

ARCPs during Covid-19 Pandemic: Specific specialty advice for Medical Specialties

Acute Internal Medicine

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes in your specialty?	SCE must be achieved prior to CCT
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	Engagement with training demonstrated by 50% of WPBA compared to decision aid (2 ACATs and 5 in total). MSF, 2 MCRs and satisfactory ES report
3. What would be the criteria for non-progression?	Significant concerns highlighted in MSF about professionalism or elsewhere about patient safety. ESR indicating that the trainee is below the level expected at this point of training. For those having a final ARCP the curriculum would need the normal sign offs and evidence against it.
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities.</p> <p>Unlikely to be a problem in AIM training. A few trainees might have been unable to rotate to a specific attachment in April, but I suspect this number will be relatively few, and programmes should have enough flexibility to make this up. This should be highlighted in a PDP after the ARCP to ensure that trainees do gain necessary experiences</p>
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan	No trainee should obtain the CCT without the SCE but otherwise most capabilities can be achieved in an acting up capacity. Period of grace could help derive leadership, teaching and management skills

Allergy

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes in your specialty?	CCT
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	Regular WPBAs to meet basic ARCP decision criteria as the burden of assessments is low. Evidence of ~ 50% of assessments defined in decision aid. Satisfactory educational supervisor's reports. MSF in ST4 and ST6. MCR Evidence of laboratory experience by end of ST4
3. What would be the criteria for non-progression?	Lack of assessments /leaving assessment until just prior to ARCP. This will be seen by review of the portfolio content including undertaking assessments and reflection prior to the pandemic. Significant concerns about patient safety/probity/professionalism
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities. Progression will continue if required capabilities have been missed solely due to the effect of the pandemic. However where there is decreased exposure to the necessary specialist clinics certain practical capabilities will be missed and can't be made up for in other ways. This will have to be recognised in a PDP and arrangements made for these missing elements to be delivered.
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	Some capabilities may be achieved in an acting up capacity but certainly none where the practical procedure may put the patient at risk. Leadership, teaching and management

Audiovestibular Medicine

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	CCT
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	MSF ST4 and ST6 Supportive ESR, MCR ~50% of SLEs as defined in decision aid
3. What would be the criteria for non-progression?	Incomplete secondments to medicine paediatrics and Otolaryngology by end of ST6 Significant concerns about patient safety/probity/professionalism Completion of less than 4 KBA papers by the time of CCT.
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	AV medicine is generally flexible in its approach and competences not acquired in any particular year can be achieved in subsequent training years. If the competences cannot be acquired an extension of training may be required.
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	Leadership and management skills. Training skills Attendance at some of the courses recommended in the curriculum

Aviation and Space Medicine

Progression questions to advise ARCPs
<p>1. What and when are the critical progression points for training programmes your specialty?</p> <ul style="list-style-type: none"> a) Passing DAvMed by end of ST5 – this could be delayed for one year b) CCT at ST6
<p>2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? e.g. workplace-based assessments etc</p> <p>Minimum data set should include a flexible assessment of the competences acquired related to the decision aid and WPBAs recorded. Positive ESR, MCR and MSF</p>
<p>3. What would be the criteria for non-progression?</p> <p>Significant adverse issues of professional behaviour; poor performance in work-place based assessments; poor MSF performance; adverse issues arising from supervisor report; issues of patient safety.</p>
<p>4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?</p> <p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
<p>5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?</p> <p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities.</p> <p>Aviation and space medicine training is spread over 4 years and it is likely that the trainees will be able to demonstrate continuing progression in generic capabilities and may be able to demonstrate catch up progress with the specialty specific competences defined after the pandemic. If a trainee has not shown adequate progression within the training time an extension to training may be required. Extra time will be allowed to pass the DAvMed.</p>
<p>6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.</p> <p>Leadership and management skills. Training skills</p>

Cardiology

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes in your specialty?	At ST5 trainees need to have completed Core Cardiology. If not the case these competences should be gained in the next year of training PYA(when possible)/last year ARCP - CCT
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training?	Can follow ARCP grid in Cardiology as far as possible with Outcome 10 if training for the specific year is not completed. Supplemental codes from CO-11 should be used to identify issues to be tackled and commentary recorded in portfolio. The ES report is important and should indicate the progress the trainee is making and how the programme has been affected thus indicating the likelihood of an outcome 10. There should be evidence of MCR x2. All trainees given an outcome 10 should have a training plan to ensure that the subsequent programme addresses learning outcome needs.
3. What would be the criteria for non-progression?	Non progression based on significant concerns of professionalism, probity or patient safety alone. For award of CCT the trainee should have portfolio evidence of the curricular defined competences and have passed the KBA in cardiology
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?	Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities Training in Cardiology is spread over 5 years. Most will be able to catch up over that time. However the curricula are competency based and some may require an extension to training time. This may apply to relevant practical skills if unlikely to be achieved by CCT date. A training plan will have to be developed for those whose progression has been affected by the pandemic
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	Leadership, management, ethics, reorganisation of services, service development, new ways of working in an acting up period or in a post CCT period of grace. It is not expected that practical procedural competency should be developed in this environment because of patient safety issues

