IMT stage 1 ARCP outcomes and guidance for 2021

Background/principles

- Current IMT trainees have been affected by the COVID-19 pandemic for much of their training. This has brought many unique and valuable training opportunities, but some aspects of training have been adversely affected with reduced training opportunities (particularly outpatients and procedures), cancelled MRCP exams, reduced breadth of experience and reduced access to core areas of the training programme in some instances (Geriatrics, ICM and acute unselected take).
- IMT is a capability based curriculum and trainees can achieve capabilities while working in different ways or in different settings (such as virtual clinics or NIV on medical wards).
- We should support IMT progression wherever possible, whilst also ensuring patient safety and addressing any significant performance concerns. In addition, any training targets should be achievable in the training time remaining.
- Trainees are able to leave IMT after the second year to enter group 2 specialty training. Thus, this becomes a critical progression point.
- Effective supervision is vital, both to signpost training opportunities, assess capabilities for progression and to support trainees at this challenging time.
- The Educational Supervisor will need to perform a gap analysis as part of the ESR to determine where the trainee should be in terms of evidence and capabilities; where they are now and what additional training/experience is required to fill the gap.
- Trainees should aim to achieve all of the capabilities and curriculum requirements as detailed in the decision aid. However, to reflect the effect of the pandemic on training, a minimum data set for progression has been devised and COVID-19 ARCP outcomes will continue to be used where appropriate.
- Employers should be made aware of trainees entering IMY3 who do not have the procedural capabilities that may have been expected at the end of IMY2

Additional derogations approved for 2021:

- Procedures: No minimum competency level for end of IMY2
- Outpatient clinics: No minimum number of clinics required in IMY1 or IMY2

Minimum data set for progression:

Evidence/requirement	Comment
Educational Supervisor Report (ESR)	The ESR should focus on the capabilities demonstrated by the trainee and entrustment levels achieved. For clinical CiP 1 the ES must make an explicit statement about whether the trainee has achieved (or by the end of IMY2, is expected to achieve) Level 3 in clinical CiP1
Curricular coverage	Supervisors should make decisions based on how the trainee has engaged with the curriculum and what capabilities they have acquired. There should be no counting of specific experiences but just a holistic assessment of the entrustment level for each CiP.
Practical Procedures	The ES should define the level of trainee capability for each procedure. A derogation has been approved by the GMC. Thus, no practical procedure capability is mandatory for progression.
Multiple Consultant Report (MCR)	Sufficient MCRs to provide evidence for the ESR, the recommended number is 4 for the training year. If concerns have been raised then further MCRs may be required (see below for acute take and out-patient clinic MCR requirements)
Multiple Consultant Report (MCR) for Clinical CiP 1 (managing an acute unselected take)	By the end of IMY2, trainees require 3 MCRs, written by consultants who have personally supervised the trainee in an acute medical setting and specifically commenting about acute care.
Multi-source Feedback (MSF)	A complete MSF is required. An incomplete MSF that has not raised any concerns should not alone affect the ARCP outcome, but the reasons for the lack of a complete MSF should be explored and documented by the ES.
Supervised Learning Events (SLEs)	Sufficient SLEs to provide evidence for the ESR. A minimum of 4 consultant SLEs to include 2 consultant ACATs.
Advanced Life Support (ALS)	An expired ALS certification should not affect trainee progression. The ES rating for clinical CiP7 (delivering effective resuscitation) should be considered. Please see JRCPTB guidance - www.jrcptb.org.uk/covid-19.
Outpatient experience - clinical CiP4 (managing outpatients with long term conditions)	Evidence is required that they have engaged in outpatient training when opportunities have been available, obtaining MCRs (ideally 2 covering OPC), the new OPCAT and SLEs where possible; (Outpatient Care Assessment Tool | JRCPTB). A 'minimum' number of clinics has not been set. The ES may be able to assess CiP4 without MCRs if they themselves have spent adequate time with the trainee in an OP setting.
Acute unselected take numbers	No defined minimum as long as engagement with acute unselected take and ESR/MCR ratings for clinical CiP1 are supportive, based on the portfolio as a whole, rather than numbers of acute unselected take patients seen

