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**Rough Guide to Implementation**

**Clinical Pharmacology & Therapeutics Curriculum**

**Guidance for training programme directors, supervisors and trainees**

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# **Introduction**

This guide for Clinical Pharmacology & Therapeutics (CPT) is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself. The curriculum, ARCP decision aid and this guide are available on the JRCPTB website.

The Rough Guide has been put together by members of the CPT SAC with additional help from many external stakeholders especially trainees. It is intended to be a ‘living document’ and we value feedback via curriculum@jrcptb.org.uk.

# **What is different about the 2022 CPT curriculum**?

**Background**

There have been two major drives to the need for change. Firstly the move away from the ‘tick-box’ approach associated with the current competency-based curricula to the holistic assessment of high level learning outcomes. The new curriculum has a relatively small number of ‘capabilities in practice’ (CIPs) which are based on the concept of entrustable professional activities (EPAs). Secondly, the GMC has mandated that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the [Generic Professional Capabilities (GPC) framework](https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework)..

**Duration of training**

CPT higher specialty training will usually be completed in four years of full-time training. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

# **The CPT curriculum**

The purpose of the curriculum is to produce doctors with the generic professional and specialty specific capabilities required to practice in Clinical Pharmacology & Therapeutics. This curriculum aims to produce trainees who in general will practice in adult medicine however the CPT scope of practice does not preclude indirect and usually non-clinical practice in children. Despite many examples of excellence in the use of medicines within specialist NHS therapeutic areas, it is critical to ensure there is an overarching, cross-specialty stewardship of all aspects of medicines use in the NHS. Clinical Pharmacologists are uniquely able to perform essential roles in 4 key domains to meet this need:

1. Specialist and generalist patient care including managing patients with complex prescribing needs including; polypharmacy, adherence and intolerance; preventing and managing adverse drug reactions; identifying and reducing medication errors; managing patients with poisoning, hypertension or other conditions requiring specialist therapeutics knowledge and skills; facilitating the transition to precision medicine, including individualised pharmacogenomic-based prescribing; and providing acute and general medical care.
2. Medicines policy and management including; providing leadership in ensuring the safe and optimal use of medicines within the health service at local, regional and national levels including the promotion of collaboration with other specialties and pharmacy; leading for medicines regulation and health economic assessments; producing prescribing guidance and medicines optimisation policy.
3. Education and training across the whole workforce in relation to all aspects of the safe, effective and economic use of medicines including design, delivery and assessment.
4. Development of medicines and other therapeutics, including; designing and leading safe and effective clinical trials, including first-in-human studies; working with the life sciences industry to discover new medicines, explore their efficacy, repurposing potential and adverse effects; bridging the translational gap between basic science and clinical practice; leading for pharmacovigilance of licensed medications; and leading NHS research facilities.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

By the end of their final year of training, the trainee will receive a dual CCT in Clinical Pharmacology & Therapeutics and Internal Medicine.

# **Capabilities in Practice (CiPs)**

The six **generic CiPs** cover the universal requirements of all specialties as described in the GPC framework. The generic CiPs are common across all physician specialties. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The eight **Internal Medicine** **clinical CiPs** describe the clinical tasks or activities which are essential to the practice of internal medicine. The clinical CiPs have also been mapped to the GPC domains and subsections to reflect the professional generic capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each of the CiPs, the doctor in training's performance meets or exceeds the minimum expected level of performance expected for completion of this stage of internal medicine training, as defined in the curriculum.

The CPT **specialty CiPs** describe the professional tasks or work within the scope of Clinical Pharmacology & Therapeutics

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice (level 4) in all clinical and specialty CiPs.

|  |
| --- |
| **Capabilities in practice (CiPs)** |
| **Generic CiPs** |
| 1. Able to successfully function within NHS organisational and management systems
 |
| 1. Able to deal with ethical and legal issues related to clinical practice
 |
| 1. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
 |
| 1. Is focused on patient safety and delivers effective quality improvement in patient care
 |
| 1. Carrying out research and managing data appropriately
 |
| 1. Acting as a clinical teacher and clinical supervisor to be assessed by DOPS

**Internal Medicine Clinical CiPs** 1. Managing an acute unselected take
2. Managing an acute specialty-related take
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions
5. Managing medical problems inpatients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills
 |
| **CPT Specialty CiPs**  |
| 1. Performing the clinical assessment, investigation and management of adverse drug reactions, medication errors and overdose at an individual and (where relevant) population level
2. Providing specialist management of patients with complex prescribing needs, including multimorbidity, polypharmacy, adherence issues, and medication intolerance
3. Providing analysis and expert opinion on pharmacokinetic, pharmacodynamic and pharmacogenomic factors to guide therapeutic decisions
4. Providing evidence-based practice and contributing to the evidence base in a therapeutic area of interest
5. Advising on the cost effective, safe and rational use of medicines on a population level
6. Delivering effective education in clinical pharmacology, therapeutics and prescribing to promote safe and effective use of medicines across the whole workforce
7. Providing expertise in the design and delivery of experimental medicine, and other types of clinical pharmacology & therapeutic research, including preclinical and clinical studies
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|  |

