Guidance on transition and gap analysis of trainees moving to new curricula in the Group 1 specialties from 2022 (GUM, Neurology and Palliative Medicine)

This guidance is for educational supervisors, training programme directors and trainees in Genitourinary Medicine (GUM), Neurology and Palliative Medicine. It provides information and frequently asked questions about how current trainees can prepare for transition to new curriculum and dual training in Internal Medicine from August 2022.

Introduction

For trainees who were recruited to training in one of the three new group 1 specialties on the previous curricula and are now preparing to move to the new ones, there will be a need to be an assessment of which capabilities have already been achieved and which need addressing. This process (gap analysis) should involve discussion between trainee and educational supervisor and will consider previous learning experiences and capabilities acquired to date. The change in the first part of physician training from core medical training to internal medicine stage 1 means that trainees from CMT may not have had opportunities to complete learning experiences that would now be required for IM stage1.

In considering the trainee's previous experience, assessment of involvement in the acute unselected take (AUT) is critical. Trainees need to be capable at level 3 for CiP 1 (i.e. capable of acting with only indirect supervision) to be able to function without immediate support in the AUT. If this is uncertain, trainees should gain experience in being the medical registrar during times when there is immediately available senior cover. Once there is certainty that the trainee can function at an appropriate level by two trainers that have worked with the trainee, this should be recorded in the ePortfolio, preferably using an educational meeting form.

Although there is a need in IMT for critical care experience it is recognised that doctors who have been working over the pandemic often have gained frequent experience of the management of the critically unwell and the escalation of treatment options. In discussion between the trainer and trainee this may be deemed adequate experience to fulfil the requirements of CiP 7 (resuscitation and the acutely deteriorating patient) and again this should be recorded in the ePortfolio as an educational meeting. If there no evidence of such experience, arrangements should be made for the trainee to be attached to a critical care team so that an appropriate learning opportunity can be offered. Other capabilities that are required by IMT should also be reviewed but it should be recognised that acquisition of capability in the other CiPs described for IM can be achieved throughout the training period before CCT and not there is no requirement to focus on them in the immediate transition period.

When should the gap analysis be done?

The gap analysis is best done early in ST3 (for those trainees starting in August 2021) so there is the opportunity to tailor the learning experiences in the coming year prior to August 2022, recognising that there may be limitations in what experiences may be gained. It is also important to identify trainees who may not be

able to transfer because it would not be in the interests of patient safety or impractical to support to move to a new curriculum. These cases should be highlighted to the postgraduate dean.

Most doctors who completed CMT/ACCS-AM will not have done an ICU post. Can they demonstrate capability in other ways?

The specific need for critical care experience is to ensure that trainees have capabilities in the management of the acutely sick. The learning outcomes for critical care are described in the Rough Guide to IMT (pages 40-41) . Experience in COVID wards that were providing enhanced levels of care could be counted. The functioning of outreach teams varies greatly so this experience should be reviewed to determine what capabilities were gained.

What should the gap analysis include?

The gap analysis should consist of a documented review of the experience gained to date and a recording of which capabilities still need to be gained either before starting Internal Medicine stage 2 or following transfer to the new curricula (specialty plus IMS2). A form has been provided to document the gap analysis and this can be uploaded to the trainee's personal library as a record and should be submitted to the relevant training programme director. The form is available on the JRCPTB website via this link. The IM stage 1 & 2 curricula are available on the JRCPTB website page for internal medicine and the specialty curricula can be accessed on the specialties webpages.

What clinical experience undertaken outside a training programme may be considered? What happens if the trainee has a gap in general medical and take experience since completing CMT/ACCS-AM?

Consideration should be given to the whole of training and clinical experience undertaken. An assessment should be made of the level of entrustment required for managing the acute unselected take and this should be recorded as part of the gap analysis. Some trainees may have maintained capability to a level where they can manage the acute unselected take with indirect supervision but others will need further experience and specific time will need to be allocated.

If gaps are identified, what is the process by which they are addressed? If extra training time required, is this OOP and how funded? And what about the gaps in the posts they were doing.

The transfer to the new curricula has to be funded within a locality and should not take the form of an OOP unless it is considered the best way in that locality and for that trainee to gain the relevant experiences. The CCT date may need to be delayed to take this into account.

Can Internal Medicine training programme directors support the gap analysis process?

If the specialty TPD is not familiar with the IM curriculum it is recommended they engage the local IM TPD to assist with the gap analysis process. This will be supported at a national level via the IMCMTAC and GIM SAC.

How can trainees record evidence of IM experience in the ePortfolio?

Trainees can use the SLEs and WPBAs to record feedback received during IM experiences and the Educational Supervisor can use the educational meeting form to record details of relevant experience. The IM stage 2 curriculum is under development and is not yet available on the ePortfolio but is available on the JRCPTB website for reference. Trainees can request that the GIM curriculum is added to their record by contacting eportfolioteam@jrcptb.org.uk.

Contents of ST3 year and subsequent ARCP

It is clear that some trainees from the new group 1 specialties who have started training in internal medicine before the official transition to the new curricula may be disadvantaged when it comes to their next ARCP because they will have been in an internal medicine attachment rather than a specialty attachment. For such individuals the ARCP outcome awarded to a trainee could be a contentious issue. The review of the year's training may suggest that an extension to training is required for all specialty capabilities to be achieved. This could result in an outcome 3 being suggested. This outcome, however, is defined as demonstrating "inadequate progress by the trainee – additional training time required". This would not be appropriate for a trainee who is making suitable progress but has anticipated transition to the new curriculum for their specialty. Although an outcome 3 should not be viewed as a punitive it is frequently seen as such by trainees.

It is suggested therefore that an holistic assessment of the training that the trainee has undertaken is reviewed and if satisfactory progress has been achieved then an ARCP outcome 1 should be used. An outcome 2 may be more appropriate if it is felt that the inclusion of IM training earlier than specified by the specialty curriculum has affected specialty training and thus this outcome would be used as an indicator that the trainee is changing curricula and their progress in both specialty and IM training should be closely monitored. The change of curriculum should coincide with a review of the CCT date to ensure that the dual specialty requirements of the new curricula are likely to be met within the anticipated period of training and a change made if necessary.

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