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 11 for your training/ARCP plan).
- 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 (Those trainees pre-Aug 2009 should use version 11 of the HH Guide)
- More detail is given below

IF YOU (OR YOUR EDUCATIONAL SUPERVISOR OR YOUR CLINICAL SUPERVISOR) DO NOT HAVE A USERNAME OR PASSWORD FOR THE E-PORTFOLIO PLEASE CONTACT eportfolioqueryoxford@nesc.nhs.uk AS A MATTER OF URGENCY (if you do not receive a response within 72 hours contact Emma vaux)
Contents

1. Educational and clinical supervision
2. Entering the eportfolio
3. Who can do your assessments of competency?
4. Time line for ST/CT1 trainee
5. Time line for ST2/CT2 trainee
6. Purpose of Annual Review of Competence Progression (ARCP)
7. ARCP requirements
8. Possible outcomes of ARCP
9. ARCP panel interview
10. Trainee absence record
11. Your support network
12. Feedback on posts and educational process
13. ST2 acting up as ST3
14. Out of programme experience
15. ST3 progression
16. Forthcoming dates for face-to-face eportfolio reviews & ARCPs
17. Enrolment with JRCPTB
18. eportfolio queries
19. ACCS Medicine trainees
20. ACKNOWLEDGEMENT THAT YOU HAVE READ AND UNDERSTOOD THE TRAINING REQUIREMENTS LAID DOWN IN THIS GUIDE
21. Appendices
1. Re your educational and clinical supervision

- You will be allocated to an educational supervisor (ES). This consultant will remain as your educational supervisor for your 2 year CMT training. The educational supervisor has an overview and is responsible for your educational progress as a whole. The ES is responsible for the trainee’s Educational Agreement.
- You should arrange regular meetings with your ES to ensure your Personal Development Plan (PDP) and eportfolio is reviewed. It is recommended that the ES should spend the equivalent of 1 hour per week per trainee to allow time for educational appraisal.
- The first meeting with your educational supervisor should be within 4 weeks of you starting your training; you meet with your clinical supervisor (CS) this should be within 2 weeks of starting their job (your CS and ES is usually the same in your first job in the Deanery – any time your CS changes you must inform Dr Vaux so their name may be added to your eportfolio)
- The CS oversees your clinical work and provides constructive feedback during a training placement

Top tips for appraisal:
- ensure you have all paperwork and eportfolio access before you meet with your supervisor
- make the appointment for the appraisal through secretary for an appropriate amount of time
- assume the educational supervisor may not be familiar with the eportfolio and be prepared to lead them through it
- fill in documentation at the time of appraisal
- make follow up appointments for mid point/end of job appraisals at this time
- make PDP aims ‘SMART’: Specific, Measurable, Agreed, Realistic, Time limited

- As you rotate through each post you will also be supervised clinically by an allocated clinical supervisor who is responsible for your on-the-job day-to-day clinical work
- Please understand that completion of your required appraisals, assessments and eportfolio record is your responsibility

Appraisal = a formative process to enable trainees to develop; a system of cyclical reviews setting personal objectives and evaluating progress against them. Value is primarily for the trainee

Assessment = a summative process evaluating performance against predetermined criteria; the value is both for the trainee and for regulation

- Ensure you keep a steady update of your eportfolio and completion of assessments; arrange appointments with your ES in a timely fashion. The more
(quality) evidence you have in your eportfolio the more likely the time spent with your ES will be productive in terms of addressing your PDP and educational planning

- Educational supervisors will seek feedback on performance from clinical supervisors

If you have difficulty identifying or meeting with your educational supervisor you should approach your COLLEGE TUTOR or CMT programme director (Emma Vaux)

2. Re eportfolio

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
- On the eportfolio ensure all details on your profile are correct, in particular your email address and GMC number under ‘personal’ and then ‘profile’
  (menu on top bar)
- Check the of your educational supervisor is correct 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 you 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 your eportfolio their name will be entered against that 4 month post only by letting your college tutor or Emma Vaux know who they are; the purpose of this is to enable the clinical supervisor to sign off competencies (with evidence) as appropriate.
- Under ‘profile’ there also details of
  o ‘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 with your educational supervisor – your ES may countersign only you have signed the declarations
  o ‘Certificates’ refer to certificates such as ALS – your ES must see the original of the certificate and then sign off that they have done so. A current ALS certificate is mandatory.
  o ‘Personal library’ allows you to upload any relevant documentation – the space is limited though to 20MB.
  o ‘Absences’ should record any unplanned absences – You should record any absences from work on your eportfolio – this will be cross-referenced with medical staffing records. This is further mandated by your sign off of your probity and health declarations. Therefore everytime you are absent for reasons of sickness/compassionate leave etc you must ensure medical staffing are informed for their records.
  o You MUST upload your photo please
• THE NEW CHANGES
  o If you are 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.
    ▪ 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)
  o If you are 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.)

