ARCP decision aid for JRCPTB specialties during the COVID-19 pandemic

Introduction

During the present COVID-19 pandemic, it is recognised by the Statutory Education Bodies (SEBs) of the 4 Nations that there are difficulties for trainees and trainers in preparing and providing evidence for ARCP.

As described in paragraph 1.12 in the eight edition of the Gold Guide (GG8), Postgraduate Deans have the discretion to make derogations from the Guide in exceptional circumstances. The SEBs consider that COVID-19 meets the criteria for highly exceptional circumstances that would enable postgraduate deans to collectively agree a set of principles for the evidence to be presented for ARCP in 2020.

GG8 defines in paragraph 4.69 that the panel delivering the ARCP process should consist of at least three panel members. Due to the expected difficulties in releasing panel members from clinical services during this pandemic, the SEBs propose that ARCP panels in 2020 will be convened with the minimum number of panellists and that the panellists will be enabled to deliver the ARCP process remotely by videoconference, telephone or similar.

Trainees who are progressing at the expected rate

If a trainee is progressing and has been developing competences/capabilities at the expected rate and whose activities have not been significantly affected by the COVID-19 pandemic then the usual ARCP codes may be used. This will probably apply to the minority of trainees in the physician specialties. If a trainee is progressing and has been developing competences/capabilities at the expected rate but progress has been affected by the COVID-19 pandemic the trainee should be awarded an **Outcome 10 (10.1 or 10.2).** Supplementary codes must be used to document the reason for this outcome and the capabilities to be developed should be documented on the ARCP form. If the outcome awarded is 10.1 the trainee can progress to the next stage of training as overall progress will be assumed to be satisfactory. If however the trainee is at a critical point in training and has been affected by the pandemic an outcome 10.2 should be awarded and further time allowed in the training programme. An Action Plan, the portfolio and a Personal Development Plan (PDP) should capture and set out the required capabilities which will be expected at the next scheduled ARCP and the time point for this review defined. Any additional training time necessary will be reviewed at the next ARCP.

ARCP has not taken place

Where an ARCP has not taken place as a result of COVID-19, it is proposed that no outcome is recorded and an N code supplied indicating **N13** and specifying the reason as being due to COVID-19. The trainee, if not at a rate-limiting step in their training (professional examination; mandatory course; specific capability), will be allowed to progress to the next year of their training when an early ARCP will be undertaken and an Action Plan and Personal Development Plan will be put in place. A planned date for the ARCP should be documented.

Trainees where concerns about professionalism, attitudes or professional practice are noted

If concerning issues are highlighted in the MSF, ESR or elsewhere in the portfolio including direct involvement by the trainee in significant incidents these should be reviewed carefully and the use of an outcome 2 or 3 may be justified.

Trainees at the end of core medical training

For trainees at end of a core programme and otherwise progressing satisfactorily but where a critical progression point criterion is missing (e.g. professional examination; mandatory course; mandatory placement) as a consequence of COVID-19, the ARCP panel should consider whether the compensatory evidence provided by the trainee would be sufficient to enable the trainee to complete core training and be issued with an **Outcome 6**. If it is not possible to use compensatory evidence to support the award of an Outcome 6 but the trainee has passed part 1 MRCP but not the other parts of the exam or has incomplete competences the trainee will be awarded an **Outcome 10.1** and can take up an ST3 post if offered. If however the trainee has not completed any part of the MRCP exam and/or has otherwise failed to progress to an acceptable extent then the trainee will be awarded an **Outcome 10.2** that will allow for further training time. An Action Plan and Personal Development Plan must be put in place for a subsequent training period. An **Outcome 3** should be awarded if there is lack of engagement with training or significant concerns are raised about patient safety or professionalism. Supplementary C codes will be used to document the reason for the award of either Outcome 10.1 or 10.2 and the capabilities to be developed should be documented on the ARCP form.

ARCP decision aid

This table below provides guidance on the minimum requirements for an ARCP outcome 10 for the JRCPTB specialties. This guidance and additional specialty specific advice is available on the JRCPTB website via this link.

Evidence / requirement	Notes
Educational supervisor report (ESR)	The ESR should focus on the capabilities demonstrated by the trainee in the review period, including relevant experience during COVID-19 which might contribute to acquisition of the Generic Professional Capabilities (GPC) or common competencies required in the curriculum. Particularly, the ESR should state whether or not there are significant issues and whether these were present pre-COVID-19, occurred as a result of COVID-19 and/or whether COVID-19 has contributed to them. If the ES is unavailable, an alternative medical educator with knowledge of the trainee (eg Programme Director) may be able to complete the ESR.
Curriculum competencies	Evidence of engagement with curricular competencies/capabilities proportionate to time spent in primary specialty

Evidence / requirement	Notes
Multiple consultant report (MCR)	There should be at least one report from the present clinical supervisor or, if the trainee has been redeployed away from their primary specialty, the CS before redeployment. One other consultant should provide an MCR. It would also be helpful if an MCR from any redeployment was available.
Multi-source feedback (MSF)	As a minimum there should be evidence of an MSF being started even if there have been inadequate numbers of assessors yet to respond. The responses of those who have responded should be reviewed. Ideally a completed MSF should be available or consideration given to any that have been undertaken prior to this year of training
Supervised learning events (SLEs): **Acute care assessment tool (ACAT)** **Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)**	There must be evidence of engagement in training by records of SLEs prior to the impact of COVID-19. There may also be further SLEs recorded during the pandemic but, while these are very useful evidence of continuing engagement with training these should not be expected. For most medical specialties there will be an expectation of ~50% of SLEs as defined by the specialty specific ARCP decision aid, this should be taken as a guide and not applied stringently
Practical procedures	Evidence of specialty specific procedures prior to lockdown Evidence of procedures specific to Internal Medicine should be recognised throughout the redeployment period
Knowledge based assessment *If applicable to specialty*	The KBA defined for each specialty will have to have been obtained before a recommendation for CCT can be made
Advanced life support (ALS) *If applicable to specialty*	Please see JRCPTB guidance – www.jrcptb.org.uk/covid-19
Quality improvement (QI) project or audit	Not required
Simulation *If applicable to specialty*	Evidence of engagement if courses have been run locally
Teaching attendance	Evidence of engagement before lockdown

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