Clinical genetics

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	<p>The only critical progression points are the SCE and CCT. Trainees should sit the SCE in ST5 or ST6 and must be passed prior to CCT</p>
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training?	<p>Individual trainee assessment as many have not been redeployed and thus the decision aid should be used. If redeployed: evidence of engagement with training and the e-portfolio with a minimum of educational supervisor report with MCRs x2 contributing where possible. MSF preferably from this year of training.</p>
3. What would be the criteria for non-progression?	<p>Non-engagement with e-portfolio, significant concerns in clinical skills, performance or attitude. Patient safety issues. Need for SCE prior to CCT</p>
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?	<p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities</p> <p>If a trainee hasn't acquired key capabilities and there is a belief that these cannot be 'made up' in the following year of training or if it is an ST6 trainee due to get their CCT, they will need an extension to training and this should be granted with no penalty for the trainee. A PDP should be developed to define the precise capabilities needed.</p>
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	<p>Many clinical genetics trainees do act up for 3 months prior to CCT and this is very valuable for them. A few may be acquired in a period of grace post CCT but monitoring this may be difficult – these may include leadership, management and teaching skills.</p>

Clinical Neurophysiology

Progression questions to advise ARCPs
<p>1. What and when are the critical progression points for training programmes your specialty?</p> <p>CCT</p>
<p>2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)</p> <p>50% of expected SLE as defined in decision aid ESR indicating satisfactory progress MCR</p>
<p>3. What would be the criteria for non-progression? Significant concerns shown in MSF or elsewhere with regard to patient safety and/or professionalism</p> <p>Lack of engagement with training with few portfolio entries for the year</p>
<p>4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?</p> <p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
<p>5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?</p> <p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities.</p> <p>All trainees who have been affected by the pandemic will have to have PDP developed with support from the ARCP panel so that relevant experience is obtained in subsequent training. This may be particularly relevant to trainees in ST3 - ST5</p>
<p>6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan</p> <p>Leadership, teaching and management skills in period of grace</p>

Clinical Pharmacology and Therapeutics

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	<p>After ST4 core competences. These can be acquired in subsequent year of training if not already achieved</p> <p>CCT</p>
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	<p>ESR demonstrating progression in the various CPT curricula elements</p> <p>~50% of SLEs achieved, MCRx2, MSF from current year or last one satisfactory</p>
3. What would be the criteria for non-progression?	<p>Lack of engagement with training as evidenced by lack of portfolio entries and adverse ESR</p> <p>Significant concerns about patient safety/probity/professionalism</p> <p>Incomplete specialty module prior to CCT</p>
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	<p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>All trainees who have been affected by the pandemic will have to have PDP developed with support from the ARCP panel so that relevant experience is obtained in subsequent training. This may be particularly relevant to trainees in ST3 - ST5 prior to specialty modules.</p> <p>Progress in specialty modules has to be completed and this may require an extension of training time</p>
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan	<p>Leadership, teaching and management skills in period of grace</p>

Dermatology

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	<p>SCE prior to CCT</p> <p>For many trainees in dermatology the ARCP should be able to proceed using the previously defined decision aid with no modification</p>
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	<p>Review of portfolio against decision aid for trainees who have continued in programme. Where the trainee has been redeployed away from their primary training programme there should be: demonstrable engagement with training and 50% of the recommended WPBAs in the decision aid, satisfactory MSF, 2x MCR and ES report</p>
3. What would be the criteria for non-progression?	<p>Significant concerns shown in MSF or elsewhere with regard to patient safety</p> <p>Failure to achieve SCE prior to CCT.</p>
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	<p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities.</p> <p>All trainees who have been affected by the pandemic will have to have PDP developed with support from the ARCP panel so that relevant experience is obtained in subsequent training. This may be particularly relevant to trainees in ST3 - ST5</p>
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	<p>Leadership, teaching and management skills but the specific exposure to the wide extent of dermatoses should not be undertaken within a period of grace. If concerns have been highlighted with regard to significant parts of the trainees overall clinical competence this should not be recommended.</p>

