A HITCHHIKER’S GUIDE TO BEING AN EDUCATIONAL SUPERVISOR -
a practical guide

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Please note the guide has been revised August 2009 – there are likely to be further changes to some parts of the eportfolio and EV will provide updates (but please do take note of any notices on the eportfolio site)

The new curricula for CMT training has come into effect Aug 09: Trainees appointed at this time should use the CMT 2009 curriculum.

In summary:
- The 2009 CMT curriculum is relevant to all trainees who start training from August 2009
- The 2009 CMT curriculum is not relevant to trainees in CMT who started before August 2009. For these trainees there is no change until they move to specialty training when they will commence specialty training on the new 2009 GIM curriculum (please refer to HH Guide version 12 for these trainees’ training plan & ARCP)
- Trainees starting CMT Aug 09 cannot progress to ST3 until full MRCP has been achieved; MRCP in all its stages maps to and enables achievement of the required competencies
- The curriculum uses a new way of “mapping” competencies across to the GMC’s document Good Medical Practice (which contains the Duties of a Doctor) with explicit assessment requirements
- The Generic Curriculum disappears but its components are taken over by the new common competencies
- The ARCP format has changed (For pre-2009 trainees please continue to use version 12 of the HH Guide)
- More detail is given below

IF YOU DO NOT HAVE A USERNAME OR PASSWORD FOR THE E-PORTFOLIO PLEASE CONTACT  eportfolioqueryoxford@nesc.nhs.uk  AS A MATTER OF URGENCY (or contact EV as above)

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1. Definition of educational supervisor

Educational Supervisors (ES) are the “educational managers” for each trainee as they progress through their rotation. Working with the College Tutors, they are responsible for ensuring that

- their nominated trainee is making the necessary clinical and educational progress, acquiring competences with evidence to support this, undergoing assessments and completing their e-portfolio throughout the two years of the CMT rotation and are attending the required teaching sessions
- they have acquired all the skills of clinical supervision, plus an appreciation of supporting educational theory, the ability to undertake appraisal, work with portfolios and provide careers advice.
- Clinical Supervisors are entering the necessary information about trainee assessments into the trainee(s) e-portfolio.
- timely action is taken in the case of trainees in difficulty, usually by liaising with the Trust (Deanery) Clinical Tutor, the College Tutor & CMT Programme Director.

- As the ST/CMT trainee’s educational supervisor you would supervise/oversee your trainee’s education/competency attainment/progress throughout the 2 year period of their core medical training.
- As the trainee progresses through each of their specialties they will also be supervised in their clinical work by their clinical supervisor (CS). A CS can now access the e-portfolio as long as the trainee has informed the CMT PD so the appropriate CS can be given access to their trainee’s e-portfolio for the appropriate training period.
- As the ES you would be wise to allocate the equivalent of an hour per week to allow time for the educational appraisal of each trainee. Inevitably, the time actually required, and the optimal length and frequency of meetings, will vary for individual trainee – supervisor pairings.
- The first meeting as educational supervisor with your trainee should be within 4 weeks of the trainee starting their training; for a clinical supervisor this should be within 2 weeks of starting their job

The purpose of educational appraisal is to:
- help identify educational needs at an early stage by agreeing educational objectives which are SMART (Specific, Measurable, Achievable, Realistic, Timebound)
- provide a mechanism to receive the report of the annual assessment (ARCP) outcome panel and to discuss any action points with the trainee
provide a mechanism for reviewing progress at a time when remedial action can be taken quickly; discuss issues of clinical governance, risk management, patient safety and any report of any untoward clinical incident involving the trainee.

assist in the development in postgraduate trainees of the skills of self-reflection and self-appraisal that will be needed throughout a professional career

enable learning opportunities to be identified in order to facilitate a trainee’s access to these

provide a mechanism for giving feedback on the quality of the training provided

make training more efficient and effective for a trainee.

• Your trainee is responsible for ensuring they arrange times to see you, are completing their eportfolio, doing sufficient workplace-based assessments (WPBAs), attending sufficient educational sessions etc. You should not have to be chasing them up!

• Most of the requirements of an educational supervisor are based on what good trainers were doing regularly anyway – they will just formalise good practice and record it – and WPBA are planned around this principle.

• Trainers really need to be trained themselves (a view endorsed by the GMC and PMETB); initially such training can be basic and self-directed to reduce the extra time burden but training days have been introduced by the Deanery (contact Emira Shepherd for more details Emira.Shepherd@nesc.nhs.uk). In addition, very good training days are provided by the RCP which can be dipped into as part of the Physician as Educators course. Please let Emma Vaux know when you have completed your appropriate ES training.

• ES should have training in use of e-portfolio, WPBA, trainee appraisal, trainee feedback, diversity and equality, and managing a trainee in difficulty. Ideally, trainee feedback should be an integral part of the ES annual appraisal. ES should be aware of the ES PMETB standards (http://www.pmetb.org.uk/fileadmin/user/QA/Assessment/PMETB_STANDARDS_FOR_TRAINERS_JAN_2008.pdf)

2. Time line for ST/CT1 trainee (From August 2009)

• Induction August
• 3 x 4 month posts (some 2 x 6 month posts)
• 8 month ES report March
• 8 month Face-to-face meeting CMT Programme Director March
• Unsatisfactory portfolios reviewed again April
• 12 month ARCP July

3 Time line for ST/CT2 trainee (pre-August 2009)

• 16 month Face-to-face meeting CMT Programme Director October
• 16 month Educational supervisor report October
• 16 month ARCP November
• Individualised e-feedback November
• Unsatisfactory portfolios reviewed again December
• 23 month Face-to-face meeting CMT Programme Director June
Time line for ST/CT2 trainee (post-August 2009)