**Evidence of capability**

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the trainee’s capability (please see the CiPs tables and the assessment blueprint). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multi-disciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

**Presentations and Conditions**

The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated. The presentation and conditions listed are either common or serious and trainees will be expected to know about these but they will not need to be signed off for individual items.

**Training Opportunities**

The SAC have put together a table of theoretical examples of activity that might be undertaken for each specialty CiP. These can be found at the end of this rough guide. It is important that trainees and supervisors understand that the list is neither mandatory nor exhaustive and is intended to give some ideas about the achievement of curriculum objectives. There is space for local ideas for CiP delivery to be drafted where other training opportunities are identified in specific training locations. These ideas can be useful in making SMART objectives for a trainee’s PDP.

# **Assessment: What is required from trainees and trainers?**

**Introduction**

Decisions about a trainee’s competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below level expected for the current year of training. For the IM clinical and specialty CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each of these CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). The levels expected are given in the grid below and in the ARCP decision aid.

**What the trainee needs to do**

For CPT there is no major change to what the trainee needs to do in preparation for their ARCP. They still need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development. They should record how many clinics they have attended and how many patients they have been involved with on the Acute Unselected Take in the summary of clinical activity form.

Each trainee must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of two reports from consultants who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self- assessment allows the ES to see if the trainee’s views are in accord with those of the trainers and will give an idea of the trainee’s level of insight.

**Interaction between trainer and trainee**

Regular interaction between trainees and their trainers is critical to the trainee’s development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

* how to meet the training requirements of the programme, addressing each CiP separately
* a plan for taking the formative Knowledge Based Assessment (KBA)
* a discussion about what resources are available to help with the programme
* develop a set of SMART Personal Development Plans (PDPs) for the training year
* a plan for using study leave
* use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including;

* develop a PDP including SMART objectives for the placement
* access to clinics and how to meet the learning objectives
* expectations for medical on-call
* expectations for inpatient experience
* expectations to gain experience in end-of-life care

Depending on local arrangements there should be regular meetings (we recommend approximately one hour most weeks) for personalised, professional development discussions which will include;

* writing and updating the PDP
* reviewing reflections and SLEs
* reviewing MCR and other feedback
* discussing leadership development
* discussing the trainee’s development as a physician and career goals
* discussing things that went well or things that went not so well

**Self-assessment**

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a ‘one-off’ event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee’s ePortfolio account.

The purpose of asking trainees to undertake this activity is:

* To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process it is important that the induction meeting with a trainee’s ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum
* To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee’s portfolio. This will help the ARCP panel make a more informed judgement as to the trainee’s progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

**What the Educational Supervisor (ES) needs to do**

The educational supervisor and trainee should meet beforehand to plan what evidence will need to be obtained. This can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

**Educational Supervisor Report (ESR)**

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following anchor statements:

|  |
| --- |
| **Below expectations** for this year of training; may not meet the requirements for critical progression point |
| **Meeting expectations** for this year of training; expected to progress to next stage of training  |
| **Above expectations** for this year of training; expected to progress to next stage of training |

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include;

* Source of the evidence and its context, outlining contradicting evidence if appropriate
* Examples (of statements)
* Direction for future development/improvement

For the **IM clinical** and **CPT** **specialty CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

|  |
| --- |
| **Level 1: Entrusted to observe only** – no provision of clinical care |
| **Level 2: Entrusted to act with direct supervision**: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision |
| **Level 3: Entrusted to act with indirect supervision**: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision |
| **Level 4: Entrusted to act unsupervised** |

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

**Important Points**

* Plan the evidence strategy from the beginning of the training year
* Write the report in good time ahead of the ARCP
* Discuss the ESR with the trainee before the ARCP
* Give specific, examples and directive narration for each entrustment decision

# **Types of Evidence**

**Local Faculty Groups (LFG)**

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of senior clinicians (medical and non-medical) who get together to discuss trainees’ progress. The purpose is not only to make an assessment of a trainee but to determine and plan on-going training. It is recommended again as an optimal way of providing information about trainees’ progress.

The LFG set-up will depend on the circumstances of the organisation. In smaller units the LFG make include all the physicians; while in larger units there may be several LFGs, each in a different department. In all circumstances, as a minimum, an LFG must be able to consider, direct and report on the performance of trainees in the acute medicine/on-call setting.