Endocrinology and Diabetes

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	SCE prior to CCT, PYA(when available)/final ARCP, CCT
4. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	As a minimum there should be an ES report, MCRx3, an MSF preferably from this year of training if in ST3 or ST6 and evidence of engagement with training as exhibited by portfolio entries prior to pandemic effect. For SLEs a flexible approach may be used to ensure that trainees have approximately 70% of competences by ST5. The SLEs presented should be assessed as positive
5. What would be the criteria for non-progression?	Lack of engagement with training or minimal evidence as mentioned above For CCT must have SCE pass and evidence in the portfolio of all relevant specialty specific competences. Significant concern about patient safety or issues of professionalism
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities. An outcome 10 should be awarded with use of the supplemental C codes. A training plan should be developed that will allow the trainee to acquire necessary experience and competences later in training.
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan	Many of the curricular defined competences could be gained in an acting up capacity but the SCE is critical prior to CCT

Gastroenterology

Progression questions to advise ARCPs	
1.	<p>What and when are the critical progression points for training programmes in your specialty?</p> <p>JAG certification for OGD by the end of year 2 unless trainees have spent a full year in liver medicine where there is no access to endoscopy. Acquisition of this certification can be delayed into the third year of training if not acquired in the second year PYA/last year ARCP, CCT</p>
2.	<p>In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)</p> <p>Should be able to demonstrate engagement in WPBA but perhaps more progression with GIM than gastroenterology, Need to see 50% of expected WPBA Evidence of engagement and progress with the GIM portfolio including evidence of completed portfolio prior to pandemic effect.– An adequate ES report that demonstrates progression and MSF for relevant years ST3 and ST5</p>
3.	<p>What would be the criteria for non-progression?</p> <p>Failure to engage with the portfolio – especially the GIM portfolio Adverse ES report that suggests trainee is not engaging with training in that there have been issues with professionalism or trainee specific significant clinical incidents. Inadequacy in progression in endoscopy by end of third year of training. MSF feedback causing significant concern</p>
4.	<p>Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?</p> <p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
5.	<p>How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?</p> <p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities. The curriculum is competency based and some may require an extension to training time. A training plan will have to be developed for those whose progression has been adversely affected by the pandemic</p>
6.	<p>Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.</p>

Greater responsibility for patient care in an environment with which the trainee is already familiar in an acting up capacity. It is not expected that practical procedural competences should be developed in this environment because of patient safety issues.

(General) Internal Medicine

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Supportive reports from MSF preferably from the year of training, MCRs x3 and ESR

3. What would be the criteria for non-progression

Significant concerns raised in any of the reports especially about professionalism or patient safety

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel. It should be noted that all ARCP panels for trainees dual training in GIM and specialty should have a member that takes responsibility for considering the GIM part of training

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities

Trainees should be allowed to progress but there should be generation of a PDP to ensure that trainees gain the necessary experiences defined in the curriculum.

6. Please provide advice regarding capabilities which may be gained in an acting up position in a period of grace post CCT, within a defined education/development plan
Many capabilities can be gained in an acting up period. Management, training and leadership would be suitable in a grace period

Genitourinary medicine

Please also see the revised ARCP decision aid on the GUM specialty [webpage](#)

Progression questions to advise ARCPs To be read in association with more detailed modified GUM decision aid	
1. What and when are the critical progression points for training programmes your specialty?	See ARCP decision aid attachment-areas highlighted in yellow
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	See ARCP decision aid attachment
3. What would be the criteria for non-progression?	Non completion of critical progression points-see ARCP decision aid attachment
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?	Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST4 without achieving the necessary core capabilities Either rolling competencies into next year of training or extension to training time-see ARCP decision aid attachment
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	Acting up is not possible post CCT. The critical competencies that are needed pre CCT and those that can be waived are listed in the revised GUM ARCP 2020 decision aid, see attached. Consent for acting up pre CCT and competencies gained during this period, needs to be assessed on a case by case basis

