General Internal Medicine (GIM) ARCP Decision Aid – AUGUST 2017

The 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.

- Each stage of training equates to 12 months for trainees on a single CCT GIM programme. Most trainees are on dual CCT programmes and there is variability when GIM experience is gained. It is recommended that the targets for the stages of training should be used as a guide for the ARCP at the end of each training year. Discretion can be used before the final CCT if the educational supervisor indicates to the ARCP panel that overall progress is satisfactory.

- 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).

- A summary of clinical activities and teaching attendance should be recorded using the form available in the assessment section of the ePortfolio. A calculator is available on the GIM specialty webpage to allow trainees to calculate their acute medical take and outpatient (or outpatient-equivalent) experience for GIM and this should be updated before each ARCP. A template is available for recording a logbook of procedures and outpatient clinics.

- Procedures should be assessed using DOPS. Please refer to procedures section and footnotes for further guidance.

- Trainees should record a self-rating with commentary 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 does not apply to emergency presentations or procedures which should be signed off individually.

- The educational supervisor (ES) should record ratings at group level (eg other important presentations) 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.

- An ES report covering the whole training year is required before the ARCP. The ES will receive feedback on a trainee's clinical performance from other clinicians via the multiple consultant report (MCR). The ES report should bring to the attention of the panel events that are causing concern e.g. patient safety issues, professional behaviour issues, poor performance in work-place based assessments, poor MSF report and issues reported by other clinicians. It is expected that serious events would trigger a deanery review even if an ARCP was not due. To be used for assessment of GIM training, it is essential that the educational supervisor's report makes specific and detailed comment about GIM training and progress (in some instances reports may be required from two supervisors, one commenting on specialty and one on GIM).

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Curriculum domain		GIM stage 1	GIM stage 2	CCT	Comments
Educational Supervisor (ES) report	Overall report	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	To cover training year since last ARCP
	Management and leadership	Demonstrate acquisition of leadership skills in supervising the work of foundation and core medical trainees during the acute medical take	Demonstrate implementation of evidence based medicine whenever possible with the use of common guidelines Demonstrate good practice in team working and contributing to multi-disciplinary teams	Able to supervise and lead a complete medical take of at least 20 patients including management of complex patients both as emergencies and in patients Able to supervise more junior trainees and to liaise with other specialties Awareness and implementation of local clinical governance policies and involvement in a local management role within directorates, as an observer or trainee representative	
Multiple Consultant Report (MCR)	Each MCR to be completed by one clinical supervisor	4-6	4-6	4-6	Feedback collated in year-end summary report. Must include feedback on GIM training to be valid
GIM Audit or GIM Quality improvement projects				Need to have led one before CCT	Quality improvement project assessment tool (QIPAT) or Audit Assessment (AA) to be completed
ALS		Valid	Valid	Valid	Must be kept valid throughout training

Curriculum domain		GIM stage 1	GIM stage 2	CCT	Comments
Supervised Leaning Events (SLEs) ACATs CbDs mini CEX	Minimum number of consultant SLEs Cumulative totals to be used when a GIM training spans more than 1 training year	10 To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	10 To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	10 SLEs To include at least 6 ACATs (each ACAT to include a minimum of 5 cases)	SLEs to be performed proportionately throughout training year by a number of different assessors across the breadth of the curriculum
Multi-source feedback (MSF) [1]	Minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical) for a valid MSF. Replies should be received within 3 months	1	1		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
Common Competencies	Ten do not require linked evidence unless concerns are identified [2]	ES to confirm evidence attached for at least 4 competencies and stage 1 level completed *(see guidance notes on levels of training)*	ES to confirm evidence attached for at least 8 competencies and stage 2 level completed	ES to confirm evidence attached for at least 12 competencies and CCT level completed	Progress to be determined by sampling trainee's evidence and self-ratings. ES should record rating at group competency level and provide justification

[1] 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
[2] Refer to JRCPTB recommendations for specialty trainee assessment and review for further details

Curriculum domain		GIM stage 1	GIM stage 2	CCT	Comments
Emergency Presentations	Cardio-respiratory arrest	Confirmation by educational supervisor that evidence recorded and GIM level achieved			ACATs, mini-CEXs and CbDs should be used to demonstrate engagement and learning. ES to confirm level completed by the end of stage 1 and record outcome in the ES report
	Shocked patient	Confirmation by educational supervisor that evidence recorded and GIM level achieved			
	Unconscious patient	Confirmation by educational supervisor that evidence recorded and GIM level achieved			
	Anaphylaxis / severe adverse drug reaction	Confirmation by educational supervisor that evidence recorded and GIM level achieved (after discussion of management if no clinical cases encountered)			
Top Presentations		ES to confirm that stage 1 level completed and evidence is recorded for at least 11 presentations	ES to confirm stage 2 level completed with evidence for all presentations	ES to confirm that CCT level completed and evidence is recorded	Progress to be determined by sampling trainee's evidence and self-ratings. ES to record rating at group level with justification
Other Important Presentations		ES to confirm that stage 1 level completed and evidence is recorded	ES to confirm that stage 2 level completed and evidence is recorded	ES to confirm that CCT level completed and evidence is recorded	Progress to be determined by sampling trainee's evidence and self-ratings. ES should record rating at group level with justification

Curriculum domain		GIM stage 1	GIM stage 2	CCT	Comments
Clinical activity	Acute Take			1000 patients seen before CCT	Mini CEX / CbD to be used to give structured feedback. Patient survey and reflective practice recommended. Summary of clinical activity recorded on ePortfolio [3]
	Clinics (or equivalents)			186 performed before CCT	
Teaching	To be specified at induction	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance. 1 Teaching Observation before CCT	Summary of teaching attendance to be recorded on ePortfolio
	External GIM			100 hours before CCT	Includes regional teaching days

Procedure	GIM stage 1	GIM stage 2	CCT	Comments
DC cardioversion (R)	Clinically independent			DOPS to be carried out for each procedure. Formative DOPS should be undertaken before summative DOPS and can be undertaken as many times as needed Summative DOPS sign off for routine procedures *(R)* to be undertaken on one occasion with one assessor
Knee aspiration (R)	Clinically independent			
Abdominal paracentesis (PLT)	Clinically independent			
Central venous cannulation by internal jugular, subclavian or femoral approach (support for U/S guidance may be provided by another trained professional)(PLT)[6]	Skills lab training completed or satisfactory supervised practice	Skills lab training completed or satisfactory supervised practice	Skills lab training completed or satisfactory supervised practice	

[3] The Specialist Advisory Committees for General Internal Medicine and Geriatric Medicine have agreed that there is equivalent outpatient experience for trainees undertaking a dual CCT in GIM and Geriatric Medicine only

[6] Obtaining clinical independence in these procedures is desirable but not mandatory

Procedure	GIM stage 1	GIM stage 2	CCT	Comments
Intercostal drainage (1) pneumothorax insertion (PLT)[67]	Skills lab training completed or satisfactory supervised practice	Skills lab training completed or satisfactory supervised practice	Skills lab training completed or satisfactory supervised practice	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[4] CMT procedural skills must be maintained[5]
Intercostal drainage (2) pleural effusion (support for U/S guidance may be provided by another trained professional) (PLT)[67]	Skills lab training completed or satisfactory supervised practice	Skills lab training completed or satisfactory supervised practice	Skills lab training completed or satisfactory supervised practice	

[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

[4] 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 may be provided by another trained professional where indicated. Two summative DOPS by two different assessors are required for life threatening procedures

[5] If a doctor has been signed off as competent in a procedure during CMT or GIM stage 1, then provided they continue to carry out that procedure it should not require further testing