The LFG should meet regularly to consider the progress of each trainee and identify training needs, putting in place direction as to how these needs are to be met. This should be documented and communicated to trainee’s Educational Supervisor and hence to the trainee. A mechanism for this to happen should be established.

**Multi-Source Feedback (MSF)**

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

**Multiple Consultant Report (MCR)**

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee’s performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The ***minimum*** number of MCRs considered necessary is two. It is advised that more should be obtained to support the entrustment decisions made by the ES especially if the trainee is struggling. All those formally appointed as CS should complete a MCR but any other consultant with whom the trainee has had significant interaction can also complete one. Consultants performing this role have to have knowledge of the CPT curriculum but do not necessarily have to be clinical pharmacology accredited to undertake this role.

Consultant supervisors completing the MCR will use the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice. If it is not possible for an individual to give a rating for one or more area they should record ‘not observed’. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

* Source of the evidence and its context, outlining contradicting evidence if appropriate
* Examples (of statements)
* Direction for future development/improvement

**Supervised Learning Events**

**Acute Care Assessment Tool (ACAT)**

The ACAT is used to provide feedback on a trainee’s performance when undertaking acute care, particularly the acute medical take. Its main focus is on multi- tasking, prioritisation and organisational skills. It should not be used to produce a “multiple Case Based Discussion”. Each ACAT should cover the care of a minimum of five patients.

**Case based Discussion (CbD)**

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

**Mini-Clinical Evaluation (mini-CEX)**

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

**Workplace-Based Assessments**

**Direct Observation of Procedural Skill (DOPS)**

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.

**Teaching Observation (TO)**

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

**Quality Improvement Project Assessment Tool (QIPAT)**

The QIPAT is designed to assess a trainee’s competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor. Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via [this link](https://www.aomrc.org.uk/wp-content/uploads/2019/06/Developing_QI_into_practice_0619.pdf).

**Project Based Discussion (PBD)**

The PBD is designed to provide structured formative feedback to trainees during a project, linked to one or more capabilities in practice (CiPs) from the Clinical Pharmacology and Therapeutics (CPT) curriculum. The content will vary depending on the project and CiPs involved but examples may include reflecting on a developing a new service or guideline, policy work relating to medicines management or aspects of clinical research e.g ethics submissions or publication. It will normally involve trainee reflection and discussion with a supervising assessor including suggestions for personal development.

**Examination**

**Knowledge based assessment (KBA)**

A formative knowledge based, online, single best answer assessment is completed by all trainees once per year. The assessment covers curriculum content delivered during the National Clinical Pharmacology and Therapeutics Specialty Training Teaching during the previous 12 months. As a formative assessment the KBA aims to allow trainees to check their learning from teaching sessions over the year and discuss progress with their educational supervisor and plan future training. Not passing this assessment on its own would not prevent a trainee from progressing.

**Reflection**

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop ‘self-knowledge’ to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events.

**Suggested evidence for each CiP**

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that trainees do not need to present every piece of evidence listed and the list is not exhaustive and other evidence may be equally valid.

# **Induction Meeting with ES: Planning the training year**

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee’s ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting review:

* Review Transfers of Information on the trainee
* Review previous ES, ARCP etc. reports if available
* Agree with the placement CSs how other support meetings will be arranged. Including;
* Arrangements for LFGs or equivalent
* Arrangements for professional development meetings

At the meeting the following need to be considered:

* Review the placements for the year
* Review the training year elements of the generic educational work schedule or its equivalent
* Construct the personalised educational work schedule for the year or its equivalent
* Construct the annual PDP and relevant training courses
* Discuss the trainee’s career plans and help facilitate these
* Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
* Discuss the teaching programme
* Discuss procedural simulation
* Discuss procedural skill consolidation
* Discuss arrangements for LTFT training if appropriate
* Plan additional meetings including the professional development meetings and the interaction with the placement CSs
* Planning of SLEs and WPBA
* Arrangements for MSF
* Review the ARCP decision aid
* Arrangements for Interim Review of Competence Progression (IRCP)
* Arrangements for ARCP and the writing and discussion of the ESR
* Pastoral support
* Arrangements for reporting of concerns
* Plan study leave

***At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions***.

**Important Points**

* Prepare for the meeting
* Make sure that knowledge of the curriculum is up-to-date
* Set up a plan for the training year

# **Induction Meeting with Clinical Supervisor (CS)**

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered;

* Review Transfers of Information on the trainee
* Review previous ES, ARCP etc. reports if available
* Arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