- 16 month ES report
- 16 month Face-to-face meeting CMT Programme Director
- Unsatisfactory portfolios reviewed again
- 23 month Face-to-face meeting CMT Programme Director
- 23 month Educational supervisor report
- 23 month ARCP

4. Purpose of Annual Review of Competence Progression (ARCP)

- Review training experience and progress
- Ensure appropriate evidence to support progression
- Identify gaps in knowledge and experience
- Completion of core medical training
- Ensure career plans realistic

ARCP panel is usually made up of:
- CMT Programme Director
- College Tutors
- Lay member
- External member
- Trust representative
- Deanery administrator

- Each trainee meets with the CMT Programme Director in the month before the ARCP panel meets, for a face-to-face meeting.
- The trainee’s eportfolio, progress, teaching attendance, absences and any other issues arising are reviewed at this meeting along with the ES report
- If a trainee is deemed to have fulfilled all the requirements to pass the ARCP they will be signed off by the CMT programme Director – 10% (randomly selected) of these trainees will be asked to attend for interview with the ARCP panel to act as a quality review of this cohort. The trainee will know if this is the case.
- If there are any concerns/issues that require addressing about a trainee raised at this meeting, or by others, then that trainee will be interviewed by the panel.

5. ARCP requirements THE NEW CHANGES

8 month eportfolio face-to-face review with CMT programme Director (CT1 trainee):
This guide has been prepared by Dr Emma Vaux, Programme Director for Core Medical Training (Oxford Region School of Medicine) (version 14) Dec 09

- Competencies: as detailed below - with evidence to support reason for sign off – needs to hold up to external scrutiny – see below
- WPBAs: The *minimum* requirement of WPBAs by Consultant Assessor to satisfy 8 month requirements: 3 ACATs (aiming for 6 per year) + 3 mini-CEX + 3 CbD + DOPS until independence in procedures demonstrated + 1 MSF (12-20 respondents, at least 4 must be a consultant assessor)(may be repeated if any cause for concern)
- MRCP progress reviewed – enables achievement of competencies; (must be verified by ES on eportfolio)
- Audit: activity – 1 audit for each ARCP period
- Probity/health and educational agreements signed off:
- Appraisals: 2 per post:
- Shared log: Approx 30 entries
- ALS certificate: valid certificate (must be verified by ES on eportfolio)
- Teaching attendance: >70% of 4 hrs mandatory teaching/week*
- Out-patient attendance: ideal
- ES report covers period:Aug-Feb
- Personal Development Plan (PDP) updated:Regular update and new goals
- PMETB survey completed
- Trainee feedback form on each post completed
- Trainee feedback on educational supervisor and educational process completed

<table>
<thead>
<tr>
<th>Eportfolio review</th>
<th>8 month</th>
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<tbody>
<tr>
<td>Emergency presentations (4)</td>
<td>Some experience of all</td>
</tr>
<tr>
<td>Top 20 presentations</td>
<td>Some experience of 1/2</td>
</tr>
<tr>
<td>Other presentations (40)</td>
<td>Competent in 1/4</td>
</tr>
<tr>
<td>Procedures (17)</td>
<td>DOPS until independence in procedures demonstrated</td>
</tr>
<tr>
<td>Common competencies (25)</td>
<td>Some experience of 1/3rd of Level 1 or 2 descriptors</td>
</tr>
</tbody>
</table>

12 month ARCP

- Progress against 8 month targets, and any action plan given at that stage, will be reviewed

16 month face-to-face eportfolio review by CMT programme Director (CT2 trainee):

- Competencies: see below - with evidence to support reason for sign off – needs to hold up to external scrutiny – see below
WPBAs: The minimum requirement for the number of WPBAs by a consultant assessor to satisfy progress since 8 month review is: 3 ACATs (aiming for 6) + 3 mini-CEX + 3 CbD + DOPS until independence in procedures demonstrated + 1 MSF (or repeated if any cause for concern)

MRCP progress reviewed – enables achievement of competencies; ensure progress updated on eportfolio and verified by ES

Audit: Activity – 1 completed audit cycle for each year

Probity/health and educational agreements signed off:

Appraisals: 2 per post:

Shared log: Approx 60 entries

ALS certificate: valid certificate

Teaching attendance: >70% of 4 hrs mandatory teaching/week*

Out-patient attendance: ideal

PDP updated: : Regular update and new goals

ES report covers period: Mar-Oct

PMETB annual survey completed

Trainee feedback form on each post completed

Trainee feedback on educational supervisor and educational process completed

<table>
<thead>
<tr>
<th>Eportfolio review at 16 month</th>
<th>16 month</th>
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<tbody>
<tr>
<td>Emergency presentations (4)</td>
<td>competent in all</td>
</tr>
<tr>
<td>Top 20 presentations</td>
<td>competent in half</td>
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<tr>
<td>Other presentations (40)</td>
<td>competent in half</td>
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<tr>
<td>Procedures (17)</td>
<td>DOPS until independence in procedures demonstrated</td>
</tr>
<tr>
<td>Common competencies (25)</td>
<td>Competent in minimum half of areas at level 1</td>
</tr>
<tr>
<td></td>
<td>and half of level 2 descriptors</td>
</tr>
</tbody>
</table>

23 month face-to-face followed by ARCP (CT2 trainee):

- Competencies: see below; the sign off must be with evidence to support reason for sign off – needs to hold up to external scrutiny – see below
- WPBAs: The minimum requirement to satisfy ARCP since last review at 16 months by consultant assessor is: 3 ACATs (aiming for 6) + 3 mini-CEX + 3 CbD + DOPS until independence in procedures demonstrated + 1 MSF per year
- MRCP (UK) Diploma - (must be verified by ES on eportfolio)