Geriatric Medicine

Progression questions to advise ARCPs

To be read in association with modified ARCP decision aid supplied

1. What and when are the critical progression points for training programmes your specialty?

Training in geriatric medicine is a continual process with a wide range of skills needing to be acquired over the course of the training programme. Not all training units can provide training across all aspects of the curriculum and therefore in a single year, different trainees will complete different curriculum objectives even if they are training in the same region. It is therefore very difficult to identify specific critical progression points except CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Curriculum domain	ST3	ST4	ST5	ST6	CCT
SCE					Passed
ALS	Valid or within period of grace for each year. If the trainee is within the period of grace for the ALS, rebooking the ALS should not delay CCT.				
Mini-CEX	3	3	3	3	3
CbD	3	3	3	3	3
ACAT	1	1	1	1	1
MSF	Trainees will need a total of 2 MSFs during five year training programme, and ideally not more than one per year of training				
QIP	Trainees must complete one QIP or closed loop audit project before CCT. One community facing audit project must be completed before CCT. A total of five QIP/Audit projects is expected for the five year training programme				
MCR	Consultant reports from consultant colleagues outside the specialty (e.g. supporting work in Nightingale units) will be acceptable.				
ESR	Satisfactory educational supervisor report required for each year.				

3. What would be the criteria for non-progression?

This will largely rest with an unsatisfactory educational supervisor report. An exception would be a failure to pass the SCE in the final year of training which will require further time to attempt a resit. Any significant concerns about patient safety/probity or professionalism

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?
Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

Remaining areas in the curriculum will have to be identified early in the trainee's next placement with their educational supervisor and arrangements made for time to be allocated to these areas. If it is unlikely that the required competences can be achieved in the remaining time then an extension to training may be necessary.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan

Leadership, teaching and management skills can be acquired in the grace period
Any additional educational activity not directly specified in the decision aid (eg movement disorders course) and ALS could be included in this area.

Haematology

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

FRCPATH part 1 in ST5 This may be delayed to the ST6 year of training but must be acquired prior to ST7
FRCPATH part 2 in ST7
Full FRCPATH critical before CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Evidence of progression in laboratory competencies by end of ST3
ESR, MCR reports being supportive of progression for each year
~50% of SLEs as defined in decision aid
MSF in ST3 and ST6
DOPS in bone marrow aspiration and trephine by end of ST4 (previous years DOPS is acceptable)
DOPS in intrathecal chemotherapy by end of ST4 (may be delayed to subsequent year in training)

3. What would be the criteria for non-progression?

Lack of engagement in training with inadequate evidence of progression in portfolio
Significant concerns about patient safety/probity/professionalism
Lack of full FRCPATH by CCT

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

Remaining areas in the curriculum will have to be identified early in the trainees next placement with their educational supervisor and arrangements made for time to be allocated to these areas. If it is unlikely that the required competences can be achieved in the remaining time then an extension to training may be necessary.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan

Leadership, teaching and management skills can be acquired in the grace period

Immunology

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?
FRCPATH part 1 (Progression from ST5 to ST6) and FRCPATH Part 2 (Eligibility for CCT)

We agreed progression from ST5 to ST6 (FRCPATH Part 1) should not adversely impact progression - and can be done in the next diet of exam
FRCPATH Part 2 (Full FRCPATH) need to remain a critical progression before CCT.

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Patient Survey, MSF can be deferred to the next year
Appropriate number of WPBA (Pro-rata) before the COVID crisis - but recognition that many trainees do these in the last 3 - 4 months
(The decisions need to be individualised as there are regional and centre specific differences with regards to the adverse impact on training)
Alternative COVID related WPBAs can be considered
Alternative COVID Immunology (Serology) Laboratory CbDs / V & V , methods etc can be considered
ALS - is not critical
Supportive ESR/MCR is critical

3. What would be the criteria for non-progression?

Significant concerns about patient safety/probity or professionalism
Lack of FRCPATH by CCT

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

For many trainees the duration of redeployment to front line will adversely impact on acquisition of speciality specific competencies. It will be suggested that some can be acquired in the available training time but some trainees may need an extension to their training duration

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan

Leadership, teaching and management skills

Infectious Diseases and Tropical Medicine

Please see joint JRCPTB/RCPATH guidance in the ARCP decision section of the specialty [webpage](#)

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes in your specialty?

Infectious Diseases only or with General Internal Medicine: Trainees in ST6 who are not in possession of the CICE should be awarded an outcome 10.

Tropical Medicine only or with General Internal Medicine: Trainees in ST7 who are not in possession of the CICE should be awarded an outcome 10.

Any infection trainee who has sufficient evidence as defined by the decision aid to present to the ARCP panel of the curriculum defined competences and who are in possession of the CICE may be awarded an outcome 1 or 2 and progress to the next year or stage of training.

Any infection trainee who has sufficient evidence to present to the ARCP panel of the curriculum defined competencies may be awarded an outcome 6 and apply for CCT if they are within 6 months of their projected CCT date.