Quality Improvement Project	Not required.
Teaching attendance, attendance at courses such as simulation	Evidence of engagement and attendance when possible which may include online learning.
MRCP	Trainees may progress within IMT stage 1 without successfully completing any part of the MRCP. However, trainee engagement with the MRCP is required and the ES report must indicate whether it is felt that it is possible for the trainee to achieve all three parts of MRCP in the IMT stage 1 time remaining (or by ST3 end if leaving for a group 2 specialty).
Training experiences	It will not be mandated that trainees have completed a minimum of 10 weeks of critical care and four months of geriatric medicine during IMT but for those who leave IMT at the end of IMY3 there would be an expectation that the relevant learning experiences will have been obtained. For those who leave at the end of IMY2 there is no requirement for these capabilities to have been achieved.

Suggested ARCP outcomes

It is important that ARCP panels make a holistic judgement on trainee progression, based on capabilities achieved and learning experiences.

Outcome 1

- No performance, engagement or patient safety concerns.
- Completing capabilities at rate expected for stage of training.
- ESR/Curriculum capabilities/CiPs/ procedural capabilities achieved at level expected for stage of training.
- MCRs/MSF/SLEs/Outpatients/Acute Take achieved at modified requirements as outlined in the minimum data set required.
- Successfully completed MRCP to the level expected at stage of training.

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Outcome 10.1

- An outcome 10.1 should be awarded when a trainee is achieving progress at the expected rate, but the acquisition of capabilities has been delayed by the impact of COVID-19. It is anticipated that these capabilities will be achieved **without a need for extension to training** and the trainee can progress to the next stage of training.
- No performance, engagement or patient safety concerns.
- ESR complete and CiPs/procedural capabilities rated by ES.
- MCRs/MSF/SLEs achieved at modified requirements as outlined in the minimum data set required.

- The capabilities that have not been achieved should be clearly defined and an action plan to support the trainees in achieving the missing competencies will be required.

Further guidance around specific key capabilities can be found below:

Clinical CiP 1 (Acute unselected take) and progression to IMY3**:**

- The ARCP panel should make a holistic decision based on the evidence available. This will include the ESR and MCRs, along with additional portfolio evidence such as ACATs and the MSF. Feedback received during a period of 'acting up' at medical registrar level or registrar shadowing may also aid an entrustment decision for CiP1, however a period of 'acting up'/registrar shadowing is not a requirement. It is also noted that trainee performance in other related CiPs may feed into the ES entrustment decisions.
- If there is uncertainty about whether a trainee has achieved entrustment level 3 for CiP 1 at the time of ARCP the guidance below around maximising progression should be followed (see below) and training opportunities should be arranged to facilitate trainees' achieving the required capabilities in the remaining time in IMY2.
- If at the end of IMY2 the ARCP panel feel that a trainee may require additional support with the medical registrar role, a decision between progression to IMY3 with enhanced supervision and mentoring if required (outcome 10.1) or remaining at IMY2 (outcome 10.2) must be made. For example, it may be appropriate for a trainee to progress to IMY3 but only to lead the acute take during the working day when direct senior supervision is available and it may also be possible for a trainee to progress to IMY3 if progress is otherwise satisfactory and the ES and panel feel the trainee will achieve entrustment level 3 after a relatively short period (for example, less than 3 months) of additional support.
- It is also recognised that some trainees may have concerns about the medical registrar role and therefore require additional support, despite achieving entrustment level 3.
- A robust and supportive action plan will be required for trainees who progress to IMY3 with an outcome 10.1 without achieving level 3 entrustment for clinical CiP 1 and those requiring additional support. This should include tailored training opportunities to enable the trainee to achieve entrustment level 3.
- Once this has been achieved and evidenced in the portfolio, then a formal review by a senior medical educator (e.g. TPD) should take place to confirm that the trainee has achieved the required capabilities and is capable of leading the acute unselected take (and therefore acting as medical registrar). This should take place at the earliest opportunity in order to facilitate the trainee gaining experience of managing the acute unselected take (acting as medical registrar) during IMY3.
- Further guidance on sign off of Level 3 entrustment for clinical CiP 1: Managing the acute unselected take can be found in the Rough guide to IMT [Rough guide to IMT revised May 2020 (jrcptb.org.uk)]

Clinical CiP 4: Outpatients

- ePortfolio evidence of CiP capability should be reviewed (MCRs, OPCAT, SLEs, ESR) and it should be noted that a minimum number of clinics has not been set. Direct supervision (entrustment level 2) is required for progression.
- It is anticipated the vast majority of trainees will achieve this and be able to progress. We acknowledge the limitations of OP experience during the pandemic and the ES may be able to make a judgement on entrustment level for OP clinic using transferable skills, such as skills observed during inpatient work and performance in other related CiPs. Ongoing development of outpatient capabilities may be a focus in subsequent training years.
- A minimum number of clinics is not required.