  o By clicking on these curricula – there is a list of all the competencies that need signing off at some stage over your CMT training period, in addition to examinations and procedures.
  o The new CMT 2009 curriculum starts with common competencies (replaces the generic) : 4 emergency, top 20 presentations and ‘other presentations’(40 of them) remain along with procedures (as in level 1 acute medicine)
  o The common competencies (25 of them) have level 1 and level 2 descriptors – by the end of CMT the trainee is expected to be competent in all to level 2 descriptor
  o All parts of the curricula have mapped assessments
  o 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
  o Clicking on the ‘i’ icon against each competency will allow you to see what standards are required to be achieved for each and what Assessment methods are required
  o Clicking on the ‘hand with a pen’ will allow sign off (by the ES or CS) 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.
  o Whichever curriculum you use, it is very important the sign off of any competency is accompanied by written comments stating what the evidence as to why this competency has been achieved (please see appendix A and B for examples). It is not acceptable for your ES (or clinical supervisor) to simply state a competency has been ‘achieved’, the reasons why must be given ( for example, this might include WPBAs, teaching attendance, MRCP, validated course/certificate, audit, ward round presentations, tutorial, on-line learning etc and/or a comment that all evidence stated has been
reviewed and agreed that competency achieved). Therefore you want to ensure your eportfolio is packed full of evidence and reflects your clinical and other activities. In addition, you should complete the self-assessment for each competency and support your comments with what you feel is relevant to support any sign off.

- As you can see from the examples in Appendix A and B, trainee self assessment may also be visualised as to where you see the stage of that competency sign off to be. Please ensure you provide as much evidence as possible here.
- Clicking on the blue icon will now allow you to link many aspects of the evidence (eg WPBA, reflective log entry, personal library entries) on your 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, you must have written comments by your 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 your own self assessment as to why you think you 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; clicking on ‘add new assessment’ will enable you to do a new entry if you so wish
  - You are able to send ‘tickets’ to assessors to enable completion of new assessments; on the new version you can also keep track of who and who has not responded.
  - Under no circumstances may you submit a WPBA on behalf of your assessor – this would be considered a serious probity issue
  - You must ensure you do enough WPBAs – there are minimum requirements for each face-to-face/ARCP stage (see section 8) but I would advise to do more, in particular ACATs to build up evidence for your competencies.
  - You should ensure your WPBA are done by the most senior doctor, preferably a consultant (please note the minimum requirement laid out in section 8). Where you use a junior member of staff they must be trained in the use of WPBA. There have been a significant number of issues where the wrong box gets ticked and probity issues are then raised needlessly
  - You must have your assessments done by a variety of people – there have been cases where they have all been done by the same person – this is not acceptable. 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 is very important and one of the most informative tools; you must ensure at least 12 respondents for this to be meaningful, ideally 20; at least 4 of the respondents should be a consultant. Please 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.

When entering an assessment, you can now reference the assessment to the level 1 acute medicine AND generic curricula, or to the new CMT 2009 curriculum if that applies to you, where appropriate by pressing on the blue icon (as described above) - it enables the build up evidence to support sign off of a particular competency. However, you must only link a WPBA to a clearly relevant competency to provide the appropriate evidence to inform sign off. Creative linking may be a genuine misunderstanding by the trainee but may suggest a probity issue and will be reviewed.

- The shared ‘reflection’ allows you to input under ‘reflective practice’ reflection on learning events or evidence of audit, teaching attendance, out-patient attendance, conferences, research, publications etc. Each entry should be shared if you want it to be seen to enable review, discussion with your ES where appropriate and signed off by your ES.
  - You should complete at least 30 shared reflection entries for each 8 month stage. Remember these are very useful to record all other activities such as out-patient attendance, audit, research and reflective practice. (You can now link these entries to your competencies, via the blue icon, so this entry may be used for evidence against both acute medicine and generic curriculum as you could on the old version). You must get each reflective entry signed off by your educational supervisor to ensure all entries are reviewed, discussed and verified.
  - You should keep a record of your teaching attendance – it is expected you attend >70% of your 4 hours mandatory teaching per week (this is usually made up of specific CMT teaching with reference to the curricula, additional CMT teaching, Grand Round and departmental teaching).
  - The educational reflection entry should name the teaching session, who it was delivered by and three main things you have learnt (enter this information under the ‘venue’). This applies to all teaching sessions but also other educational activity such as on-line learning.
  - In addition you should record any teaching sessions you give – this activity should be encouraged along with documented formal feedback. A formal feedback form can be provided if required. You should review this feedback with your ES.
  - Careers management enables a record to be kept of any discussions regarding your 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). Please encourage this to be completed with detailed written comment by your supervisor.
• The **personal development plan** should be completed and ensure you have discussed this with your educational supervisor, regularly updated and added to for changing needs – this can be a very useful to identify areas of weakness and development.