Where the ability of trainees to present evidence of all competencies due to the effect of the pandemic an outcome 10 should be awarded.

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

The Educational Supervisors will be a key part of the evidence required along with a portfolio of evidence provided by the trainee including WPBAs that reflects engagement with training. The requirement is for at least 50% of WPBAs that would normally be required and 2 MCRs.

There is clear guidance in each curriculum and/or in additional guidance about the requirements for each stage or year of training. ARCP Panels are encouraged to refer to these, and existing ARCP guidance and make a judgement about progression for each trainee, taking into account any interruptions to training.

3. What would be the criteria for non-progression?

Serious concerns arising out of a recent Multi Source Feedback exercise.
Any evidence presented in relation to serious probity/patient safety concerns.
Trainees who have not passed CICE. This includes where examinations have been deferred. Trainees should be given an outcome 10 extension to training in order to allow them the necessary time to revise and sit the requisite examination.

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities
Progression will continue if required capabilities have been missed solely due to the effect of the pandemic.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.

Trainees are encouraged to follow the course of action that is right for their individual circumstances and with the support of their Educational Supervisor/Training Programme Director. The acting up capacity may be used to acquire capabilities but no trainee should be awarded CCT without fulfilling essential curricular requirements including the CICE. However leadership, teaching and management skills may be augmented in a grace period

Medical Oncology

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	<p>There are no critical progression points between entry at ST3 level and award of CCT.</p>
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	<p>For trainees whose training has been disrupted: The portfolio should be reasonably populated up to the point where training in specialty was affected by pandemic An MCR from one (or more) consultants involved with trainee and an ES report stating that training was proceeding satisfactorily. Evidence of portfolio activity during pandemic e.g. personal reflections on situations encountered, involvement in re-organisation of services etc.</p> <p>For trainees whose training programme is minimally disrupted (due to geography or type of unit worked in) normal rules should apply. ARCP panels will need ESs to document the degree of disruption for larger and more disparate programmes’.</p>
3. What would be the criteria for non-progression?	<p>For trainees whose training is significantly disrupted: Clear evidence of unsatisfactory performance or professionalism including clear lack of engagement with training. For those whose training is not significantly disrupted: usual criteria as defined by the decision aid</p> <p>For a CCT to be awarded the trainee must have portfolio evidence of the relevant competences as defined in the curriculum and have passed the SCE.</p>
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	<p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel..</p>
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities For the award of CCT the trainee must have: Passed the Medical Oncology SCE and competence in the mandated tumour types</p> <p>To aid in the latter assessment: The currently required 4/6 month WTE experience will not be strictly applied provided that the portfolio clearly documents full competence in that tumour type – ES reports</p>

can document this and this should be supported by the breadth of WPBAs in the portfolio

A maximum of 2 tumour areas can be counted in any given period of training time with proviso that the portfolio clearly documents the appropriate level of competence in both. This will automatically apply to all ST5/6 trainees who have progressed satisfactorily to date, and may be applied to more junior trainees who have at least 12 months of accredited training (or close equivalent e.g. those who fill StR level Fellow posts in a training unit before obtaining an NTN and who function in those posts exactly as the NTN-holding trainees in that unit). ES discretion here will be needed.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.

Non-clinical and generic skills may continue to be developed during the pandemic. An acting up period in medical oncology could be to pass the SCE where this is the only outstanding element to complete training. Management, teaching and leadership skills could be augmented in a grace period.

Medical Ophthalmology

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

ST3 (OST entry) trainee must have attempted MRCP part one by the end of ST3
ST4 (CMT entry) trainee must have attempted FRCOphth part 1 by the end of ST4
ST4 (OST entry) trainee must have attempted MRCP part two by the end of ST4
ST5 Trainees must have passed both MRCP and FRCOphth to progress to ST6
ST6 Trainees must have passed the refraction certificate to progress to ST7
All must have been passed prior to CCT but each element could be delayed to the next year of training where required

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Work place based assessments – minimum 50%
Educational supervisors report that is supportive of the trainee and explains changes in role during coronavirus pandemic
Satisfactory multiple consultant reports - minimum 2
Evidence of an MSF where required (ST3 and 5) with adequate raters and positive in its tone
ST4 (OST entry) should have passed MRCP part 1
Evidence of reflection on training

3. What would be the criteria for non-progression?

Less than 50% work place based assessments
Unsatisfactory educational supervisor/ multiple consultant report
Trainee has not passed MRCP part 1 by the end of ST4
For CCT trainees must have portfolio evidence of all relevant clinical competences and have passed all relevant exams.