Procedural capabilities

- A trainee may progress without achieving the target recommendations for the training year - derogation agreed with the GMC.
- A supportive action plan is required to facilitate trainees achieving the procedure capabilities required during the remaining training time.

MRCP

- Trainees must have engaged in the MRCP and parts of the exam that are still required should be documented as well as previous attempts and cancelled exams.
- Trainees may be awarded an outcome 10.1 and progress even if all parts of Membership exam are outstanding.
- It should be noted that all those who have applied for a group 2 specialty must have already passed part 1 to be allowed to apply.

Outcome 10.2 (end IMY2 only):

- An outcome 10.2 should be awarded when a trainee is achieving progress, but the acquisition of certain capabilities has been delayed by the impact of COVID-19 to an extent that these capabilities **cannot be achieved during the remaining training programme and an extension of training time is required.** This would be expected to be a minority of trainees who have had their training and acquisition of capabilities (CiPs) severely disrupted (for example shielding trainees that have missed a very significant amount of training opportunities) and therefore cannot safely progress to IMY3 or ST3. It should be remembered that trainees may have achieved the entrustment level required for each CiP while working in different ways or in different settings during the COVID -19 pandemic and trainee performance in related CiPs may feed into the ES entrustment decisions. The capabilities that have not been achieved should be clearly defined. An action plan to support trainees in achieving their missing capabilities will be required to identify the indicative period of time and defined learning experiences that will be required within the training extension.
- We recognise that a minority of trainees may have spent a significant amount of time away from clinical practice during the COVID-19 pandemic, due to a variety of reasons. Although IM training is

capability based, we feel that it is highly unlikely that a trainee would be able to achieve the capabilities required for completion of IMY2 with less than 18 months clinical experience within the two years of IMT that has been available. In this case additional training time at the current level would likely be required and an outcome 10.2 awarded at IMY2 ARCP. (It is recognised that ACF trainees may have completed academic placements during IMY1-2 and pre-existing guidance around minimum clinical time and progression should be followed for this group - 9 months academic placement over 3 years IMT stage 1 training. See integrated academic training and IMT guidance).

- No performance, engagement or patient safety concerns.
- ESR complete and CiPs/procedural capabilities rated by ES.
- An outcome 10.2 should not be issued at the end of IMY1 as this is not a critical progression point.
- An outcome 10.2 should not be issued for lack of progress with procedure capabilities
- A 10.2 should not be issued for lack of progress with the MRCP exam unless the ES report suggests that the trainee is unable to achieve all parts of the MRCP examination that are outstanding within the remaining training time.

Further guidance around specific key capabilities can be found below:

CiP 1 (acute unselected take):

- An outcome 10.2 should only be awarded if a trainee has not achieved entrustment level 3 (indirect supervision) and additional training time is required. This will be appropriate in trainees who are a significant way off achieving level 3 entrustment and the ARCP panel feel that the trainee will be unable to achieve entrustment level 3 by the end of IMY2 (despite tailored training opportunities and support) or following a relatively short period of enhanced support at the start of their IMY3 (see further guidance above).

CiP 4 (outpatients):

- Level 2 (direct supervision) is required by the end of IMY2 and it is envisioned most trainees will achieve this. If a trainee has only achieved entrustment level 1 (observe only – no provision of clinical care) by the end of IMY2 this would merit an outcome 10.2. We acknowledge the limitations of OP experience during the COVID 19 pandemic and the guidance in the minimum data set and above regarding achieving capabilities while working in different settings/different ways and trainee performance in related CiPs aiding entrustment decisions should be followed.

