Core Medical Training (CMT) ARCP Decision Aid – AUGUST 2017

The CMT ARCP decision aid documents the targets to be achieved for a satisfactory ARCP outcome at the end of each training level. This document replaces all previous versions from **August 2017**. Please see guidance notes below.

Evidence of engagement with curricular competencies

- Evidence should include supervised learning events (SLEs) and workplace based assessments (WPBAs), personal development plans (PDPs), reflective practice, quality improvement projects, e-learning and feedback on teaching delivered. It is suggested that the evidence for emergency and top presentations should include a supervised learning event (SLE). An ACAT is evidence of management of a group of acute patients but not the management of the individual cases.
- Trainees should link evidence and record a self-rating with comments for the curriculum competencies covered
- Supervisors should sample approximately 10% of these competencies and record their supervisor ratings with explanatory comments for each one sampled (additional evidence and/or sampling may be required if there are concerns)
- Sampling will not apply to (1) emergency presentations as the supervisor must check that evidence is recorded for each presentation and CMT level has been achieved for all emergency presentations by the end of CT1 and (2) practical procedures which require individual sign off
- Educational supervisors (ES) should record ratings at group competency level (with the exception of procedures) as indicated in the ARCP decision aid. This will normally be done as part of the review of the ePortfolio in order to complete the ES report
- Procedures should be assessed using DOPS as detailed in the procedures section of this decision aid. Please refer to the relevant footnotes
- Please refer to the JRCPTB recommendations for specialty trainee assessment and review for more detailed guidance on linking and sampling of evidence.

Clinic activity

Trainees who start CT1 in August 2017 must attend a minimum of 40 outpatient clinics by completion of CMT, in line with the JRCPTB quality criteria for CMT. For trainees who started CT1 in August 2016 or before the minimum requirement is 24 clinics by end of CT2. The educational objectives of attending clinics are to understand the management of chronic diseases; be able to assess a patient in a defined time-frame; to interpret and act on the referral letter to clinic; to propose an investigation and management plan in a setting different from the acute medical situation; to review and amend existing investigation plans; to write an acceptable letter back to the referrer and to communicate with the patient and where necessary relatives and other health care professionals. These objectives can be achieved in a variety of settings, including less traditional clinic models (a procedure list should not be considered as clinic attendance). Trainees should see at least some patients on their own but all patients should be reviewed with a consultant. Clinic letters written by the trainee should also be reviewed and feedback given. The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be two or more hours. Clinic experience should be used as an opportunity to undertake SLEs and reflection.

Organisations must ensure learners have an appropriate level of clinical supervision at all times by an experienced and competent supervisor, who can advise or attend as need (see COPMeD guidance for more information on appropriate supervision in outpatient clinics).

Clinic activity should be recorded using the summary of clinical activities and teaching attendance form available on the ePortfolio in the assessment section (or locally agreed equivalent). A template logbook for recording outpatient clinics and procedures is available on the JRCPTB CMT page and should be uploaded to the ePortfolio.

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Curriculum domain		CMT year 1	CMT year 2	Comments
Educational Supervisor (ES) report		Satisfactory with no concerns	Satisfactory with no concerns	To cover the whole training year since last ARCP (up to the date of the current ARCP)
Multiple Consultant Report (MCR)	Minimum number Each MCR is completed by one clinical supervisor	4	4	The range of MCRs should reflect all aspects of work, eg specialty and on-call. Feedback collated in end of year summary report. Any actions to be recorded in ES report
MRCP (UK)[1]		Part 1 passed	MRCP(UK) passed	Exam results will be uploaded to the ePortfolio automatically
ALS		Valid	Valid	Must be valid throughout CMT
Supervised Leaning Events (SLEs): ACAT CbD Mini-CEX	Minimum number to be carried out by consultants	10 To include at least 4 ACATs (each ACAT to include a minimum of 5 cases)	10 To include at least 4 ACATs (each ACAT to include a minimum of 5 cases)	SLEs should be performed proportionately throughout each training year by a number of different assessors to cover the breadth of the curriculum. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee.
Multi-source feedback (MSF)[2]	Minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical) for a valid MSF	1	1	Replies should be received within 3 months (ideally within the same placement). MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF

[1] Failure to achieve MRCP(UK) Part 1 by the end of CT1 should lead to an ARCP 2 outcome if other aspects of training are satisfactory. Failure to achieve MRCP(UK) after 24 months in CMT will normally result in an outcome 3 if all other aspects of progress are satisfactory

[2] Health Education West Midlands use Team Assessment of Behaviour (TAB) as a multisource feedback tool. West Midlands trainees should refer to local guidance for requirements