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Plan for minimum three person ARCP panel as TPDs cannot do ARCP for their own trainees. Use of Head of School or TPD from another area may be appropriate
Lay rep desirable not essential

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST4 without achieving the necessary core capabilities

Trainees will be required to fulfil the missing curricular requirements during the following training year. Trainees will be asked to meet their educational supervisors to plan how to meet the curricular requirements.

Trainees who are unable to demonstrate that they have acquired the necessary capabilities at the ARCP in 2021 will be offered additional training time.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.

Competencies relating to common progressive elements may be completed in a period of grace post CCT.

Medical ophthalmology specialty specific elements should be completed prior to CCT with additional training time granted if required.

Neurology

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty? SCE prior to CCT Only explicit progression point is the CCT.	
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc) ESR, MCR x3 and MSF recognising that these may come from areas where trainees may have been redeployed. Evidence of engagement with training prior to the pandemic with ~50% of required WPBAs recorded in portfolio.	
3. What would be the criteria for non-progression? Lack of engagement with training, Significant concerns about patient safety/probity professionalism.	
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep? Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.	
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled? CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities. The SCE may be supplemented by trainees undertaking questions from ebrain with review by the ES. During redeployment trainees may be assessed on patients seen in the COVID wards. All trainees should have a training plan identified after ARCP so that specific curricular targets can be set. If not possible within the training time left and extension to training may be necessary.	
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan Leadership, teaching and management in grace period.	

Nuclear Medicine

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	FRCR by ST5 but can be delayed to next year of training. KBA (FRCR and Diploma) to be passed by CCT
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	ESR, MSF (ST6 and ST8) MCR Evidence of engagement with training including evidence of SLEs in portfolio to link to curricular competences
3. What would be the criteria for non-progression?	Significant issues of patient safety/probity or professionalism. Lack of engagement with training programme. Lack of post graduate diploma in nuclear medicine prior to CCT.
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	ARCPs for nuclear medicine are held nationally, and it is conceivable that this can be done by assessing the documents first and then tele-meeting between the various panel members and trainee from their respective places. Lay reps not required.
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	All trainees will be assessed according to the competence acquisition demonstrated and a training plan created. Depending on where they are in training it may be possible for all competences to be acquired in the residual training time.
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan	Management teaching and leadership skills in grace period

Paediatric Cardiology

Progression questions to advise ARCPs	
1. What and when are the critical progression points for training programmes your specialty?	<p>Progression to 'special interest training' ST6-7 PYA (when available) at ST7 CCT ST8 The SCE must be achieved prior to CCT</p>
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	<p>Most trainees have not been affected significantly by the pandemic and therefore ARCPs should proceed using the normal decision aid.</p>
3. What would be the criteria for non-progression?	<p>Lack of engagement with training as exhibited by few portfolio entries. Need ESR, MCR and MSF preferably from this year of training.</p> <p>CCT cannot be achieved without evidence of success in KBA and relevant competences being recorded in e-portfolio.</p>
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	<p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>Most trainees enter paediatric cardiology through paediatric qualifications. Such individuals will have to have a specific training plan developed for them so that they can acquire the necessary competences that have been defined.</p> <p>Trainees in the programme who have been affected will also need a specific training plan to accommodate any areas of experience that are necessary into subsequent training. For example trainees who have had experience in adult congenital heart disease must this incorporated into the training plan for the future programme.</p>
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	<p>Leadership teaching and management capabilities in an acting up capacity.</p>

Palliative medicine

Please also see the revised ARCP decision aid on the [GUM specialty webpage](#)

Progression questions to advise ARCPs	
To be read in association with specialty specific modified decision aid	
1. What and when are the critical progression points for training programmes your specialty?	<p>PYA at ST5. In the absence of a PYA during this year there should be arrangements for this to take place as soon as possible, CCT on completion of ST6</p>
2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)	<p>SLE requirements reduction by 50% based on the ARCP decision aid. One DOPS in the training year (mandatory =9) Satisfactory MSF, MCR x2 and ES reports highlighting progress in training</p>
3. What would be the criteria for non-progression?	<p>Unsatisfactory educational supervisor report, Lack of engagement in training via e-Portfolio, SLEs/DOPS etc. prior to March 2020. Highlighted concerns about professionalism from MSF or elsewhere about patient safety</p>
4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?	<p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?	<p>CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities</p> <p>The pandemic might impact on some subspecialty training in some programmes, where trainees have dedicated blocks of time, e.g. oncology. Where individual trainees feel that they have not had sufficient experience in one area, we will need to review this within training programmes and consider how future placements can be adjusted to meet individuals' needs. For a ST6 if there are any outstanding DOPS a review to look for alternative evidence of attainment, e.g. in a skills lab if available or via other WPBAs should be undertaken.</p>
6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.	

