e-Portfolio, Supervision & ARCP

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CMT Induction 2018

Plan

- A brief guide to the e-portfolio
- Clinical and Educational Supervision
- The ARCP
- Internal Medicine (IM-1) and CT2 rotations

Remember!

- Signing up for JRCPTB and e-portfolio
  - Compulsory
  - £338
  - Via the JRCPTB website
  - Trainee Self-Administration from July 2018 – allows trainee to add and edit all rotations within your training programme and update supervisors
  - Any questions, ask Cath Smith (CMT administrator)

Supervision

- Educational Supervisor
  - Same for the year
  - Appraisals for 1st rotation (& end of placements)
  - ESR to cover year for ARCP
- Clinical Supervisors
  - Change with each rotation
  - Appraisals for beginning of other rotations
  - MCRs

e-Portfolio – trainee homepage

https://www.jrcptb.org.uk/eportfolio-information/accessing-eportfolio Copy and paste to Google Chrome

- Profile
- Curriculum
- Assessment
- Reflection
- Appraisal
- Progression

Supervision

- Appraisals

- Your responsibility to arrange
- Prepare

- At least 2 per rotation

  (midpoint not mandatory unless 6/12 post

  or there are concerns)

Supervision

- Initial Meeting

  Within 2 weeks

- Before meeting

  Be familiar with e-portfolio – check personal details and supervisor details

  Be familiar with Curriculum

  Complete PDP

    Curriculum based

    Specific Measurable Achievable Realistic Time scale

  Sign declaration of probity and health

Supervision

- Initial Meeting:

  Review PDP and set out learning objectives

  Induction appraisal form

  Sign educational agreement (ES must also sign EA)

Supervision

- Profile - Declaration and agreements

	Trainee	ES
Educational Agreement	√	√
Probity and Health	√	

ES countersigns Educational Agreement for year

Supervision

- End of post Appraisal
  - Review progress using e-portfolio
  - Review PDP / objectives
  - Review assessments / evidence
  - Review / sign off curriculum competencies and evidence
  - Highlight concerns and future needs

Supervision

- Educational Supervisor’s Report (ESR)

  MANDATORY prior to ARCP

  Covers period from August to ARCP i.e. whole year

  Required for progression

Supervision & Support

- CS
- ES
- RCP Tutor
- Director of PGME (local)
- DTPD
- TPD
- Catherine Smith!
- HoS

ARCP Process

- Annual Review of Competence Progression
- Summative assessment of progress

SPECIALTY TRAINING CURRICULUM

FOR

CORE MEDICAL TRAINING

August 2009

(AMENDMENTS 2013)

Administrative change May 2016

Joint Royal Colleges of Physicians Training Board

5 St Andrews Place
Regent's Park
London NW1 4LB

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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.

ARCP Process

- April/May 2018
- Interim review
- Formative process
- Remote e-Portfolio review
- Trainee led

CMT Year1 ARCP 2016

Trainee:
Educational Supervisor:
Panel Chair:

Satisfactory record of teaching attendance	*Y/N*	
Valid ALS	*Y/N*	
MRCP (Part 1 required)	***Part1, Part2, PACES***	
Number of Clinics (10 required)		
QIP completed with QIPAT assessment (1 in current year)	*Y/N*	
Common Competencies. Evidence linked to at least 5 competencies AND CT1 level group sign off by ES	*Y/N*	
Emergency Presentations. Individual CMT sign off by ES for all 4 with minimum 2 pieces satisfactory evidence linked (of which 1 **must** be SLE)	*Y/N*	
Top Presentations. Evidence linked to at least 11 competencies AND CT1 level group sign off by ES	*Y/N*	
Other Presentations. Evidence linked to at least 15 competencies AND CT1 level group sign off by ES	*Y/N*	
Number of Essential Procedures Part A (5 with skills lab training completed or satisfactory supervised practice with DOPS evidence)		
Number of Consultant ACATs (minimum 4)		
Total number of Consultant SLEs (minimum 10)		
MSF (minimum 12 raters including non medical staff and 3 Consultants)	*Y/N*	
Concerns	*Y/N*	
Comments		
Educational Supervisor report (to cover whole year)	*Y/N*	
Multiple Consultant Report (minimum 4)	*Y/N*	
Concerns	*Y/N*	
Comments:		
CMT year 1 ARCP requirements achieved	*Y/N*	
Comments: **(this section will be added to trainee's eportfolio for feedback purposes)**		