Outcome 2

- Performance, engagement or patient safety concerns not related to the COVID -19 pandemic.
- No additional training time required
- Guidance as per Gold Guide. Gold Guide - 8th Edition - Conference Of Postgraduate Medical Deans (copmed.org.uk)

Outcome 3

- Performance, engagement or patient safety concerns not related to the COVID -19 pandemic.
- Additional training time required
- Guidance as per Gold Guide. Gold Guide - 8th Edition - Conference Of Postgraduate Medical Deans (copmed.org.uk)

Outcome 4

- Guidance as per Gold Guide Gold Guide - 8th Edition - Conference Of Postgraduate Medical Deans (copmed.org.uk)

Maximising progression (IMY2 end):

- If at the time of the IMY2 ACRP the trainee has not met the capability requirements for a 10.1, but there is the possibility of achieving this by the end of IMY2 an outcome 5 should be issued and reviewed before the end of the training year. An action plan to support trainees in achieving their missing capabilities will be required and TPDs should work with ES and trusts to facilitate training opportunities that will enable trainees achieving the missing capabilities prior to IMY2 end whenever possible. This is not necessary for IMY1 as it is not a critical progression point..
- If an ARCP panel feels that the critical capabilities cannot be achieved prior to completing IMY2 (for example a trainee who has spent a very significant amount of time away from clinical practice due to the COVID -19 pandemic) an outcome 10.2 should be awarded (see above).

Action plans, subsequent review and access to missed training opportunities

- All ARCP outcomes, except outcome 1, require a formal action plan in order to support trainees in achieving the required capabilities. This should be completed with the ES, reviewed by the TPD and communicated to the host trust as well as the trust that the trainee is planned to rotate to. TPDs should work with trusts in order to support trainees in achieving their missed capabilities due to the COVID-19 pandemic. This may involve making adjustments to planned rotations or facilitating bespoke training opportunities.
- Reasons for the outcome should be recorded carefully in the ARCP section of the portfolio to inform future ARCPs (which may be in a new programme if the trainee is leaving for a group 2 speciality).
- Trainees who have spent a significant amount of time away from clinical practice should be supported back into clinical practice when they are able to do so. A supported return to training including a supernumerary period is likely to be required. The Educational Supervisor should complete a gap analysis to determine where the trainee should be in terms of evidence and capabilities, where they are now and what additional training and experience is required to fill the gap.
- A trainee may have demonstrated level 3 entrustment for clinical CiP 1 (acute unselected take), but not demonstrated independence in the core procedures that a medical registrar may be expected to perform. This should not prevent the trainee leading the acute unselected take, and trusts must ensure that competent individuals are available to perform the procedures if required. (Federation procedures statement (www.jrcptb.org.uk)

- Trainees moving into IMY3 on a 10.1 will need to catch up on one or more, or potentially all, of the following:
    - All parts of MRCP
    - Procedural skills
    - Demonstration of CiP 1 Level 3
    - Demonstration of Critical Care training outcomes
    - Demonstration of Geriatric Medicine training outcomes
    - Demonstration of Outpatient training outcomes

For each trainee it is critical that an assessment is made whether the trainee is likely to be able to acquire all of the missing elements of IMT training. No trainee should be subjected to undue pressures in the final year of IMT and, if the elements of training missing are considerable, consideration of an outcome 10.2 to allow enough time for capability acquisition may be thought appropriate.

Impact assessment

Trainees entering IMY3:

The majority of trainees will be able to enter IMY3 on either an Outcome 1,2 or 10.1. Those with requirements considered to be too burdensome should be given an Outcome 10.2. Some who enter IMY3 with a 'developmental' outcome may ultimately require an extension at the end of IMY3 but the numbers cannot be estimated at this stage.

Tra*inees exiting IMY2 for a Group 2 specialty*:

Trainees may exit IMY2 for a Group 2 specialty if they meet the application and entry requirements. Those without all parts of the MRCP Diploma will be required to attain it by the end of ST3; if they do not do so they will need an extension. If all IMT required procedural capabilities have not been attained the trainee will have to gain the procedural capabilities that are relevant to their specialty and have to demonstrate the skill at the required level before the end of ST3. If they are not able to do so an extension to training will be required. The precise numbers that this will affect cannot be estimated at this stage.

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