Enhanced management and leadership roles, as leaders of a clinical team. In the current context, trainees acting up can lead ward teams; supervise junior medical staff; assume clinical responsibility for patients under their care; lead the risk/safety agenda for their teams; support teams' wellbeing and provide informal and formal teaching. These are likely to be provided in an acting up period

Pharmaceutical medicine

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

Progression points occur at the end of each training year but by the end of ST6 a trainee should have passed the Diploma in Pharmaceutical Medicine examination. This may be delayed to the next year training but has to be passed prior to CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

There must be a supportive supervisor's report and, if the trainee's programme has not been affected by the pandemic, five to 10 WPBAs across the curriculum, reflections and evidence to support achievement of curriculum competencies across the seven modules. For those that have been redeployed a minimum of a supportive supervisors report and evidence of engagement with training would be expected in addition to 5 WPBAs. In ST4 and ST6 trainees must have undertaken a round of MSF

3. What would be the criteria for non-progression?

If there are highlighted concerns within the MSF about professionalism or elsewhere about patient safety. No trainee can achieve CCT without the Diploma in Pharmaceutical Medicine and successfully provided evidence curriculum competences across the seven modules.

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities.

The ARCP panel would issue an Outcome 10 and ensure that a PDP was developed to enable the trainee to gain the necessary curricular defined experiences.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan

It is unlikely that would be applicable in this specialty.

Rehabilitation medicine

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Usual decision aid of trainees not involved in pandemic medical care. If redeployed need evidence of engagement in training with 50% of WPBAs as defined in decision aid.

Supportive MSF, MCR x2 and ES reports.

3. What would be the criteria for non-progression?

Lack of engagement in training will lack of evidence of portfolio completion prior to impact of pandemic.

Significant concerns highlighted in MSF about professionalism or patient safety in MSF, MCR or ES report focussing on progression in training and whether progression has been affected by the pandemic.

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities.

If trainees have been adversely affected by the pandemic there should be identification of specific experiences that need to occur before CCT and a PDP developed to accommodate these.

6. Please provide advice regarding capabilities which may be gained in an acting up position in a period of grace post CCT, within a defined education/development plan.

Leadership, teaching and management capabilities in a grace period.

Renal Medicine

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

Completion of SCE prior to CCT; pre-OOP (R) for planning of clinical credits and PYA(when available)
Final ARCP
CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

Satisfactory MCRs x2 and ES report would be core.
One each DOPS and ACAT

3. What would be the criteria for non-progression?

Poor MCR /ES report. Failure to engage with training and eportfolio prior to March 2020 (flu pandemic). To achieve outcome 6, the curricular requirements including the KBA should have been completed or planned for completion within an acting up period

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

CMT trainees who still need to acquire capabilities not achieved in core training will have a training plan created that facilitates such acquisition. Trainees will not progress beyond ST3 without achieving the necessary core capabilities

Earlier year trainees will have time to acquire capabilities. However specific experiences e.g. acute transplant experience it may be necessary to prolong training or use focused intensive weeks with some online learning, joining video MDTs. Each trainee will need a PDP to determine what experiences are required before CCT.

Success in the KBA will remain critical to get to CCT but may be gained in an acting up period.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan

Leadership and management very relevant but with support some competencies could be gained post CCT grace period. More likely this will be in an acting up period.

Respiratory Medicine

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

SCE required before CCT. Experience of critical care prior to CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

ES report, MCR x2, 50% of SLEs expected for year
MSF if there has not been one satisfactorily performed earlier in training
DOPS (or continuing competence mentioned in ES report) for NIV and chest drain
Ideally DOPS for bronchoscopy

3. What would be the criteria for non-progression?

Unsatisfactory ES report. Non-completion of SCE by time of CCT
Significant concerns about patient safety or professionalism

4. Are there any circumstances where a complete ARCP panel would be required rather than Only need full (or fuller) panel if significant competence or attitudinal issues identified.

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

There are some specific experiences usually required, which many regions have to obtain externally, namely:

- i) lung transplant
- ii) pulmonary hypertension
- iii) cystic fibrosis
- iv) occupational lung disease.