ARCP Process

- Tutor/TPD review
- E-Portfolio entry filed under Interim Review
- No return

  e-Portfolio not reviewed

  e-Portfolio entry - ‘failure to engage’

ARCP Process

- June 2018
- ARCP proper
- Remote e-Portfolio ARCP panel review (i.e. trainee not present)
- Comprehensive and meticulous!
- ARCP Decision Aid (August 2017)
- e-Portfolio lockdown 2 weeks before ARCP

ARCP Process

- Outcome 1

- All required competencies achieved
- Satisfactory progress

- CT1 ARCP e-Portfolio form completed and released
- ARCP process complete

ARCP Process

- Outcome 2

- All required competencies not met
- CT1 ARCP e-Portfolio form completed and saved in draft pending interview

- Letter sent detailing reason(s) for Outcome 2
- Invite sent to attend Discussion ARCP Panel
- CT1 ARCP e-Portfolio form completed and released
- Outcome reviewed at 6 months

ARCP Process

- Outcome 5
- Insufficient evidence to make a decision

  e.g. missing Course certificate, pending exam result, missing SLE

  missing FORM R
- Temporary Outcome – maximum 4 weeks
- CT1 ARCP e-Portfolio form completed and released
- Invitation to attend ARCP panel
- No further Outcome 5 can be expected

ARCP Process

- July 2018
- Discussion ARCP Panel
- 'Face to face' interview
- Final Outcome (1 or 2, rarely 3!)
- CT1 ARCP e-Portfolio form completed and released
- ARCP process complete
- ACCS
  - outcome 6 (successful completion of training)
  - outcome 3 (additional training time)

ARCP Process

- Revalidation
- Evidence considered
    - ES report
    - Employer Exit Report
    - Enhanced Form ‘R’
- Responsible Officer is Post Graduate Dean

ARCP Process

- Form 'R' mandatory requirement
- If not submitted:

    Outcome 5 (2 weeks)

    Invited to Discussion ARCP Panel
- If still not submitted:

    Outcome 2 or 3

    Referral to GMC

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 Learning 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

Assessements

- ESR
  - to cover whole training year
- MCR
  - each to be completed by single CS (not ES unless also CS)
  - minimum x4

Assessments

- MRCP
  - Part 1 (CT1)
  - Full MRCP (CT2)
  - results automatically uploaded
- ALS
  - Valid at all times
  - Confirmed by Supervisor (or by administrator)

Assessments

- SLEs (ACAT, Mini-CEX, CbD)
  - minimum 10 per year (Consultant)
  - to include 4 ACAT (Consultant)
  - proportionately through year

- MSF
  - 1 per year
  - minimum 12 raters
  - to include 3 Consultants & non medical staff

Assessments

- QIP

  - 1 per year
  - QIP project plan
  - QIP report
  - with assessment (QIPAT)

Quality improvement project		1	1	Quality improvement project plan and report to be completed. To be assessed 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

Competencies

- Common competencies
  - Evidence linked to at least 5
  - AND *<u>CT1 level group sign off</u>* by ES
  - 10 do not require evidence unless concerns raised

  (-Evidence linked to at least 10 competencies AND *<u>CMT level group sign</u>* off at CT2 by ES)

Competencies

- Emergency Presentations

  -*Individual CMT sign off* by ES for all 4

  -minimum 2 pieces satisfactory evidence

  -1 **must** be SLE

Competencies

- Top Presentations
  - robust evidence linked to at least 11
  - Suggest minimum of 2 SLEs

    -AND *CT1 level group sign off* by ES

    (-Evidence linked to ALL competencies AND *CMT level group sign off* by ES at CT2)

Competencies

- Other Presentations
  - Evidence linked to at least 15
  - Can include reflection and e-learning

-AND *CT1 level group sign off* by ES

(-Evidence linked to at least 30 competencies AND *CMT level group sign off* by ES)

Evidence

- Assessments / SLEs (2 competencies per Mini-CEX/CBD, 8 per ACAT)
- Courses / Certificates *with reflective entries*
- Reflection

  e.g. incidents, learning experiences, clinics
- Teaching
- Independent / Self directed

  e.g. online modules, audit, research, journals, clinical meetings
- MRCP is not acceptable as evidence