- Audit: Activity - 1 completed audit cycle per year
- Probity/health and educational agreements signed off:
- Appraisals: 2 per post:
- Shared log: approx 90 entries
- ALS certificate: valid certificate
This guide has been prepared by Dr Emma Vaux, Programme Director for Core Medical Training (Oxford Region School of Medicine) (version 14) Dec 09

- Teaching attendance: >70% of 4 hrs mandatory teaching/week*
- Out-patient attendance: ideal
- PDP updated: Regular update and new goals
- ES report covers period: Nov-Jun
- PMETB survey completed
- Trainee feedback form on each post completed
- Trainee feedback on educational supervisor and educational process completed

<table>
<thead>
<tr>
<th>ARCP competency sign off</th>
<th>23 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency presentations (4)</td>
<td>competent in all</td>
</tr>
<tr>
<td>Top 20 presentations (20)</td>
<td>competent in all</td>
</tr>
<tr>
<td>Other presentations (40)</td>
<td>competent in minimum 34/40</td>
</tr>
<tr>
<td>Procedures (17)</td>
<td>Competent in all procedures</td>
</tr>
<tr>
<td>Common competencies (25)</td>
<td>competent in all to Level 2 descriptor</td>
</tr>
</tbody>
</table>

*Teaching provision within each trust has been variable. An educational log should be kept by each trainee of their educational activity – this would include CMT-targeted teaching, medical grand round, departmental teaching, on-line learning, other educational activity. It is expected the trainee should attend >70% of 4 hours mandatory teaching per week. For each educational log entry the name of the teaching session, who it was delivered by and at least 3 learning points recorded.
# Core Medical Training ARCP Decision Aid – standards for recognising satisfactory progress

## CMT Year 1

<table>
<thead>
<tr>
<th>Competence</th>
<th>CMT Year 1</th>
<th>CMT Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Competences (25)</td>
<td>Competent in minimum of a third at level 1 or 2 descriptor (ACAT/ CbD/ mini-CEX/ MSF)</td>
<td>Competent in minimum half of areas at level 1 and half of level 2 descriptors (ACAT/ CbD/ mini-CEX/ MSF)</td>
</tr>
<tr>
<td>Emergency Presentations (4)</td>
<td>Some experience of all (ACAT/ CbD/ mini-CEX)</td>
<td>Competent in all (ACAT/ CbD/ mini-CEX)</td>
</tr>
<tr>
<td>Top 20 Presentations (20)</td>
<td>Some experience of half (ACAT/ CbD/ mini-CEX)</td>
<td>Competent in half (ACAT/ CbD/ mini-CEX)</td>
</tr>
<tr>
<td>Other Presentations (40)</td>
<td>Competent in a quarter (ACAT/ CbD/ mini-CEX)</td>
<td>Competent in half (ACAT/ CbD/ mini-CEX)</td>
</tr>
<tr>
<td>Procedures (17)</td>
<td>Independent in at least half (DOPS)</td>
<td>Independent in at least two thirds (DOPS)</td>
</tr>
<tr>
<td>Examinations</td>
<td>Review MRCP Pt1/Pt2 progress Enables achievement of competences</td>
<td>Review MRCP Pt1/ Pt2 /PACES progress Enables achievement of competences</td>
</tr>
<tr>
<td>ALS</td>
<td>Valid</td>
<td>Valid</td>
</tr>
<tr>
<td>Minimum number of workplace assessments by Consultant Assessor in each 8 month Block</td>
<td>3 X ACAT 3 X CbD 3 X mini-CEX</td>
<td>3 X ACAT 3 X CbD 3 X mini-CEX</td>
</tr>
<tr>
<td>Annually Required</td>
<td>1 X MSF DOPS until independence in procedures demonstrated</td>
<td></td>
</tr>
<tr>
<td>Events giving concern</td>
<td>The following events occurring at any time may trigger review of trainee’s progress and possible remedial training: issues of professional behaviour; poor performance in work-place based assessments; poor MSF performance; issues arising from supervisor report; issues of patient safety</td>
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</tr>
</tbody>
</table>

## CMT Year 2

<table>
<thead>
<tr>
<th>Competence</th>
<th>CMT Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1 MSF completed and satisfactory.</td>
<td>Competent in all to level 2 descriptor (ACAT/ CbD/ mini-CEX/ MSF)</td>
</tr>
<tr>
<td>Common Competences (25)</td>
<td>Competent in minimum half of areas at level 1 and half of level 2 descriptors (ACAT/ CbD/ mini-CEX/ MSF)</td>
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6. Possible outcomes of ARCP

For the core medical trainee

- This is usually Outcome 1 which indicates satisfactory progress.
- **Outcome 2** means the trainee may continue in their training progression but may have a number of issues that require addressing such as an absent educational supervisor report at the time of their ARCP or no valid ALS certificate. Additional training time is not required.
- **Outcome 3** means inadequate progress by the trainee and a formal additional period of remedial training is required which will extend the duration of the training programme.
- **Outcome 4** means the trainee is released from training programme if there is still insufficient and sustained lack of progress, despite having had additional training to address concerns over progress. The trainee will be required to give up their National Training Number.
- **Outcome 5** means incomplete evidence has been presented and additional training time may be required.
- **Outcome 6** gained all required competences; will be recommended as having completed the training programme and for award of a CCT or CESR/CEGPR (not applicable here).

*All trainees will be interviewed by the ARCP panel

For trainees in FTSTAs, out of programme, or undertaking “top-up” training within a training programme

**Outcome for Fixed-term Specialty Trainee (FTSTAs)**

- Evidence of regular in-work assessments and documentary evidence of progress will be considered by the ARCP panel and should result in an FTSTA outcome.