In case these attachments are now no longer possible and the trainee is approaching CCT, compensatory evidence may be provided in the form of any evidence of online learning in these subject areas. Ideally the training plan created post ARCP would enable trainees to gain at least some of these external experiences

6. Please provide advice regarding capabilities which may be gained in an acting up position or in a period of grace post CCT, within a defined education/development plan.

If there are any specific competencies which have not been completed e.g.

- i) Occupational lung disease
- ii) Tuberculosis and atypical mycobacterial disease
- iii) HIV related lung disease
- iv) Genetic and developmental lung disease
- v) Respiratory manifestations of systemic disease
- vi) Interstitial lung disease

These may be completed in a period of grace, post CCT.

Rheumatology

Progression questions to advise Rheumatology ARCPs

1. What and when are the critical progression points for training programmes your specialty?

Penultimate year ARCP and final ARCP
CCT

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)

At least 2 mini CEX, CBD and 2 DOPs for the stage of training

MSF and patient survey: Can be deferred

Audit/Research/Teaching/Management: Engagement for stage of training and encourage completion after pandemic

ESR: Comprehensive report is key for assessment

MCR: Minimum 2
<p>3. What would be the criteria for non-progression?</p> <p>Significant concerns or unfavourable ES report /MCR report with clear reasons for non progression. Lack of any engagement with portfolio prior to March 2020. SCE non completion for final year trainees</p>
<p>4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?</p> <p>Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.</p>
<p>5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?</p> <p>Competency based training, thus if trainee and ES agree that this can be acquired in remaining time and placement then conditional progression could be agreed with an a repeat ARCP 4-months if possible.</p>
<p>6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.</p> <p>Audit/ teaching/management requirements can be completed during grace period. Reasonable recommendations on WBAs can be suggested during grace period and reviewed periodically.</p>

Sport and Exercise Medicine

Progression questions to advise ARCPs
<p>1. What and when are the critical progression points for training programmes in your specialty?</p> <p>Exam to be achieved by the end of ST5 but this will be relaxed so progression can occur to ST6 but it will need to be achieved before completion of training.</p>
<p>2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training? (e.g. workplace-based assessments etc)</p> <p>50% of WPBAs on the decision aid. More emphasis will be put on 2 MCRs and ES report. The ES report may be provided a trainer who clearly knows the trainee and has been supervising them for a minimum period 4-6 months</p>
<p>3. What would be the criteria for non-progression?</p>

Evidence of competencies/capabilities not being achieved at the expected rate outside of pandemic affected parameters. This is likely to have been present and highlighted before the pandemic affected training.

Not passing the exam by the end of training would incur additional training time.

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested? Should all panels have a lay rep?

Generally 2 is fine. Pre-screening may indicate trainees who are more likely to receive a non-standard outcome and these should be reviewed by a 3 member panel.

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

Progression will continue if required capabilities have been missed solely due to the effect of the pandemic.

A PDP must be developed and indicate the capabilities from the training programme that should be acquired before the next defined time of review. If there is the possibility that training will need to be extended then there will be a review arranged prior to the next ARCP, in approximately 6 months.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan.

Acting up in SEM could fulfil exposure to MSK clinics at consultant level in a period of grace if this has not been completed. Many SEM trainees have been taken out of MSK services and moved to ED so this is likely to be the biggest area of impact and a key capability (leading a MDT MSK service)

Stroke Medicine

Progression questions to advise ARCPs

1. What and when are the critical progression points for training programmes your specialty?

OOPT programme that usually requires trainees to complete a year of experience.

2. In the present circumstances associated with the pandemic what would be the minimum data set for each year of training?

(e.g. workplace-based assessments etc)

ESR, MCRx2 and MSF. 50% of SLEs required in usual decision aid

3. What would be the criteria for non-progression?

Significant concerns about patients safety/probity/professionalism.

4. Are there any circumstances where a complete ARCP panel would be required rather than the 2 people ARCP panel that is being suggested?

Should all panels have a lay rep?

Panel should have three members as the decision for each trainee from these small numbers is bound to have affected progress and an informed training plan will be required according to local circumstances

5. How will progression of trainees who have been unable to acquire capabilities in their core programme due to the impact of Covid-19 be facilitated especially if specific components of the curriculum have been unfulfilled?

Most stroke programmes are likely to require an extension of training simply because of the short time allowed for the 'stroke year'. Alternatively trainees should be allowed to use a percentage of the week to undertake further stroke training after returning to the parent specialty.

6. Please provide advice regarding capabilities which may be gained in an acting up position of in a period of grace post CCT, within a defined education/development plan

Continuing experience of stroke patients in parent specialty

Updated 07 May 2020