* Review the training placement elements of the generic educational work schedule or its equivalent
* Construct the personalized educational work schedule for the placement or its equivalent
* Construct the set of placement-level SMART objectives in the PDP
* Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
* Discuss procedural skill consolidation
* Discuss arrangements for LTFT training if appropriate
* Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
* Arrangements for MSF
* Review the ARCP decision aid
* Pastoral support
* Arrangements for reporting of concerns
* Plan study leave

**Professional Development Meetings**

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

* Discuss cases
* Provide feedback
* Monitor progress of learning objectives
* Discuss reflections
* Provide careers advice
* Monitor and update the trainee’s PDP
* Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
* Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
* Provide support around other issues that the trainee may be encountering

# **Transition arrangements for trainees already in programme**

The GMC has published a [new policy statement on the transition of learners to a new curriculum](https://protect-eu.mimecast.com/s/LEucCoY76FrV5NqtQLATh?domain=email.rcplondon.ac.uk). The policy statement sets out the GMC’s requirements for doctors in training who are working towards a CCT to move to the most recent GMC approved curriculum and programme of assessment. The transition should be completed as soon as it is feasibly possible, taking account of patient and trainee safety whilst also balancing the needs of the service. Some cohorts of trainees may experience a greater impact than others and require longer to prepare for the transition. As a guide, the GMC considers two years from the implementation date to be a reasonable transition period for all trainees to have moved to new curricula. Doctors in their final year of training (pro rata for less than full time trainees), or for whom it would not be in the interests of patient safety or impractical to support to move to a new curriculum, will normally remain on the curriculum in place prior to the new approval. An individual plan for each trainee should be made with their Educational Supervisor and available at the first ARCP after the curriculum is introduced.

Trainees who are training in CPT only or are in dual CCT programmes with non-GIM specialties may not be able to transfer to the new curriculum and may remain on the previous curriculum, providing this is agreed and approved by the postgraduate dean. They should be considered on a case by case basis.

Guidance on transition to new curricula is available on the JRCPTB website [here](https://www.jrcptb.org.uk/training-certification/shape-training-and-physician-training-model/transition-new-curricula-jrcptb).

# **Annual Review of Competence Progression (ARCP)**

**Introduction**

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

**Clinical Pharmacology & Therapeutics training and the ARCP**

The change from the tick-box style competencies to the high-level Capabilities in Practice (CiPs) will have a major impact on how trainees are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in trainees failing to achieve a standard ARCP outcome by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: “Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?”

**Relationship with Educational Supervisor (ES)**

It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

**Clinical supervisor (CS)**

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR). The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because

* Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
* They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
* They allow the excuse for trainees to receive targeted and constructive feedback from a senior colleague.

**Completing reports**

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the “normal” trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

**ARCP preparation**

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

* All appropriate certificates have been uploaded to the personal library and are clearly signposted
* An appropriate amount of reflection has been documented
* As a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio
* MSF has been completed and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF
* MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
* The trainee has self-rated themselves for each CiP on the curriculum page
* The SMART objectives documented in their PDP have either been achieved fully and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
* An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel
* The ES report should contain reference to the KBA performance

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

**The ARCP**

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed. If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should examine more detail in the ePortfolio and review more of the SLEs and other subsidiary information.

# **ARCP Decision Aid for Clinical Pharmacology & Therapeutics**

This decision aid provides guidance on the requirement to be achieved for a satisfactory ARCP outcome at the end of each training year. All numbers are indicative for guidance and the ARCP panel should make a holistic assessment of the trainee’s progress. The training requirements for Internal Medicine (IMS2) are set out in the IMS2 ARCP decision aid. The ARCP decision aids are available on the JRCPTB website.