**Out of programme for research, approved clinical training or a career break (OOPR/OOPT/OOPC)**

- **OOPT** (on a PMETB prospectively approved training placement which will contribute to the competences of the trainee’s programme): an OOPT document as well as in-work assessments etc demonstrating the acquired competences is considered by the ARCP panel.
- **OOPR**: the trainee must produce a research supervisor’s report along with the OOPR document indicating that appropriate progress in research is being made, in achievement of the registerable degree.
- **OOPC**: OOPC document should be sent to the panel by the trainee, indicating that the trainee is still on a career break with their indicative intended date of return.

7. The educational supervisor report

The ES report should be completed on-line. It is found on the eportfolio for each trainee under ‘progression’ and then ‘summary overview’. The ES report for the
month face-to-face should be completed against the 2\textsuperscript{nd} 4 month job, the 16 month face-to-face against the fourth 4 month job and the 23 month ARCP against their last job.

The ES report should reflect the learning agreement and objectives developed between the trainee and his/her educational supervisor and should:

- be supported by evidence from the WPBAs planned in the learning agreement
- take into account any modifications to the learning agreement or remedial action taken during the training period for whatever reason

- It is very important that this is completed with detail to support your yes/no answers. It is important that any areas of unsatisfactory progress are recorded and must be completely honest. There have been cases where trainees have got a ‘good’ ES report and ‘passed’ MRCP but were deemed unappointable at ST3 interview. When the ESs were challenged about this they agreed the trainee’s performance was not satisfactory but they had difficulty putting this in the report. ‘Hearsay’ (eg. corridor conversations/email) regarding a trainee’s probity, health and/or professional behaviour not supported by substantive evidence may be potentially damaging and at worse defamatory and would not hold up to external scrutiny - documentation supported by evidence is essential.

- If there are any difficulties in completing the report please liaise with your RCP College Tutor or the CMT programme Director

- Probity and health issues are very important to identify and record. The trainee’s absence record should be reviewed and commented upon and verified with their medical staffing record.

Please ensure you discuss the contents of the ES report prior to the ARCP with your trainee.

8. Competency sign off

\textit{It cannot be emphasised enough how important it is to provide written documentation with informed comments in all areas of the eportfolio}

The competencies that the trainee is expected to have achieved by the end of ST/CT2 are all of Level 1 Acute Medicine and Level 1 of Generic Curriculum for pre-August 2009 trainees. It may be they have achieved some of Level 2 and this may be signed off where appropriate. However Level 2 is primarily aimed at ST3 and above.

Please note the generic curriculum for Level 1 and Level 2 is under the same heading – the drop down menu will tell you what is expected for each level.

For the August 2009 trainees, the generic competencies have been replaced by the common competencies (level 1 and 2) – it is expected by the end of year 2 they will have achieved competency in all to level 2 descriptors. The 4 emergency, top 20 presentations and ‘other presentations’(40 of them) remain along with procedures (as in level 1 acute medicine)
It is important that each competency is signed off with a statement stating what your judgement is on review of the supportive evidence that has taken place and the evidence holds-up to external scrutiny. This evidence builds up over time. Examples of evidence include occasional direct observation of performance by the ES, but mainly satisfactory WPBAs undertaken by others and identified in the e-portfolio. Having done a particular CT post in a speciality is not evidence of competence in any area within that speciality. The trainee should have a number of WPBA to support different competencies (may be viewed under ‘summary overview’). In addition, the trainee will have evidence of attended educational sessions, shared ‘reflective practice’ entries, audit and their self-assessment record.

It is important for the educational supervisor to review the WPBAs
- ideally WPBAs should be done by a consultant where possible (There is now a minimum requirement for the number of WPBAs done by a consultant as stated above against each stage of the trainee’s training; the other is usually by a SpR – see below)
- it is important that there are a number of different assessors and that not all assessments are done by the same person
- The WPBAs now have a separate section to clearly state what the competency level achieved in this WPBA has been relevant to their stage in training
- the MSF should have at least 12 responses, ideally 20, with at least 4 consultant responses – it is important the individual responses are reviewed.
- ACATs are considered one of the most discriminatory of the WPBAs and your trainee should be encouraged to do well above the minimum requirement (6 per year) as evidence of competence in Acute Medicine.
- **Under no circumstances may a trainee submit a WPBA on behalf of their assessor** – this would be considered a serious probity issue

The new eportfolio version can allow the CS access to complete significant parts of the competency sign off. The eportfolio now allows the CS to be labelled as a clinical supervisor. The trainees are currently informing the CMT Programme Director of their CS so they may have access to their eportfolio during that post to enable this to happen.

**9. Who can do assessments of competency?**

- Assessors should always be a grade above the trainee (i.e SPR or consultant)-exceptions are where other professionals supervise aspects of your training eg a specialist nurse.
- Any assessor must have received training in completing WPBAs
- There is now a minimum requirement for the number of assessments done by a consultant (this may not be possible in the case of DOPS)
• If this requirement is not satisfied then the trainee may not find they have completed the required minimum number of assessments
• Please note that for a MSF there must be at least 12 respondents for this to be meaningful, ideally 20; at least 4 of the respondents should be a consultant. The trainee has been asked to ensure the person completing the MSF understands what they are doing - saying yes to probity issues by being careless in completion can have major implications.
• WPBAs should include detailed written comments on the assessment of the trainee. Those that do not are not contributory or helpful – the trainees are encouraged to ensure that the assessor must write in detail.
• Where WPBAs are not being done in sufficient number, have no written comments, are done by very few people or by the same grade this should give cause for concern and be explored further
• **Under no circumstances may a trainee submit a WPBA on behalf of their assessor – this would be considered a serious probity issue**
• *If you agree with a trainee to do a WPBA, please do it and not forget*

10. Declarations sign off

The probity/health and educational agreements need to be counter-signed off by the ES for each post. This can only be done if your trainee has signed their agreements first. You will find this facility under ‘Profile’ and ‘Declarations’ (see below how to access this).

