown on the Decision Aid.

ALS

You must have a valid ALS certificate. You can use it as evidence on the curriculum page for the four emergency presentations, for CPR in essential procedures (A) and for DC cardioversion in essential procedures (B). It must be renewed before the expiry date. If you have difficulty in booking yourself on to a refresher course, you must seek help from your RCP Tutor, so that you are given priority. You should not be working on a cardiac arrest team without this document.

Supervised learning events (SLEs); mini-CEX, CbDs, ACATs

You must acquire at least 10 SLEs per year (including at least 4 ACATs), completed by consultants. You can arrange other SLEs with other medical staff but only the *consultant-based forms* will be counted. It is important that the consultant assessor inserts his/her grade on the form accurately as a consultant. Many forms completed this year by consultants showed "doctor more senior than F2" or "other", making the provenance of the form difficult to discern for ARCP panels, who will not know all the medical staff in your hospital.

An ACAT must list at least five patients assessed during the "take".

Multi-source Feedback (MsF)

This is a different form from the MCR and covers different information.

There must be at least 12 responses, including three consultants but it should include other medical staff, nursing staff, other health professionals and administrative staff. It is not satisfactory to obtain 12 MsFs from doctors.

It is best to commission 20 MsFs to improve the chance of obtaining 12 responses. If one block of MsFs in a three month period does not achieve the minimum number, another MsF must be requested, even if the two blocks are separate on that section of the e-portfolio. The ARCP panel is happy to aggregate the blocks.

Quality Improvement Projects (QIP)

The ARCP panel will be rigorous in assessing your QIP. This is different from audit and should be completed in a short time. The QI project plan for the year should be entered on the assessment section of the e-portfolio in the autumn and a QI report entered on completion of the project. This then leads to a QIPAT report by your Educational Supervisor.

The ARCP panel will expect to see all these forms. Incomplete projects will be rejected by the ARCP panel and lead to an unsatisfactory ARCP outcome.

Details about QI methodology can be found on the JRCPTB website, which should be consulted early in the academic year. Please consult your ES or RCP Tutor for advice.

All QI projects should be submitted to the Regional QI presentation day, held in early June.

Common Competences

There are 25 domains, but only 15 require evidence from SLEs or reflections (at least 5 in CT1 and 10 by the end of CT2).

This section must then be ratified by the trainee and the ES as either CT1- or CT2-achieved by the end of each year of CMT.

This requires only one ratification of the title section, rather than up to 25 separate ratifications of each domain, saving considerable time.

Emergency Presentations

These four domains must be completed by the end of CT1, with evidence from SLEs and ratified en bloc as CT1-CMT achieved by trainee and ES. One group ratification is sufficient, but all four domains must show evidence. Ratification as “some experience” is inadequate at the end of CT1.

It is unlikely that trainees will manage a case of anaphylaxis and the other forms of evidence will satisfy the requirement.

Top Presentations

Evidence from SLEs and reflective practice should be added to at least 11 domains during CT1 and to all 22 by the end of CT2, allowing a single group ratification by trainee and ES, as CT1- or CT2-achieved.

Other Presentations

Evidence from SLEs and reflective practice should be added to at least 15 of the 39 domains during CT1 and to at least 30 by the end of CT2, allowing a single group ratification by trainee and ES, as CT1- or CT2-achieved.

General Points

Do not use MRCP certificates as evidence on the common, emergency, top or other presentation domains.

Each mini-CEX and CbD should only be linked to two topics and each ACAT to no more than eight topics on the curriculum page. Over-linkage will be obvious to the ARCP panel, if curriculum domains show large amounts of evidence in relation to the number of SLEs.

Essential Procedures

You should register on a skills lab training course during CT1, in order to achieve the minimum evidence for essential procedures (A) and use your ALS certificate as evidence of training in advanced CPR. Formative DOPS showing ability under supervision can also be used for this section during CT1.

During CT2, you must link evidence from *summative* DOPS to show participation in the cardiac arrest team, and independent performance of ascitic tap, lumbar puncture and naso-gastric tube insertion. These summative DOPS forms should show independence to perform the task and be passed. Formative DOPS forms will not suffice during CT2, but can be performed before moving to the mandatory number of summative DOPS. There should not be any inconsistency in the information on the summative DOPS form i.e. a summative DOPS should not show "passed" if supervision is needed.

You must link new DOPS during CMT, even if you have performed these tasks during Foundation Training, in order to show continuing competence.

Essential Procedures

DOPS can be completed by anyone competent to do the procedure and to assess its performance and this does not necessarily have to be a doctor.

Pleural aspiration requires *two separate summative DOPS* to show independence to perform the procedure, apart from the ultrasound, which usually requires assistance from another practitioner. These must show that the DOPS have been passed and that the trainee is independent. The free text part of the DOPS form can be used to state any assistance with ultrasound.

Essential procedures (B) require linked evidence of skills lab training or supervised formative DOPS by the end of CT2. Two summative DOPS are needed to show independence for CVP insertion and chest drain insertion and are desirable but not mandatory. Link ALS certificate to the DC cardioversion domain, by the end of CT2, as a minimum requirement.

Some Trusts have specialist teams to perform pleural aspiration and ascitic tap and you will need to liaise with such teams to attain these skills in those hospitals. This should be done in good time before the ARCP.

Clinics

The ARCP Decision Aid has not been changed this year, but the wording is unclear, regarding the need for at least 24 or at least 40 separate clinic attendances by the end of CT2. HEEoE regards 24 as being mandatory and 40 as being desirable. At some unknown time, the target will rise to 40 by the end of CT2. It is important not to fall behind with achieving clinic attendance. Attendance for half a clinic session is sufficient, and patients should be seen independently and then discussed with a consultant. Trainees should dictate the letter to the referring doctor. CbDs can be performed for clinic consultations but are not essential for every patient.

The ARCP panel will need to see a dated list of clinic attendances (from clinic 1 to at least 24), on a dedicated spreadsheet (Excel template logbook,) in the personal library of the profile section of the e-portfolio. This needs to be clearly displayed and is easier for ARCP panels than using the reflective practice section, where other material is stored, making it difficult to count the number of clinics.

Teaching

Log your teaching episodes on a spreadsheet in the personal library, to allow your ES to ratify it in the ES report. At least 100 hours of teaching should be recorded annually e.g. Grand Round; Departmental Teaching; Regional CMT Teaching, MRCP teaching, Simulation Teaching.

General Points

HEEoE requires and will request a form R to be completed and submitted before each ARCP, as a requirement for appraisal and revalidation. The HEEoE Postgraduate Dean is the Responsible Officer for the latter duty.

General Points

All CT1s must register for and attend a day of clinical simulation training in one of the Regional Centres. Details can be found on the HEEoE website. These courses are highly regarded by all participants.

General Points

Three CMT Regional Training Days are held each year and you should attend at least three of the six held during CMT.