• Under ‘**progression**’ and then click on ‘**summary overview**’ a summary of all assessments, appraisals, supervisor's reports and ARCP forms recorded by post.
  o there is the facility for your ES to **complete the ES report online** and this can be accessed by the ES against the appropriate post for that ARCP (see above) under ‘summary overview’. **Please encourage your ES to complete the report with as much detailed comment as possible as this will be most valuable to you in being given written feedback.**
  o there is also the facility here to complete the ARCP form – please note this is only done by the ARCP panel

• **Audit** is important and audit activity needs to be demonstrated and most importantly evidence of **completion of an audit cycle yearly** – this should be documented under ‘reflection’

• **Out-patient attendance** is desirable – – this should be documented under ‘reflection’

• Currently **MRCP** part 1 is only required by the end of ST/CT2 for pre-August 2009 trainees – BUT the **new change is the requirement for full MRCP by the end of CT2 year** - you will not be able to progress to ST3+ without full MRCP.

• Remember to use the eportfolio to demonstrate areas of excellence - quality evidence and quality documentation is important.

• The annual PMETB survey is mandatory and you will need to provide evidence that you have completed this

---

3. **Who can do your assessments of competency?**

• Assessors should always be a grade above you (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

• It is expected at least 50% of all assessments are done by a consultant (this may not be possible in the case of DOPS)

• If this requirement is not satisfied then you may not find you have completed the required minimum number of assessments

• Please note that for a MSF you must ensure at least 12 respondents for this to be meaningful, ideally 20; at least 4 of the respondents should be a consultant. **Please 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.**
This guide has been prepared by Dr Emma Vaux, Programme Director for Core Medical Training (Oxford Region School of Medicine) (version 13) Mar 2010

- You must ensure your assessor completes your WPBA with written comments. It is the written comments that are the most contributory in assessing your performance
- **Under no circumstances may you submit a WPBA on behalf of your assessor – this would be considered a serious probity issue**

4. 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

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

- 16 month Face-to-face meeting CMT Programme Director October
- 16 month Educational supervisor report November
- 16 month ARCP November
- Individualised e-feedback November
- Unsatisfactory portfolios reviewed again December
- 23 month Face-to-face meeting CMT Programme Director June
- 23 month Educational supervisor report June
- 23 month ARCP July

6 Time line for ST/CT2 trainee (post-August 2009)

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

6. 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

7. Re ARCP requirements

NEW CHANGES

8 month eportfolio face-to-face review with CMT programme Director (CT1 trainee):
- 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>
</tr>
</thead>
<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>
</tbody>
</table>
Procedures (17)

DOPS until independence in procedures demonstrated

Common competencies (25)

Some experience of 1/3rd of Level 1 or 2 descriptors

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

Eportfolio review at

Emergency presentations (4)
Top 20 presentations
Other presentations (40)
Procedures (17)

16 month

competent in all
competent in half
competent in half
DOPS until independence in procedures demonstrated
This guide has been prepared by Dr Emma Vaux, Programme Director for Core Medical Training (Oxford Region School of Medicine) (version 13) Mar 2010