If a trainee has had **more than one verified unplanned absence (especially from night or weekend duties)** there is a process for dealing with these. Please consult your College Tutor about this process BEFORE SIGNING THE TRAINEE OFF.

11. Entering the eportfolio

This is actually a more user-friendly new version – just a question of getting used to it again!
• You will be given a username and password – this should only be used by you
• Check your trainee is correct!
• Check your name is against the educational supervisor slot under ‘profile’ and then ‘posts/supervisor details’. The ‘tutor’ refers to the College Tutor for your particular Trust.
• Under ‘posts/supervisor details’
  o There are the details for each post your trainee will rotate through – the current post is at the top; the other post details are below.
  o Please note that to allow the clinical supervisor access to the trainee’s eportfolio their name will be entered against that 4 month post (they will also be labelled as educational supervisor as the eportfolio only allows two names ‘tutor’ and educational supervisor); the purpose of this is to enable the clinical supervisor to enable competency sign off (with evidence) as appropriate.
• Under ‘profile’ there also details of
‘Declarations and agreements’ – the probity and health declarations need to be completed for each training year; the educational agreement needs to be signed off once for each trainee – you may countersign only when the trainee has signed their declarations.

‘Certificates’ refer to certificates such as ALS – you must see the original of the certificate and then sign off that you have done so. A current ALS certificate is mandatory.

‘Personal library’ allows the trainee to upload any relevant documentation – the space is limited to 20MB.

‘Absences’ should record any unplanned absences – the Trainee absence record should be reviewed and verified with medical staffing record (see below).

Your trainees are asked to upload a photo of themselves.

Under ‘curriculum’ you will find the Physician level 1 acute medicine and generic curricula for the pre-August 2009 appointed trainees, and the CMT curriculum for the August 2009 + trainees, that you will want to complete over the two years with the trainee.

If you have a trainee starting CMT training prior to August 2009 you should continue to record your experience against the General Medicine Level 1 and Generic curricula (and use version 12 of the HH guide).

Under ‘curriculum’ you will find the Physician level 1 acute medicine and generic curricula that you will want to complete over the two years with your ES (and CS where appropriate).

If you have a trainee starting CMT training from August 2009 you should record your experience against the Core Medical training 2009 curricula.

This is found under ‘curriculum’ too.

(please note the General Internal Medicine 2009 curriculum is for ST3+ trainees starting after 31/07/09 in a dual programme leading to a CCT in General Internal Medicine.)

It is very important the sign off is accompanied by written comments stating what the evidence is that this competency has been achieved (please see appendix A and B for examples from the pre-Aug 2009 curriculum). It is not acceptable to simply state a competency has been ‘achieved’, the reasons why must be given i.e ‘shows how’ and ‘does’ (for example, this might include WPBAs, teaching attendance, validated course/certificate, audit, ward round presentations, tutorial, on-line learning etc and/or a comment that all evidence stated (now that the link is working) has been reviewed and agreed that the competency achieved).

All parts of the curricula have mapped assessments.

The new change for the CMT 2009 curriculum is that MRCP in its three components (pt 1,2 PACES) maps to all parts of the curriculum for the CMT stage of GIM training and is necessary for full completion of CMT.
By clicking on acute medicine level 1 or the CMT curriculum – this will list all the competencies that need signing off at some stage over their CMT training period, in addition to examinations and procedures.

- Clicking on the ‘i’ icon against each competency will allow you to see what standards are required to be achieved for each.
- Clicking on the hand with a pen will allow sign off of each competency to the appropriate stage. Evidence as to why the competency has been signed off should be entered in the ‘comment’ box below.

- Clicking on the generic curriculum (or the common competencies under the CMT curriculum) will list all the relevant competencies for sign off – again, evidence must be stated as to why a competency has been signed off. Please note it is the level 1 competencies that are relevant to CMT training for the generic curriculum for pre-August 2009 trainees, although by the end of their training they may have achieved some level 2 competencies. Please note for August 2009 trainees level 1 and 2 descriptors of all the common competencies must be signed off.

- As you can see from the examples in Appendix A and B, trainee self assessment may also be visualised as to where they see the stage of that competency sign off to be.

- Clicking on the blue icon will now allow the trainee to link many aspects of the evidence (eg WPBA, reflective log entry, personal library entries) to their eportfolio to a particular competency and vice versa – this evidence is identified in brown against the relevant competency. This will allow a good build up of evidence over time (and should make the whole process more intuitive. However, there must be written comments by the ES stating that a thorough review of the evidence has taken place plus any other additional evidence added in support. This should also be in addition to the trainee’s own self assessment as to why they think they are competent.

Under ‘assessment’ the WPBAs can be found. The link of WPBAs to competencies is now available - click on the blue icon and it will allow retrospective linkage to the appropriate competencies (both acute medicine and generic) - therefore the many log entries, WPBAs, personal library info done relevant to each competency will then be highlighted.

- There are details of what WPBA have been achieved under each post – the magnifying glass means there is an entry and clicking on this will allow you to review this entry – please ensure each WPBA entry is reviewed and any issues (positive or negative) are discussed with the trainee; clicking on ‘add new assessment’ will enable you to do a new entry if you so wish

- The trainees are able to send ‘tickets’ to their assessors to enable completion of new assessments; on the new version they can also keep track of who and who has not responded.