| **Evidence / requirement** | **Notes** | **Year 1 (ST4)** | **Year 2 (ST5)** | **Year 3 (ST6)** | **Year 4 (ST7)** |
| --- | --- | --- | --- | --- | --- |
| Educational supervisor (ES) report | To cover the training year since last ARCP (up to the date of the current ARCP) | Confirms meeting or exceeding expectations and no concerns | Confirms meeting or exceeding expectations and no concerns | Confirms meeting or exceeding expectations and no concerns | Confirms will meet all requirements needed to complete training |
| Generic capabilities in practice (CiPs) | Mapped to [Generic Professional Capabilities (GPC) framework](https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework) and assessed using global ratings. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP | ES to confirm trainee meets expectations for level of training | ES to confirm trainee meets expectations for level of training | ES to confirm trainee meets expectations for level of training | ES to confirm trainee meets expectations for level of training |
| Specialty capabilities in practice (CiPs) | See grid below of levels expected for each year of training. Trainees must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each CiP  | ES to confirm trainee is performing at or above the level expected for all CiPs  | ES to confirm trainee is performing at or above the level expected for all CiPs | ES to confirm trainee is performing at or above the level expected for all CiPs | ES to confirm level 4 in all CiPs by end of training |
| Multiple consultant report (MCR) | Each MCR is completed by a consultant who has supervised the trainee’s clinical work. The ES should not complete an MCR for their own trainee | 2 (i.e. minimum two contributions from CSs or other consultants familiar with trainee and curriculum) | 2  | 2 | 2 |
| Multi-source feedback (MSF)  | 12 raters including 3 consultants and a mixture of other staff (medical and non-medical). MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF | 1*During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context* | 1*During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context* | 1*During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context* | 1*During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context* |
| Supervised Learning Events (SLEs): Acute care assessment tool (ACAT) *and/or* Case-based discussion (CbD) *and/or* mini-clinical evaluation exercise (mini-CEX) *and/or* Project Based discussions (PBD) | To be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are identified. SLEs should be undertaken throughout the training year by a range of assessors. Structured feedback should be given to aid the trainee’s personal development and reflected on by the trainee.Indicatively there should be at least one SLE per specialty CiP per year and two PBDs for each relevant CiP (1,2,3,5,6,7) by the end of training.  | 7 of which at least 3 should be PBD | 7 of which at least 3 should be PBD | 7 of which at least 3 should be PBD | 7 of which at least 3 should be PBD |
| Knowledge based assessment | Formative annual KBA | Completion each year with reflection and discussion recorded with ES. This is a formative assessment and not passing the KBA on its own would not prevent a trainee from progressing |
| Advanced life support (ALS) |  | Valid | Valid | Valid | Valid |
| Patient Survey (PS) |  | 1 satisfactory in ST4-ST5 | 1 satisfactory in ST6-ST7 |
| Quality improvement (QI) project | Project to be assessed with quality improvement project tool (QIPAT)  | Participation in quality improvement project or audit | Participation in quality improvement project or audit | Completion of quality improvement project with satisfactory QIPAT | Portfolio of quality improvement / audit involvement. Must include at least one QIP focused on CPT specifically |
| Teaching  | Attendance is either in person or evidence of engagement with recorded sessions.  | 70% attendance at regional/national CPT teaching days | 70% attendance at regional/national CPT teaching days | 70% attendance at regional/national CPT teaching days | 70% attendance at regional/national CPT teaching days |
| Leadership & Management |  | Evidence of participation in and awareness of aspects of management relevant to CPT e.g. taking part in formulary and policy and guideline committees | Evidence of participation in and awareness of aspects of management relevant to CPT e.g. taking part in formulary and policy and guideline committees | Evidence of participation in and awareness of aspects of management relevant to CPT e.g. taking part in formulary and policy and guideline committees | Evidence of participation in and awareness of aspects of management relevant to CPT e.g. taking part in formulary and policy and guideline committeesEvidence of leadership & management capability (eg completion of a management course) |

# **Levels to be achieved by the end of each training year for Clinical Pharmacology & Therapeutics specialty capabilities in practice (CiPs)**

**Level descriptors:** Level 1: Entrusted to observe only – no clinical care; Level 2: Entrusted to act with direct supervision; Level 3: Entrusted to act with indirect supervision; Level 4: Entrusted to act unsupervised

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Specialty CiP** | **ST4** | **ST5** | **ST6** | **ST7** |  |
| 1. Performing the clinical assessment, investigation and management of adverse drug reactions, medication errors and overdose at an individual and (where relevant) population level
 | 2 | 2 | 3 | 4 | **CRITICAL PROGRESSION POINT** |
| 1. Providing specialist management of patients with complex prescribing needs, including multimorbidity, polypharmacy, adherence issues, and medication intolerance
 | 2 | 2 | 3 | 4 |
| 1. Providing analysis and expert opinion on pharmacokinetic, pharmacodynamic and pharmacogenomic factors to guide therapeutic decisions
 | 1 | 2 | 3 | 4 |
| 1. Providing evidence-based practice and contributing to the evidence base in a therapeutic area of interest
 | 1 | 1 | 3 | 4 |
| 1. Advising on the cost effective, safe and rational use of medicines on a population level
 | 1 | 2 | 3 | 4 |
| 1. Delivering effective education in clinical pharmacology, therapeutics and prescribing to promote safe and effective use of medicines across the whole workforce
 | 2 | 2 | 3 | 4 |
| 1. Providing expertise in the design and delivery of experimental medicine, and other types of clinical pharmacology & therapeutic research, including preclinical and clinical studies
 | 1 | 1 | 3 | 4 |