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

Procedures Part A

- Routine
  - -Advanced CPR
  - -Ascitic Tap
  - -LP
  - -NGT
- Potentially life threatening
  - -Pleural aspiration

Skills lab training completed or satisfactory supervised practice

<u>DOPS evidence for each</u>

Procedures Part A

CT2

Clinical independence in all

Summative DOPS for each

X2 Summative DOPS *x2 Assessors* for Pleural Aspiration

Procedures Part B

CT2

- CV Cannulation
- ICD insertion
- DCCV

Skills lab training completed or satisfactory supervised practice

<u>DOPS evidence for each</u>

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 [7] **or** pleural fluid (PLT)	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

Clinics

- Minimum 20 per year (40 by CT2)
- ACCS 20
- SLEs in clinic e.g. CbD, mini-CEX
- Recorded on JRCPTB spreadsheet and uploaded to personal library
- reflective entries on clinics

JRCPTB
Joint Royal Colleges of Physicians Training Board

Record of procedures and clinics (Core Medical Training)

Record of clinics

Date	Type of clinic	Specialty	New/Follow Up	Description	WPBA Undertaken	Reflection Recorded

This logbook can be used to record clinics undertaken in core medical training (CMT). Use the drop down pick-list to select the type of clinic, the specialty and whether the patient was new or a follow up. The description column allows free text for clinical details and complexity/difficulty of the case (anonymised). You should also indicate whether an assessment was carried out and reflection recorded. Please see guidance for clinics tab for the CMT curriculum requirements for clinics.

Procedures | Clinics | Guidance for procedures | Guidance for clinics

Page: 1 of 1

Date	Type of clinic	Speciality	New/ Follow up	Description	WPBA complete	Reflection
01/09/19	Elderly medicine	Elderly medicine	mixture	Saw 4 patients, sob, weight loss, anaemia and dizziness	Yes CBD weight loss patient by Dr K Hall	Yes-Clinic 1 in portfolio
3/9/19	Medical assessment unit	General medicine	new	3 patients, possible DVT, headache and hypertensio n	Yes CBD by Dr S Ismail for headache	Yes-Clinic 2 in portfolio
7/9/19	Chest pain clinic	Cardiology	mixture	Saw 4 patients 2 non cardiac chest pain, 1 for angio, 1 medication	No	Yes clinic 3 in portfolio

Formal Teaching

- Local opportunities:
  - Grand rounds
  - Departmental Clinical Governance Meetings
  - Local teaching for all trainees
- Regional Programme: 85% attendance mandatory
  - Spread over region
  - 7 days per year + simulation (days repeated)
  - Or 6 days and one day of agreed personal study

Trainee’s Role

- Trainees will not be “chased”….
- ….evidence of progress must be spread over the whole of the time period of review and not clustered to a period immediately prior to the ARCP

(Gold Guide 7.35, 7.44, 7.46).

- “WPBAs completed over a short space of time, relatively close to the ARCP, may be judged to demonstrate lack of engagement and to not therefore be satisfactory progress.”

Trainee's role

- Familiarising themselves with their specialty curriculum, assessment arrangements and other documentation required for the assessment of their progress (Gold Guide 7.37)
- Familiarising themselves with the requirements of the GMC's "Good Medical Practice" (Gold Guide 7.38)
- Initiating the Workplace Based Assessments (Gold Guide 7.13)
- Ensuring that the documentary evidence and their portfolio is complete (Gold Guide 7.44, 7.46)
- Recording all absences accurately in their training portfolio and on Form R (Gold Guide 6.123, 6.125)
- Familiarising themselves with the HEE YH school website and noting the dates for submitting evidence for/and panel dates for ARCPs

Support Available

- Clinical / Educational Supervisor
- CMT administrator
- TPD & DTPDs
- College Tutor
- Director of Postgraduate Medical Education (Local)
- Deanery:
  - Take Time / Workplace Wellbeing
  - Coaching Service

Questions

IM Curriculum-changes to your training

- 1. IM training will start in August 2019 and as a result this will likely result in changes to some CT2 posts
- 2. Your CT1 posts are guaranteed so there will be no changes to those for the next year
- 3. All Elderly and Acute medicine posts, along with some specialty posts are being placed in IM1 training from August 2019 and this will therefore change a number of your CT2 rotations.
- 4. We will look at each trainee's already allocated posts for CT2 and try to ensure you do some of the posts you were originally allocated to.