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
- 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 all 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**                          | **CMT Year 2**                          | **CMT Year 2**                          |
| Month 8/9 ePortfolio review (locally)   | ARCP at month 11 or 12                 | Month 16 ePortfolio review (locally)    |
| Common Competences (25)                | Competent in minimum of a third at level 1 or 2 descriptor (ACAT/ CbD/ mini-CEX/ MSF) | Competent in minimum half of areas at level 1 and half of level 2 descriptors (ACAT/ CbD/ mini-CEX/ MSF) |
| Year 1 MSF completed and satisfactory. |                                        |                                        |
| Emergency Presentations (4)            | Some experience of all (ACAT/ CbD/ mini-CEX) | Competent in all (ACAT/ CbD/ mini-CEX) |
|                                        |                                        |                                        |
| Top 20 Presentations (20)              | Some experience of half (ACAT/ CbD/ mini-CEX) | Competent in half (ACAT/ CbD/ mini-CEX) |
|                                        |                                        |                                        |
| Other Presentations (40)               | Competent in a quarter (ACAT/ CbD/ mini-CEX) | Competent in half (ACAT/ CbD/ mini-CEX) |
|                                        |                                        |                                        |
| Procedures (17)                        | Independent in at least half (DOPS)    | Independent in at least two thirds (DOPS) |
| Examinations                           | Review MRCP Pt1/ Pt2 progress          | Review MRCP Pt1/ Pt2/PACES progress    |
|                                        | Enables achievement of competences     | Enables achievement of competences     |
| ALS                                    | Valid                                  | Valid                                  |
| Minimum number of workplace assessments by Consultant Assessor in each 8 month Block | 3 X ACAT 3 X CbD 3 X mini-CEX | 3 X ACAT 3 X CbD 3 X mini-CEX |
| Annually Required                      | 1 X MSF DOPS until independence in procedures demonstrated | 1 X MSF DOPS until independence in procedures demonstrated |
| Events giving concern                  | 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 |
8. 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.

9. ARCP panel Interview
The ARCP process is essentially a virtual experience ie you do not need to be present and your eportfolio will be accessed remotely by the panel.
Each trainee meets with the CMT Programme Director in the month before the 23 month ARCP panel meets, for a face-to-face meeting. For the 12 month ARCP, the trainee will have had a 8 month eportfolio review; at present there is no planned 11 month eportfolio face-to-face review (as per the new ARCP decision aid)
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.

10 Trainee absences

- Please note that you must be aware of each trust’s process on who to notify when absent, in particular for any unplanned absence (ie other than annual, professional or study leave)
- You must enter all unplanned absences on your eportfolio record and ensure your educational supervisor is aware of any unplanned absences
- Unplanned absences are taken very seriously by the Trusts and the Deanery.
- Any recurrent unplanned absences, particularly from night or weekend shifts will be reviewed
- If you have more than one unplanned absence from work this will be reviewed with you by your educational supervisor and/or college tutor.
- For repeated unplanned absence you may be referred to Occupational Health, for counselling, to the Careers Development Unit or for disciplinary procedures.

11. The Support network available to you

1. Please ensure if you have concerns/issues that you 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 you 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
   • There is a CMT trainee rep, Aneil Malhotra (aneilmalhotra@gmail.com) – please do contact him with any issues/concerns etc

   • If difficulties are identified there are formal processes in place to address these and hopefully help and deal with any issues effectively
   • If you feel your concerns are not being taken seriously or addressed in a way that you feel they should then please contact the CMT programme Director (Emma Vaux) or the Head of School of Medicine (Tony Bradlow) directly.

12. Feedback on posts and educational process

You will be asked to kindly complete as mandatory:
   • Annual PMETB survey - you must have a receipt of doing so sent to Emma Vaux at time of completion
   • Trainee feedback form on each post completed – requested at time of ARCP
   • Trainee feedback on educational supervisor and educational process completed - requested at time of ARCP

13. Re ST2 acting up as ST3

CT2s may not ‘act up as a ST3

14. Time Out of Programme (OOP) during Core Training
Out of programme for research, approved clinical training or a career break (OOPR/OOPT/OOPC)

All out of programme experience is at the discretion of the programme director and head of school of medicine

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 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.

15. ST3 progression

The Oxford deanery is contractually bound to provide all ST trainees appointed in August 2007 (or ACF trainees) with run through training with ST3 posts assuming adequate career progression. The contract does not entitle ST2 to a post in a specific specialty: availability of vacancies will depend on SPRs completing training programme (attainment of CCST) and releasing national training numbers. Predictions of vacancies are subject to change with SPRs delaying completion of CCST by: taking OOP for research ill health; failure of career progression or maternity leave. The deanery will endeavour to give indicative estimates of ST3 vacancies for these trainees.

A local competitive process will be undertaken early in the year to allocate regional vacancies; candidates unsuccessful in attaining the specialty of their choice will be able to compete for national vacancies in open competition. The exact details of the national process and guidance for local allocation are not yet available.

Future ST3 appointments for post-August 2009 appointed trainees are not run-through and are made through local and national recruitment programmes

16 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 October 6th (Oxford), 7th (Reading), 13th and 20th (Oxford) precede this

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 OJune 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 - your e-portfolio MUST be completed as laid out in this guide and what your 8 month action plan indicates

17 Enrolment with JRCPTB

All trainees should enrol with the JRCPTB promptly – this will allow you access to your e-portfolio and your CMT certificate once you have completed the training satisfactorily.