# **Training Opportunities - Theoretical examples of activities by entrustment level**

|  |  |
| --- | --- |
| **Capabilities in Practice (CiP)** | Performing the clinical assessment, investigation and management of **adverse drug reactions, medication errors** and **overdose** at an individual and (where relevant) population level |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | (Level 2 is expected by the end of ST4 - therefore Level 1 may often be skipped for this CiP or only early in specialty training)Attendance on Toxicology or specialty ward roundAttendance at Hospital Drug Safety Committee (or equivalent)Shadow clinical pharmacologists chairing serious incident (SI) panels relating to medicines | (Attendance and engagement are NOT synonymous - therefore it is vital that observation is supported by some evidence even if not a full SLE)Reflective practice |   |
| **Level 2: Entrusted to act with direct supervision** | Assess patients with ADRs/overdose on the acute takeComplete and audit Medication error reports / yellow cardsActive Participation in Hospital Drug Safety Committee (or equivalent) - contributing to data collection, analysis, report writingAttendance at regional or national medicines committees (e.g. MHRA, AWMSG) | ACAT from acute takeMini-CEX or CbD on patients with medication error, Overdose or ADRAudits (written up as PbD)MCR from supervising consultants Reflective practice |   |
| **Level 3: Entrusted to act with indirect supervision** | (as per level 2 PLUS)Leading ward round for patients with ADRs/overdose on the acute take (under supervision)Lead Quality Improvement projects on Medication errors, overdose or ADRsActive Participation in Hospital Drug Safety Committee (or equivalent) - leading data collection, analysis, and report writingReviewing medication errors through Incident Reporting Systems / Governance panels and Supporting SI investigationsLead (under supervision) on an adverse event review in a clinical trial | ACAT from ward roundQIPATMCR from supervising consultants Reflective practicePbD |   |
| **Level 4: Entrusted to act unsupervised** | (as per level 3 PLUS)Leading ward round for patients with ADRs/overdose on the acute take (independent)Leading medication error investigations / serious incidents Leading on an adverse event review in a clinical trial | Reflective Practice PbD |   |
|  |  |  |  |
| **Capabilities in Practice (CiP)** | Providing specialist management of patients with complex prescribing needs, including multimorbidity, polypharmacy, adherence issues, and medication intolerance |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | (Level 2 is expected by the end of ST4 - therefore Level 1 may often be skipped for this CiP or only early in specialty training)Attendance on specialty ward roundAttendance at Polypharmacy clinics, MDTs (or equivalent) | (Attendance and engagement are NOT synonymous - therefore it is vital that observation is supported by some evidence even if not a full SLE)Reflective practice |   |
| **Level 2: Entrusted to act with direct supervision** | Assess patients with complex prescribing needs on the acute take, from inpatient referrals and in outpatient clinicsCase reporting, Audit work or Pharmacoepidemiological analysis on patients with complex prescribing needs | ACAT from acute takeMini-CEX or CbD on patients with complex prescribing needsCase reports or Audits (written up as PbD)MCR from supervising consultants Reflective practice |   |
| **Level 3: Entrusted to act with indirect supervision** | (as per level 2 PLUS)Leading ward round for patients with complex prescribing needs (under supervision)Lead Quality Improvement projects on patients with complex prescribing needsPresent cases to polypharmacy MDT, virtual clinics etc.  | ACAT from ward roundQIPATMCR from supervising consultants Reflective practicePbD |   |
| **Level 4: Entrusted to act unsupervised** | (as per level 3 PLUS)Leading ward round for patients with complex prescribing needs (independent)Running polypharmacy MDT, virtual clinics etc.  | Reflective Practice PbD |   |
|  |  |  |  |
| **Capabilities in Practice (CiP)** | Providing analysis and expert opinion on pharmacokinetic, pharmacodynamic and pharmacogenomic factors to guide therapeutic decisions |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | Attendance at relevant CPD activities (e.g. PK, PD, PG course) and National Virtual Training (when appropriate) | Course certification |   |
| **Level 2: Entrusted to act with direct supervision** | Assess data from PK, PD or PG to assist in managing individual patients in practice Audit or project work on PK, PD, PG issues  | CBD/ mini-CEXCase reports or Audits (written up as PbD)MCR from supervising consultants Reflective practice |   |
| **Level 3: Entrusted to act with indirect supervision** | (as per level 2 PLUS)Contributing to teaching on relevant courses involving PK, PD, PG issuesAnalyzing patient or population level data on PK, PD, PG and creating relevant action plans  | Teaching ObservationMCR from supervising consultants PbD |   |
| **Level 4: Entrusted to act unsupervised** | (as per level 3 PLUS)Leading teaching on PK, PD, PG issuesContributing to the development of new NHS services or guidelines on incorporating PK, PD, PG problems | Teaching ObservationPbDReflective practice |   |
|  |  |  |  |
| **Capabilities in Practice (CiP)** | Providing evidence-based practice and contributing to the evidence base in a therapeutic area of interest |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | Attendance at Therapeutic area of interest clinical activity (ward round, OP clinic) | (Attendance and engagement are NOT synonymous - therefore it is vital that observation is supported by some evidence even if not a full SLE)Reflective practice |   |