- Please ensure every WPBA is reviewed closely. The trainees are encouraged to ensure their assessor completes each WPBA with detail. The written comments are particularly important and any giving cause for action or concern should be explored and an action plan made.
Please refer to trainee in difficulty section if more detailed action is required. WPBAs with no written comments, all done by the same assessor or same grade could highlight cause for concern.

- Please do make careful scrutiny of how many competencies a WPBA has been linked to; the WPBA should be clearly relevant to that competency and provide the appropriate evidence to inform sign off. Creative linking may be a genuine misunderstanding by the trainee but may suggest a probity issue.

- The shared ‘reflection’ allows you to view the entries the trainee has inputted under reflective practice – this maybe reflective or evidence of audit, teaching attendance, out-patient attendance, conferences, research, publications etc. Click on each entry and details of the log entry will be revealed. Each entry should be reviewed, discussed with the trainee where appropriate and signed off.
  - The educational reflective entries are particularly important in terms of being able to review what the trainee has been attending etc, including on-line learning. The trainees are asked to give the title of the educational session, by whom it was delivered by and 3 main things they have learnt.
  - In addition they should record any teaching sessions they give – this activity should be encouraged along with documented formal feedback which you should go through with the trainee. A formal feedback form can be provided if required.
  - Careers management enables a record to be kept of any discussions regarding this trainee’s career pathway.

- Under ‘Appraisal’ the appraisals should be done for the beginning and end of each job. The mid-post appraisal is desirable but not mandatory – these appraisals are completed ideally by the clinical supervisor (who will now have access to the eportfolio to do this).
  - As you are hopefully aware allowing enough time, being enthusiastic, and prepared and tailoring your approach to that particular trainee should hopefully ensure the appraisal process is a positive, beneficial and rewarding one. Appraisal should review the trainee performance, plan their training (what learning opportunities are there or what ones are missing?), develop their goals and offer career guidance.

- The personal development plan should be completed by the trainee. PDP should be updated and reviewed regularly – this can be a very useful for the trainee in identifying areas of weakness and development. Specific training may need to be targeted to achieve some of this.

- Under ‘progression’ and then click on ‘summary overview’ a summary of all assessments, appraisals, supervisor's reports and ARCP forms recorded by post.
  - there is the facility to complete the ES report online and this can be accessed against the appropriate time wrt ARCP (see above) under ‘summary overview’
  - there is also the facility to complete the ARCP form – please note this is only done by the ARCP panel
12. Trainee in difficulty

Events occurring at any time may trigger concern and a review of the trainee’s progress. These may include:
- issues of professional behaviour
- poor performance in WPBAs
- poor MSF performance
- issues arising from educational supervisor/clinical supervisor meetings
- issues of patient safety
- a pattern of unplanned absences from work

Please seek help early if you have any concerns. This maybe with the college tutor, clinical tutor and/or CMT programme director. Documentation is all important and there is no room for ‘hearsay’ (which can be very damaging).

It is important the we recognise the failing trainee, are prepared to give realistic assessments/appraisal of their abilities and support them in their further development as required. It cannot be emphasised enough that a documentation trail is very important when dealing with these trainees.

It is very important that such a trainee is dealt with by the mechanisms in place within the Deanery and by those trained in this often tricky area. The educational supervisor has a critical role in early recognition and ensuring the mechanism is put into action.

13 The Support network available to the trainee

1. The trainees are asked to ensure if they have concerns/issues that they raise them, and raise them early
2. The Oxford Deanery is not prepared to tolerate bullying or intimidation within postgraduate medical and dental education.
3. Examples of bullying behaviour in the context of PGMDE
   - Teaching by humiliation;
   - Undermining status and credibility, e.g. criticism in the presence of others, possibly patients or the public;
   - Using threats, abuse or swearwords or shouting inappropriately;
   - Excessive criticism over minor things;
   - Undervaluing or even ridiculing contribution and/or genuine effort;
   - Changing objectives or expectations without consultation or explanation;
   - Deliberately setting unreasonable objectives or tasks with impossible deadlines;
   - “Sending to Coventry”, ignoring or devaluing;
   - Exclusion from meetings an individual might reasonably expect to attend;
   - Unrealistic expectations/demands concerning a trainee’s out of hours responsibilities.
4. There are a number of people who are able to provide support to the trainee be it pastoral or career advice – please see below

- Educational supervisor
- Clinical supervisor
- College Tutor
- Associate College Tutor – not all trusts have appointed these to date – this maybe something you are interested in doing.
- Clinical Tutor/Trust Medical Education Director
- CMT Programme Director
- Head of School of Medicine
- Trust Clinical Tutor

- If difficulties are identified there are formal process in place to address these and hopefully help and deal with any issues effectively
- If the trainees feel their concerns are not being taken seriously or addressed in a way that they feel they should then they are asked to please contact the CMT programme Director or the Head of School of Medicine directly.

14 The Support network available to the ES

- Your College Tutor, the CMT PD and Head of School of medicine as well as the administrative staff within the Deanery may all be contacted at any time and are here to provide support to you in this very valuable role

15 ST2 acting up as ST3

ST2s may not ‘act up as a ST3’

16 Annual appraisal as educational supervisor

Annual NHS appraisal should ideally include appraisal of your role as an educational supervisor. This should include trainee feedback.

In addition, at the time of each ARCP the trainees will complete feedback on their posts, their educational supervisors (which will be fed back to you) in addition to the mandatory annual PMETB survey.