Quality improvement project		1	1	Quality improvement project plan and report to be completed. To be assess using the quality improvement project tool (QIPAT)
Common Competencies	Ten of these competencies do not require linked evidence unless concerns are identified[3]	ES to confirm CT1 level completed and evidence attached for at least 5 competencies	ES to confirm CMT level completed evidence attached for at least 10 competencies	Group sign off acceptable Progress to be determined by sampling trainee's evidence and self-ratings. ES should record a rating at the group competency level and provide justification for this rating in the comments section
Emergency Presentations	Cardio-respiratory arrest	Confirmation by educational supervisor that evidence recorded and CMT level achieved		Individual sign off required Mini-CEXs, CbDs and ACATs should be used to demonstrate engagement and learning. ES to confirm CMT level completed by the end of CT1 and record outcome in the ES report
	Shocked patient	Confirmation by educational supervisor that evidence recorded and CMT level achieved		
	Unconscious patient	Confirmation by educational supervisor that evidence recorded and CMT level achieved		
	Anaphylaxis / severe Drug reaction	Confirmation by educational supervisor that evidence recorded and CMT level achieved (after discussion of management if no clinical cases encountered)		

[3] Refer to JRCPTB recommendations for specialty trainee assessment and review for further details

Top Presentations		ES to confirm that evidence is recorded for at least 11 presentations	ES to confirm completed all with evidence for all presentations	Group sign off acceptable Mini-CEXs, CbDs and ACATs should be used to demonstrate engagement and learning. Progress to be determined by sampling trainee's evidence and self-ratings. ES should record a rating at the group competency level and provide justification for this rating in the comments section
Other Important Presentations		ES to confirm that evidence is recorded for at least 15 presentations	ES to confirm evidence for at least 30 presentations	Progress to be determined by sampling trainee's evidence and self-ratings. ES should record a rating at the group competency level and provide justification for this rating in the comments section
Clinics	See guidance above for definition of clinics and recording of attendance in ePortfolio	Satisfactory performance in 20 outpatient clinics by completion of CT1	Satisfactory performance in 40 outpatient clinics by completion of CMT[4]	Mini CEX / CbD to be used to give structured feedback. Patient survey and reflective practice recommended. Summary of clinical activity recorded on ePortfolio
Overall teaching attendance	To be specified at induction (eg grand rounds, local and regional CMT teaching and simulation training)	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Summary of teaching attendance to be recorded on ePortfolio (Audit and Teaching section)

[4] Trainees starting CT2 in August 2017 or before may not have had the opportunity to attend 40 clinics by the end of CMT and a minimum of 24 clinics can be accepted

Category	Procedure	CMT year 1	CMT year 2	Comments
Essential CMT procedures Part A: clinical independence essential [5]	Advanced CPR (may include external pacing) (R)	Skills lab training completed or satisfactory supervised practice	Clinically independent	DOPS to be carried out for each procedure. Formative DOPS should be undertaken before summative DOPS as many times as needed. Summative DOPS sign off for routine procedures *(R)* to be undertaken on one occasion with one assessor Summative DOPS sign off for potentially life threatening procedures (*PLT*) to be undertaken on at least two occasions with two different assessors (one assessor per occasion) if clinical independence required Foundation procedural skills must be maintained A logbook of procedures should be maintained[6]
	Ascitic tap (R)	Skills lab training completed (or satisfactory supervised practice)	Clinically independent	
	Lumbar puncture (R)	Skills lab training completed (or satisfactory supervised practice)	Clinically independent	
	Nasogastric tube placement/checking (R)	Skills lab training completed (or satisfactory supervised practice)	Clinically independent	
	Pleural aspiration for pneumothorax **or** pleural fluid (PLT)[7]	Skills lab training completed or satisfactory supervised practice	Clinically independent	
Essential CMT procedures Part B: clinical independence desirable[5]	Central venous cannulation by internal jugular, subclavian or femoral approach, with support for U/S guidance (PLT)		Skills lab training completed or satisfactory supervised practice. Two summative DOPS are required for clinical independence (with support for U/S guidance)	
	Intercostal drain insertion for pneumothorax **or** pleural fluid (PLT) [7]		Skills lab training completed or satisfactory supervised practice. Two summative DOPS are required for clinical independence	
	DC cardioversion (R)		Skills lab training completed as a minimum. Summative DOPS required for clinical independence	

[5] Clinically independent is defined as competent to perform the procedure unsupervised, recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties where appropriate. Support for ultrasound guidance is required from another trained professional where indicated. Two summative DOPS by two different assessors are required for life threatening procedures

[6] Excel template logbook is available on the JRCPTB website (www.jrcptb.org.uk)

[7] Pleural procedures should be undertaken in line with British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended, except for large effusions. Ultrasound guidance should be provided by a pleural-trained ultrasound practitioner