Frequently asked questions on trainee progression during the COVID-19 pandemic

Educational Supervisor (ES) report

Q1. If you disagree with the view of you ES what right of appeal do I have and how will this be facilitated?

Your ES report should be shared with you before your ARCP. You do not have to agree with it. If there are elements with which you disagree you should firstly discuss these with your ES. If you still strongly disagree with the report then you can raise this with your Training Programme Director prior to the ARCP itself.

Supervised Learning Events (SLEs)

Q2. Will we have to catch up on the number of SLEs in the final year? Can you publish the new overall number to be achieved over the three years? Is this a 'pro rata' number?

SLEs are formative rather than summative and as such are a vehicle for facilitating feedback and therefore the number should be driven by the need to provide evidence of your capabilities for your ES report. There will be no total overall to be achieved over the programme and no requirement to "catch up" those that have been missed during the pandemic. However, you should do as many as possible to maximise your opportunities for feedback from the more senior staff with whom you work and demonstrate your capabilities. Guidance is provided on our Covid-19 webpage.

Outpatient Clinics

Q3. With no minimum number for outpatient clinics, decisions regarding capability will be determined by individual educational supervisors. How will we ensure that this is fair across all trainees and regions?

The number of clinics specified in the curriculum was designed to allow trainee to develop and demonstrate their outpatient capabilities. Difficulties for trainees getting outpatient experience during the pandemic has meant that we have had to adjust our approach. To facilitate assessment of capabilities all ES should have received training in making holistic judgements on your progression. These judgements will be based on the collected opinion of other senior clinicians with whom you have worked. These opinions are collected using the various methods of feedback which include SLEs, MCR etc. A specific outpatient care assessment tool (OPCAT) has been developed and it is strongly recommended that this is used to provide extra evidence of outpatient capabilities.

If your ES does not have sufficient evidence on which to base a decision, they can ask you to provide more evidence. Because of the pandemic we are very aware that trainees' outpatient experience has been adversely affected. The outpatient experience can include a range of environments, including participating in virtual clinics, both telephonic and using video linked software. Your local deanery will be working closely with providers to ensure that your training needs are taken into consideration as service recovery also occurs.

Please see our guidance on learning outpatient skills

Q4. Will we be required to 'catch up' on clinic numbers in IMY3? If not what how many clinics would we be expected to have attended by the end of IMY3?

The need for a set number of clinics has been removed and there will be no requirement to 'catch up' clinics that have been missed during this COVID year. We anticipate mandating the clinic requirement in subsequent years. An indicative minimum number of 20 clinics is required in IMY3 as a guide.

Procedures

Q5. Will I be required to go back and prove competency of a procedure if I go into a Group 2 specialty? What happens if I then want to join a Group 1 specialty?

If you have missing procedural competencies and enter a group 2 specialty, your new Training Programme Director will assess whether you need to demonstrate the IMS1 requirement to train within your new specialty. In many group 2 specialties there will be no requirement for procedural ability whereas in others (e.g. Medical Oncology, Haematology etc) certain procedural competencies will be required. If you transfer to a Group 1 speciality then you would undergo a gap analysis on transfer and that would highlight the requirement to attain all of the IMS1 procedural competencies before the end of IMS1.

Q. How will trainees be supported to gain these competencies in their final year?

***Q. Who should I speak to if my trust does not have a way of supporting procedures that I cannot perform*?**

No trainee should be put in a position as a matter of service delivery of having to perform a practical procedure that they are not competent to perform. The provision of practical procedure training to support the acute take and other aspects of patient care is a clinical governance issue and is the responsibility of the medical director (see Federation statement on practical procedures). Trainees should seek access to suitable training either in a simulation setting or under close clinical supervision depending on the practical procedure and levels of previous training.

Training experiences

Q. If we do not need to do four months of Geriatric Medicine and ten weeks of Critical Care now, then why should we have to do it at all?

When trainees start IMY3 they must meet with their ES and undergo a gap analysis to see which experiences they have had and which capabilities they should have achieved during IMY2. An agreement will be drawn up to ensure that 'gap' can be filled. Many trainees who have been heavily involved with COVID will have had a great deal of critical care experience with non-invasive ventilation and other forms of respiratory support so

will have gone a long way towards demonstrating that particular CiP. If additional experience in any particular area is required then the ES will attempt to arrange it.

As clinical work and training returns towards normal the experiences during our usual clinical work are likely to be less intense and the need for formal critical care experience will return. Similarly, we expect the benefit from gaining experience in care of the elderly will help trainees understand better the clinical needs of the elderly. Trainees who feel they need specific experience in these areas should discuss this with their ES as part of the gap analysis.

Q. How can trainees ensure they get this experience when their jobs may not include these rotations in IMY3 or are we just accepting that they may have missed out on this experience due to COVID?

Even if trainees have not had a formal critical care and/or geriatric medicine attachment during IMY1 and IMY2 and it is not scheduled in IMY3, they will probably have had a lot of experience and training towards the Capabilities in Practice (mainly but not confined to CiP 3, 6 and 8). Once again, the gap analysis will identify whether further specific critical care and geriatric experience are essential either by extending training or by shortening other attachments.

Q. Will I be a worse registrar if I have not had access to these experiences?

No. We believe that even with the disruption of training during Covid, most trainees will have had a different but no less adequate experience and training and with assessment, support and filling of any "gaps" following appropriate analysis they will be every bit as effective and safe in the registrar role. They will be well equipped to progress into higher specialist training.

MRCP

Q. What is defined as 'engagement' with MRCP(UK)?

There is no strict definition of engaging with MRCP(UK) but essentially it means demonstrating that a trainee has made reasonable efforts to achieve appropriate parts of the MRCP(UK) including applying to sit the relevant exams. If a trainee has applied but then there has been good justification for not sitting e.g. cancelled exams, cancelled courses, inadequate time for study etc. this will still be considered engagement with MRCP.

Q. What if MRCP(UK) is not achieved by ST3?

Trainees cannot progress beyond ST3 without achieving MRCP(UK). It is recognised that this may present a challenge for trainers and trainees when entering a Group 2 specialty where there may be less focus on the acute unselected take. However, a gap analysis will reveal exactly what experience and learning opportunities are required to achieve full MRCP(UK). If necessary, trainees will be given an ARCP outcome 3 or 10.2 on completion of ST3 and will have extended opportunities to achieve exam success

Q. Will attainment of parts of the MRCP(UK) be part of the interview assessment for higher specialty training?

There will be no assessment of MRCP attainment in the interview process unless it is indicated that examination results may be awaited. If this is the case, then the interviewers may enquire about the outcome.

ARCP outcomes

Q. How are you ensuring that outcomes are applied fairly and consistently?

The only influence that we have over ARCP panels is by providing as much guidance and information as possible prior to the panels and encouraging Heads of Schools to try and ensure that our guidance is implemented equitably.

Q. If I need my training extended, will this happen in the Trust I currently work at or will this be at a different Trust? Will I have the same ES during the extension period?

Extensions to training are controlled by Deanery Schools of Medicine and Trusts but the hope is that as far as possible it would be within the same Trust and with the same ES.

May 2021