17 Time Out of Programme (OOP) during Core Training

The PMETB and the Deanery discourage this in all but exceptional cases (eg a once – only opportunity to undertake a much – sought fellowship). Trainees need to get the permission of the Deanery at an early stage in planning; the relevant forms need to be completed early. There should be no direct approaches to the JRCPTB. The Deanery
This guide has been prepared by Dr Emma Vaux, Programme Director for Core Medical Training (Oxford Region School of Medicine) (version 14) Dec 09

is the relevant authority in deciding whether or not to grant OOP (Gold Guide reference too (6.69)). Cover arrangements need to be in place for the OOP trainee before any request for OOP can be considered.

18 Future dates for face-to-face reviews & ARCPs

CT2 16 month ARCP November 17th 2009 (CMT, ACCS medicine, ACF-CMT)
Face-to-face meetings with CMT PD precede this: October 6th(Oxford), 7th (Reading),13th and 20th (Oxford)

CT1 8 month face-to-face March 2010
Face-to-face meetings with CMT PD March 9th and 16th(Oxford), 17th (Reading)

CT2 23 month ARCP July 6th, 2010
Face-to-face meetings with CMT PD June 6th(Oxford), 7th (Reading),13th and 20th (Oxford) precede this

CT1 12 month ARCP, July 6th 2010
No Face-to-face meetings planned currently as per new ARCP decision aid – you will have been given an action plan at your 8 month review - the trainee’s e-portfolio MUST be completed as laid out in this guide and their 8 month action plan indicates.

Appendix A: An example of part of a Generic Record of Competencies for a trainee half-way through their CMT training

<table>
<thead>
<tr>
<th>Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic Focus Area 1 - Good Clinical Care</strong></td>
</tr>
<tr>
<td>1.1i History Taking</td>
</tr>
<tr>
<td>Supervisor Rating: Achieved, 21/10/2008 (by)</td>
</tr>
<tr>
<td>Supervisor Comment: Extensive experience on admissions unit and wards, outpatients clinics. Several mini-CEXs and CbDs. Assessed under exam conditions in PACES- passed</td>
</tr>
<tr>
<td>Trainee Rating: Achieved, 21/12/2007</td>
</tr>
<tr>
<td>Trainee comment: Demonstration of competence through clinical experience in acute, in-patient and out-patient settings across a range of medical specialties. Validation through work-based assessments (notably mini-CEX, CbD and ACAT), also taken note of feedback from peers both informally &amp; formally via MSF. Formal assessment of skills during PACES as part of MRCP.</td>
</tr>
<tr>
<td>Evidence:</td>
</tr>
<tr>
<td>MiniCEX (17/10/2008 17:29:37)</td>
</tr>
<tr>
<td>ACAT (12/11/2008 15:00:55)</td>
</tr>
<tr>
<td>ACAT (11/11/2008 10:12:50)</td>
</tr>
<tr>
<td>ACAT (19/10/2008 15:19:23)</td>
</tr>
<tr>
<td>ACAT (09/10/2008 14:22:06)</td>
</tr>
<tr>
<td>MRCP certificate.jpg</td>
</tr>
<tr>
<td>Cbd (13/11/2008)</td>
</tr>
<tr>
<td>1.1ii Examination</td>
</tr>
<tr>
<td>Supervisor Rating: Achieved, 21/10/2008 (by)</td>
</tr>
</tbody>
</table>
Supervisor Comment: Lots of experience on wards and admissions. Also clinical teaching for PACES. Several mini-CEX forms done assessing skills. Assessed under exam conditions in PACES- passed
Trainee Rating: Some Experience, 21/02/2008
Trainee Comment: Able to perform comprehensive and accurate examination of the patient - understanding the basis for clinical signs and able to do this in even complicated patients. Passed PACES. Teach examination technique to clinical medical students for 3 Oxford colleges and junior doctors on a regular basis.
Evidence:
MiniCEX (17/10/2008 17:33:26)
MiniCEX (17/10/2008 17:29:37)
ACAT (12/11/2008 15:00:55)
ACAT (11/11/2008 10:12:50)
ACAT (19/10/2008 15:19:23)
ACAT (09/10/2008 14:22:06)
Reflection on your teaching (18/11/2008 18:09:11)

1.1v Information Management

Supervisor Rating: Achieved, 10/07/2008 (by)
Supervisor Comment: Notes formally reviewed on multiple post-take rounds, good knowledge of local IT systems
Trainee Rating: Achieved, 29/10/2008
Trainee Comment: Demonstration of competence through clinical experience in acute, in-patient and out-patient settings across a range of medical specialties. Validation of capabilities & knowledge through work-based assessments. Attended relevant training sessions organised at local level (e.g. formal CMT teaching, eIDD training session) - see Reflective Practice. Involved in writing case report and awareness of confidentiality & ethical issues within this area. -
Evidence:
Reflection on Learning Event (23/09/2008 12:10:00)
Reflection on Learning Event (16/09/2008 13:06:30)
DOPS (17/09/2008 17:44:32)
ACAT (02/09/2008 08:55:04)
CbD (21/08/2008 14:58:19)
Summary MSF (19/11/2008 15:38:15)

1.2i Time Management

Supervisor Rating: Achieved, 11/11/2008 (by)
Supervisor Comment: very organised , excellent time management skills.
Trainee Rating: Achieved, 29/10/2008
Trainee Comment: Extensive experience across range of medical specialties, most notably in acute general medicine - experience of running hospital arrest team(s) at JRH and Churchill, working as RMO as HaN SHO on acute medical take, running ward rounds in all specialties through CMT rotation. Participation in OPD clinics to understand separate issues regarding time management and clinical prioritisation in this setting in variety of medical specialties (see Reflective Practice). Assessed via work-based assessments including ACAT and mini-CEX
Evidence:
<table>
<thead>
<tr>
<th>Event</th>
<th>Date/Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reflection on Learning Event</td>
<td>23/09/2008 12:10:00</td>
</tr>
<tr>
<td>Reflection on Learning Event</td>
<td>16/09/2008 13:06:30</td>
</tr>
<tr>
<td>DOPS</td>
<td>17/09/2008 17:44:32</td>
</tr>
<tr>
<td>ACAT</td>
<td>02/09/2008 08:55:04</td>
</tr>
<tr>
<td>Summary MSF</td>
<td>19/11/2008 15:38:15</td>
</tr>
</tbody>
</table>