| **Level 2: Entrusted to act with direct supervision** | New patient assessment of patients within therapeutic area of interest (prior to senior review)Involvement in audit, QI or project work on therapeutic area of interest | ACATMini-CEX or CbD on patients within therapeutic areas of interestCase reports or Audits (written up as PbD)MCR from supervising consultants Patient surveyReflective practice |   |
| **Level 3: Entrusted to act with indirect supervision** | (as per level 2 PLUS)Leading ward round or clinic for patients within therapeutic area of interest (under supervision)Lead Quality Improvement projects on therapeutic area of interest | ACATMini-CEX or CbD on patients within therapeutic areas of interestQIPATMCR from supervising consultantsPbD |   |
| **Level 4: Entrusted to act unsupervised** | (as per level 3 PLUS)Leading ward round or clinic for patients within therapeutic area of interest (independent)Contributing to new evidence or guidelines in therapeutic area of interest | Reflective Practice PbDResearch output e.g. protocols, papers, conference papers |   |
|  |  |  |  |
| **Capabilities in Practice (CiP)** | Advising on the cost effective, safe and rational use of medicines on a population level |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | Attendance at Hospital or Trust Drugs and Therapeutics Committee (or equivalent) | Reflective Practice  |   |
| **Level 2: Entrusted to act with direct supervision** | Active Participation in Hospital or Trust Drugs and Therapeutics Committee (or equivalent) - contributing to new drug evaluation or audit workAttendance at regional or national medicines committees (e.g. RMOC, NICE, MHRA, SMC, AWMSG) | Mini-CEX or CbD on new drug evaluationsCase reports or Audits (written up as PbD)MCR from supervising consultants Reflective practice |   |
| **Level 3: Entrusted to act with indirect supervision** | (as per level 2 PLUS)Lead Quality Improvement projects on Medication Management issues (rational use of medicines etc)Active Participation in Hospital or Trust Drugs and Therapeutics Committee (or equivalent) - conducting new drug evaluations or audits | QIPATReflective practicePbD |   |
| **Level 4: Entrusted to act unsupervised** | (as per level 3 PLUS)Leading medication management work (e.g. new drug implementation guidelines) | Reflective Practice PbD |   |
|  |  |  |  |
| **Capabilities in Practice (CiP)** | Delivering effective education in clinical pharmacology, therapeutics and prescribing to promote safe and effective use of medicines across the whole workforce |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | (Level 2 is expected by the end of ST4 - therefore Level 1 may often be skipped for this CiP or only early in specialty training)Shadow clinical pharmacologists in educational roles (lecturing, chairing curriculum meetings, etc)Attend PSA question writing training | Reflective Practice Course certification |   |
| **Level 2: Entrusted to act with direct supervision** | Contribute to teaching of therapeutic principles to UG and PG trainees (under supervision) PSA Question writer (junior - attended writing workshop and early question development) | Teaching ObservationTeaching evaluation data Teaching diary |   |
| **Level 3: Entrusted to act with indirect supervision** | Independent contribution to teaching activities across a range of therapeutic and prescribing issues (within defined curriculum)PSA Question writer (senior - attended peer review events and active questions in PSA bank) | Teaching ObservationPbDReflective practiceTeaching evaluation data Teaching diary |   |
| **Level 4: Entrusted to act unsupervised** | Leading therapeutic courses and developing new teaching within therapeutic and prescribing areasPSA assessment board member | Teaching ObservationPbDReflective practice |   |
|  |  |  |  |
| **Capabilities in Practice (CiP)** | Providing expertise in the design and delivery of experimental medicine, and other types of clinical pharmacology & therapeutic research, including preclinical and clinical studies |
| **Entrustment Level** | **Theoretical Example of Activity** | **Assessment Methods / Tools** | **Local ideas for CiP delivery** |
| **Level 1: Entrusted to observe only** | Undertake GCP trainingAttendance at relevant CPD activities (research training)Shadow clinical pharmacologists in research roles (e.g. research ethics committee, research clinics) | Course certificationReflective practice |   |
| **Level 2: Entrusted to act with direct supervision** | Providing research expertise in any area of therapeutic research (patient consent, contributing to protocol development, conducting experimental research) | PbDMCR from supervising consultants  |   |
| **Level 3: Entrusted to act with indirect supervision** | Named investigator on clinical trialsContributing to teaching experimental medicine and therapeutic research | PbDMCR from supervising consultantsReflective practice |   |
| **Level 4: Entrusted to act unsupervised** | Developing new research protocols and delivering a research project (at any scale)Active Member of research ethics committeeLeading on teaching experimental medicine and therapeutic research | PbDReflective practiceResearch output e.g. protocols, trial delivery, papers, conference presentations |   |

# **Training programme**

In addition to the ideas for CiPs noted above, there are some key areas where trainees may be able to achieve their competencies.

