Recognition of time spent Out of Programme (OOP)

Background

Prior to 2003 a trainee was deemed to be clinically and managerially competent after they had completed a specified time in an approved training programme. It is recognised that this determination is based on an educationally unsound assumption that all trainees could and would achieve competency at the same rate. It was also possible in several specialties to take time out of training programme, often for research activity, and this research activity would be allowed to count for up to one year of training. The clinical experience and training that any individual trainee may accrue during aa period spent out of programme will vary dramatically. Some trainees may spend the entire period in a laboratory where they may not be gaining any clinical capability (although of course they will be acquiring generic capability). Others may have considerable patient contact during OOP and may be able to acquire and demonstrate in and out-patient increased capability. As we move into a system that relies on the acquisition, and assessment, of clinical capability the mechanism by which out of programme experiences may 'count' towards training has to be reviewed.

Proposal

It is suggested that the system of prospective recognition of OOPs should be maintained but instead of there being automatic recognition of such time counting towards training there should be a review of the trainee as they return to the clinical training programme. This review would be analogous to a gap analysis during which experience and capability acquisition that is relevant to training would be assessed. It is very likely that progress in the generic CiPs would have achieved during the OOP period and where trainees have maintained clinical activity there could also be progression within the clinical CiPs. There should be an ARCP performed during each year of research and the trainee should accumulate evidence of CiP acquisition by logging the clinical activities that they undertake, including acute take, out-patient and ward work experiences. All of this should be recorded in the e-portfolio and shared with an appropriate educational supervisor who can comment on clinical CiP progression. This may be the academic supervisor who also has the requisite clinical training or if that is not the case, a educational supervisor from a clinical background would need to be identified. This level of supervision provides an opportunity for educational supervisor reports to highlight how the trainee is progressing both in their research and also in the generic and clinical CiPs. At the ARCP prior to the trainee returning to clinical practice there should be a review of the CCT date; this can be altered according to the trainee's progress. As the trainee recommences the clinical training programme the educational supervisor should undertake a gap analysis with the trainee with specific curricular defined learning opportunities defined for the coming year of training. Depending on trainee progress the next ARCP panel should again review the proposed CCT date and confirm or modify as appropriate.

Overall, this may reduce the total training time that the trainee had to take under the old system that relied on 'counting of time'. It emphasises the acquisition of capabilities as the currency by which all training programmes should be judged. Conversely, however, it also means that if continuing clinical activity, that results in CiP acquisition, is not possible during OOP time then the ARCP panel assessment of progress in training may result in the CCT date being delayed with the total training time being extended.

It is important that trainees maintain contact with their educational supervisors so that they may be advised appropriately throughout their training programme and progress expedited according to the fulfilment of curricular requirements.

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