From November 2009 the PTB will cross match the eportfolio users against the list of on-line enrolment applications. If after two warnings you still have not enrolled, the right to access to the eportfolio will be removed.

18. eportfolio queries

- Try eportfolioqueryoxford@nesc.nhs.uk first (Emira Shepherd is the contact at the Deanery)
- If no luck, email Emma Vaux, CMT PD (Emma also sits on eportfolio committee at JRCPTB so if any suggestions on how things on the eportfolio might be improved, email her!!)
- Otherwise there is an email at JRCPTB eportfolioteam@jrcptb.org.uk if we are unable to help

19 ACCS Medicine trainees

- Your Programme director is Emma Vaux
- The ARCP requirements are the same as for CMT trainees
- The ARCP panel is the same as for CMT trainees
- Emergency medicine & anaesthesia have specific requirements that must be signed off by the appropriate clinical supervisor to the satisfaction of that specialty PD
- It is anticipated that you are unlikely to achieve the requirements for CMT completion by the end of year 2 and a third year in acute medicine specialties will be offered to those trainees where this is the case (and PACES not achieved)

20. ACKNOWLEDGEMENT THAT YOU HAVE READ AND UNDERSTOOD THE TRAINING REQUIREMENTS LAID DOWN IN THIS GUIDE

Please send email acknowledgement as above to Emma Vaux, CMT programme Director within 4 weeks of receiving this guide to emma.vaux@royalberkshire.nhs.uk
21 Appendices below are from completed generic and level acute medicine curricula; examples from CMT 2009 curriculum will be added at a later date

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>
</tbody>
</table>

**1.1i History Taking**

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

**Supervisor Comment:** Extensive experience on admissions unit and wards, outpatients clinics. Several mini-CEXs and CbDs. Assessed under exam conditions in PACES- passed

**Trainee Rating:** Achieved, 21/12/2007

**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 & formally via MSF. Formal assessment of skills during PACES as part of MRCP.

**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)
- MRCP certificate.jpg
- Cbd (13/11/2008)

**1.1ii Examination**

**Supervisor Rating:** Achieved, 2/11/2008 *(by)*

**Supervisor Comment:** Lots of experience on wards and admissions. Also clinical teaching for PACES. Seveal 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:
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)
CbD (23/09/2008 16:42:13)
ACAT (02/09/2008 08:55:04)
Summary MSF (19/11/2008 15:38:15)

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>10/07/2008</td>
<td>Achieved</td>
<td>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.</td>
</tr>
<tr>
<td>14/11/2008</td>
<td>Achieved</td>
<td>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</td>
</tr>
</tbody>
</table>

**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

## Emergency Presentations

### Cardio-respiratory arrest

**Supervisor Rating:** Some Experience, 01/04/2008 *(by ............)*

**Supervisor Comment:** has been on acls 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.

**Trainee Rating:** Level 1 Competent, 22/03/2008

**Trainee Comment:** DOPS 10/3/8, ALS

**Evidence:**
- ACAT (12/11/2008 15:00:55)
- ACAT (16/08/2008 21:31:54)
- Attendance at organised teaching (02/10/2008 16:13:28)
- CbD_11-07.doc
- ALS

### Shock

**Supervisor Rating:** Level 1 Competent, 01/04/2008 *(by ............)*

**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

**Trainee Rating:** Level 1 Competent, 18/10/2008

**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.

**Evidence:**
- ACAT (12/11/2008 15:00:55)
- Attendance at organised teaching (18/11/2008 13:50:47)
- ACAT (09/10/2008 14:22:06)

### Unconscious patient

**Supervisor Rating:** Some Experience, 01/04/2008 *(by ............)*

**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, hypoglycaemia. Able to stabilise and resuscitate then reassess for underlying cause and request appropriate investigations. Has also discussed unconscious patients with worried families and completed mini CEX

**Trainee Rating:** Level 1 Competent, 22/03/2008

**Trainee Comment:** Demonstration of competence through clinical experience in the acute setting across a range of medical specialties. Validation of knowledge and clinical skills through ward-based assessments and formally through MRCP examination(s). Been part of and led arrest teams during CMT rotations, most
notably during AGM at John Radcliffe Hospital (ST1) and Chest (ST1) and Renal Medicine (ST2) at Churchill Hospital. Experience in airway management during AICU & Anaesthetics (FY2), AGM and Chest Medicine (ST1). Attendance at ALS training (July 2005 - recertifying in 2009), ALERT and BASIC courses. Attendance at relevant organised teaching sessions (see Reflective Practice)

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)
miniCEX_3-08.doc