**Medicines management and governance**

Capabilities are assessed *in practice* and represent professional activities that trainees are entrusted to perform by completion of training. Therefore, active involvement in Medicines Management and Governance work is necessary to meet the requirement of CiP 5 - Advising on the cost effective, safe and rational use of medicines on a population level. Examples of such activity include attendance, active participation and ideally regular membership at Medicines Management and Governance meetings. Trainees will be encouraged to attend and/or participate in any relevant medicines meetings within their training institution in their trainee capacity – these may include (depending on location) Area Prescribing Committees, Medicines Optimisation committees, All Wales Medicines Strategy Group (AWMSG), Scottish Medicines Consortium (SMC), etc. We would expect trainees to participate in medicines management activities throughout their curriculum relevant to their level of entrustment (i.e. attendance through to active involvement in later years).

**Clinical Pharmacology Research**

In order to meet the requirements of CiP 7 (Providing expertise in the design and delivery of experimental medicine, and other types of clinical pharmacology & therapeutic research, including preclinical and clinical studies), trainees need to be actively involved in Clinical Pharmacology Research. How this training is delivered will vary by training area and according to the structure of CPT departments and service delivery.

**Area of therapeutic interest**

The curriculum aims to develop a cohort of CPT consultants who together have specialist expertise in the therapeutics of many or most diseases or clinical areas. Thus across the UK CPT workforce there will be consultants with particular interest in hypertension, infectious disease, neurology, cardiovascular risk, mental health therapeutics and so forth. This expertise aims to support local, regional and national safe, effective and efficient use of medicines. It may be of particular value to the work of the MHRA, NICE, RMOC and BNF for example. Trainees, in conversation with TPDs and ES, are expected to select an area of therapeutic interest based on their own interests but also considering the opportunities and structure and services available in their training location. Trainees are not partial versions of other specialists. Rather there is a specific focus on the therapeutics of that disease area and how those therapeutics are developed and used safely and effectively. How the trainee enacts their involvement in this area of interest will vary widely, but is likely to be increasing exposure to clinics, consultations and other clinical activities as training progresses.

# **Training resources links**

[JRCPTB CPT specialty page](https://www.jrcptb.org.uk/specialties/clinical-pharmacology-and-therapeutics) - curriculum, decision aid, rough guide

[JRCPTB physician trainer resources](https://www.jrcptb.org.uk/training-certification/physician-trainer-resources)

British Pharmacological Society (bps.ac.uk)

[National Institute for Health and Care Excellence](https://www.nice.org.uk/)

[Scottish Intercollegiate Guidelines Network (sign.ac.uk)](https://www.sign.ac.uk/)

[National Institute for Health and Care Research](https://www.nihr.ac.uk/)

Medicines and Healthcare products Regulatory Agency (www.gov.uk)

[Yellow Card scheme (mhra.gov.uk)](https://yellowcard.mhra.gov.uk/)

[National Poisons Information Service](https://www.npis.org/)

[TOXBASE](https://www.toxbase.org/) - Poisons information database for clinical toxicology advice

[British and Irish Hypertension Society](https://bihsoc.org/)

[HEE pharmacogenomic education](https://www.genomicseducation.hee.nhs.uk/)

# **Glossary of abbreviations**

|  |  |
| --- | --- |
| ACAT | Acute Care Assessment Tool  |
| ALS | Advanced Life Support |
| ARCP | Annual Review of Competence Progression |
| CiP | Capabilities in Practice |
| CbD | Case-based Discussion |
| CCT | Certificate of Completion of Training |
| CS | Clinical Supervisor |
| DOPS | Direct Observation of Procedural Skills |
| EPA | Entrustable Professional Activity |
| ES | Educational Supervisor |
| GPC | Generic Professional Capabilities |
| GMC | General Medical Council |
| HoS | Head of School |
| JRCPTB | Joint Royal Colleges of Physicians Training Board |
| KBA | Knowledge Based Assessment |
| MCR | Multiple Consultant Report |
| Mini CEX | Mini Clinical Evaluation Exercise |
| MSF | Multi-Source Feedback |
| NTN | National Training Number |
| PBD | Project Based Discussion |
| PDP | Professional Development Plan |
| PS | Patient Survey |
| SLE | Supervised Learning Event |
| WPBA | Workplace Based Assessment |