**Supervisor Rating:** Achieved, 21/10/2008 *(by)*

**Supervisor Comment:** Working with team on wards and in CDU. ACAT evidence

**Trainee Rating:** Achieved, 10/11/2008

**Trainee Comment:** On the wards, in CDU, dealing with take pressures. Able to delegate and prioritise effectively

**Evidence:**

- MiniCEX (17/10/2008 17:29:37)
- ACAT (12/11/2008 15:00:55)

### 1.2ii Decision Making and Clinical Reasoning

**Supervisor Rating:** Achieved, 10/07/2008 *(by)*

**Supervisor Comment:** Lots of experience in managing inpatients and admissions. Independent ward rounds, decisions checked the next day. Clinic decisions reviewed by consultants. CBDs and ACAT forms to support.

**Trainee Rating:** Achieved, 14/11/2008

**Trainee Comment:** Lots of experience in clinical decision making, although will continue to benefit from further experience I feel have achieved the curriculum. CbD/CEX/ACAT forms evidence

**Evidence:**

- MiniCEX (17/10/2008 17:29:37)
- ACAT (12/11/2008 15:00:55)
- ACAT (11/11/2008 10:12:50)
- ACAT (19/10/2008 15:19:23)
- ACAT (09/10/2008 14:22:06)
### Appendix B: An example of some Level 1 acute medicine Competencies

#### Record halfway through CMT training

<table>
<thead>
<tr>
<th><strong>Emergency Presentations</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardio-respiratory arrest</strong></td>
<td></td>
</tr>
<tr>
<td>Supervisor Rating: <strong>Some Experience</strong>, 01/04/2008 <em>(by ...................)</em></td>
<td></td>
</tr>
<tr>
<td>Supervisor Comment: has been on acl course and has attended several arrests when on call for acute medicine and for ward cover as part of the crash team. Completed DOPS 10/3/08. In addition has a written portfolio of evidence which I have reviewed which supports previous signed off experience by her clinical supervisor Dr H Clifford.</td>
<td></td>
</tr>
<tr>
<td>Trainee Rating: <strong>Level 1 Competent</strong>, 22/03/2008</td>
<td></td>
</tr>
<tr>
<td>Trainee Comment: DOPS 10/3/8, ALS</td>
<td></td>
</tr>
<tr>
<td>Evidence:</td>
<td></td>
</tr>
<tr>
<td>ACAT (12/11/2008 15:00:55)</td>
<td></td>
</tr>
<tr>
<td>ACAT (16/08/2008 21:31:54)</td>
<td></td>
</tr>
<tr>
<td>Attendance at organised teaching (02/10/2008 16:13:28)</td>
<td></td>
</tr>
<tr>
<td>CbD_11-07.doc</td>
<td></td>
</tr>
<tr>
<td>ALS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Shock</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Rating: <strong>Level 1 Competent</strong>, 01/04/2008 <em>(by ............)</em></td>
<td></td>
</tr>
<tr>
<td>Supervisor Comment: Has assessed and managed hypovolaemic, septicaemic and cardiogenic shock during emergency on calls and on wards, including cases on HDU, occasionally with CVP monitoring. No ICU experience with inotropes etc. I have supervised her management of such patients on more than one occasion and she has demonstrated competence</td>
<td></td>
</tr>
<tr>
<td>Trainee Rating: <strong>Level 1 Competent</strong>, 18/10/2008</td>
<td></td>
</tr>
<tr>
<td>Trainee Comment: Seen a wide variety of patients who have been shocked therefore experienced in the management of the different causes of this. Able to elucidate the main causes of shock, institute appropriate immediate resuscitation and involve other specialists ie ITU as needed.</td>
<td></td>
</tr>
<tr>
<td>Evidence:</td>
<td></td>
</tr>
<tr>
<td>ACAT (12/11/2008 15:00:55)</td>
<td></td>
</tr>
<tr>
<td>Attendance at organised teaching (18/11/2008 13:50:47)</td>
<td></td>
</tr>
<tr>
<td>ACAT (09/10/2008 14:22:06)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Unconscious patient</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor Rating: <strong>Some Experience</strong>, 01/04/2008 <em>(by.................)</em></td>
<td></td>
</tr>
<tr>
<td>Supervisor Comment: Both on call in CDU and during all attachments, has been exposed to patients with coma and precoma of varying causes, including stroke, metabolic disturbance, organ failure, space occupying lesion, post ictal state, subdural haematoma, opiate toxicity, hypoglycemia. Able to stabilise and resuscitate then reassess for underlying cause and request appropriate invesgations. Has also discussed unconscious patients with worried families and completed mini CEX</td>
<td></td>
</tr>
<tr>
<td>Trainee Rating: <strong>Level 1 Competent</strong>, 22/03/2008</td>
<td></td>
</tr>
<tr>
<td>Trainee Comment: MINICEX 28/2/8</td>
<td></td>
</tr>
<tr>
<td>Evidence: MiniCEX (17/10/2008 17:29:37)</td>
<td></td>
</tr>
<tr>
<td>ACAT (12/11/2008 15:00:55)</td>
<td></td>
</tr>
<tr>
<td>ACAT (11/11/2008 10:12:50)</td>
<td></td>
</tr>
</tbody>
</table>