

Guidance Notes for the Implementation of Curriculum 2010: Renal Medicine

These notes are to be used in conjunction with the 2010 Curriculum for Renal Medicine, in particular the ARCP Decision Aid found on page 112. They were developed in accordance with discussions held during a Curriculum Implementation Workshop facilitated by the JRCPTB Education Unit on 5th April 2011 and are endorsed by the joint Renal SAC and Renal Association Curriculum Committee.

1. Curriculum 2010 automatically applies to any trainee commencing renal training at ST3 level in August 2010 or later. There was an opportunity to for trainees to switch to this from earlier curricula but this closed in July 2011.
2. *Length of training.* The 2010 curriculum is competency based but there are minimum requirements for the length of training based on common sense and compliance with European directives. For trainees seeking single accreditation in nephrology only 3 years clinical exposure is required; for dual accreditation in Renal and GIM the is 5 years with significant GIM exposure in at least 2 of these years (see below, point 6). The exception to this rule is trainees following an academic pathway (i.e. Academic Clinical Fellows). ACF posts, which have 25% protected research time are not intended to automatically extend the overall length of training (i.e. 1 year ACF = 1 year clinical training) and depending on whether the appointment was made at ST1 or ST3 – or even later in some cases – may or may not include nephrology training. Academic Clinical Lecturer posts vary significantly in their clinical training opportunities and will likely need individual assessment to ensure a balanced exposure (see point 5); historically most ACL posts have been 50% clinical and it is unlikely that trainees would achieve sufficient clinical experience to complete training in less than 3 years equivalent clinical exposure. It is also the case that trainees obtaining ACL posts will have very variable training histories. For example it is possible that a trainee has already obtained a postgraduate research degree at the time of commencing nephrology training at ST3 level at which point they gain an ACL appointment which is generally funded for 4 years with 50% clinical – i.e. unlikely sufficient time. As with any other trainee they will have to demonstrate clinical competency across the curriculum (including generic competencies) before being eligible for their CCT. For additional guidance see <http://www.academicmedicine.ac.uk/careersacademicmedicine/postgrad.aspx> For OOP and less than full time training (LTFT) previous rules apply, see: <http://www.jrcptb.org.uk/specialties/Pages/Out-of-Programme.aspx>
3. The greatest difference between the 2010 and previous curricula is the incorporation of a large range of common competencies; assessment of these competencies needs to be embedded in the existing assessment processes (e.g. mini-Cex) rather than generating a large number of additional assessments. Trainees can then cross-link these assessments to both common and renal specific curriculum items using the e-portfolio. It is however

essential that these common skills are addressed properly in the annual educational supervisors report (see below, point 7).

4. The other main difference between the 2010 and previous curricula is the incorporation for each area levels of competency to be expected at different stages of training. There are either 3 or 4 levels described and they map to the year of training as shown on the ARCP decision aid. These level descriptors are designed to help trainees bench mark themselves against the expectation of them at each stage of their training and to inform the choice and complexity of assessments undertaken. *For example*, the curriculum clearly states that in the last 12 to 24 months of training that trainees are expected to be able to lead a quality control meeting for the management of dialysis patients. It is therefore entirely appropriate that this is assessed by a mini-Cex (which can easily be adapted to address more complex situation, e.g. ward rounds, on-call performance); in turn this will assess a number of skills including knowledge of dialysis treatment, multi-disciplinary team working and leadership.
5. *Competency assessment versus the experiential component of training.* It is recognised that training is more than signing off a series of competencies and must recognise some measure of exposure to the various aspects of nephrology that also results in an appropriate balance of experience within the speciality. It is expected that for the main sub-speciality areas within nephrology (e.g. transplantation, PD, HD, CKD, general nephrology etc) that a minimum outpatient clinic exposure of 3 months for each is obtained over the course of training. Trainees are encouraged to keep a record of their training opportunities (e.g. number of clinics in each sub-speciality area with typical patient numbers, numbers of procedures etc). However a log book requiring individual cases is not required and if kept by the trainee must respect patient confidentiality.
6. It is agreed that clinical experience gained in speciality clinics can also count towards the outpatient training opportunities required for GIM accreditation. The current expectation from the GIM SAC is that trainees will over the course of their training be able to 'double count' the equivalent of 2 clinics per week over three years (i.e. 240 clinics); this should include new patients although the current request that this should be 25% of the total is not achievable in renal speciality clinics and remains under discussion.
7. *Assessments.* It is important to recognise that the assessments undertaken by trainees are seen as a representative sampling of competencies obtained rather than a comprehensive record of every competency in all aspects of the curriculum. In this context the educational supervisor plays a critical role in ensuring that the sample is representative and addresses not just the known strengths but also potential weaknesses of the trainee. For example, in undertaking the MSF, while trainees can choose a representative selection of assessors the educational supervisor can add to this to ensure areas of concern are covered. It is emphasised that the educational supervisors report it the single most important piece of evidence that informs the ARCP.