Advice to Head of Emergency Medicine Schools, and Emergency Medicine STC Chairs, re assessment of competencies for the ARCP 2008

Introduction

We have produced this document to help Emergency Medicine Heads of School (HOS) and Specialty Training Committee (STC) chairs in determining the criteria for successful sign off at the ARCP 2008. This will also support the emergency medicine HOS and STC chairs in providing guidance for trainees in how to achieve the full complement of competences for progression to C/ST3 and above. We recognise that since this is the first year of the programme, there has been uncertainty about the requirements and therefore clarity needs to be restored.

Trainees who were appointed to run through training (RTT) in 2007 will be the first to be assessed by this system, which has been agreed with PMETB. In the case of emergency medicine (EM) this has also required agreement with other Colleges who contribute to the ACCS curriculum.

We are conscious that this agreement has taken some time to be publicised and are keen to provide guidance to assist in the review of a trainee's progress within the framework agreed.

This document should be read in conjunction with the Gold Guide recommendations for the actual conduct and outcomes of the ARCP process.

Overall Assessment Framework

The table below shows the number and type of assessments that a RT trainee, appointed in 2007 should have completed prior to the award of CCT (please note that trainees appointed in 2007 should be known as ST3, rather than CT3 – as this is only applicable to trainees who will uncouple).

Overall Assessment Framework for Emergency Medicine for 2008

	ACCS						HST		
	CT1		CT2		CT3		ST4	ST5	ST6
	EM	AM[1]	Anaesth[2]	ITU	MSK	PEM			
Mini-Cex	2	8	4	3	2	2	4	4	2
ACAT		12							
CbD	2	8	2	2	2	2	4	4	2
DOPs	2	8	6	4	2	2	4	4	2
STR (by CS or ES)	1	1	1	1	1	1	1	1	1
MSF	1		1		1		1	1	1
Portfolio review	1		1		1		11	1	1
MCEM A	desirable		desirable		essential				
MCEM B&C			desirable		desirable		essential		
Life support Courses[3]	desirable		desirable		At least 2		All 3		

1 The trainee would be expected to gain these competencies over a 2 year period and not all whilst in AM
2 Anaesthetic competencies are assessed at 3 moths and are listed in the RCA web page
3 UK advanced life support courses, which are ATLS, ALS and EPLS or PALs

Details of the individual assessments are available on the relevant College web sites.

Trainees who entered in Aug 2007 may not have been fully aware of this advice until January 2008 and therefore suitable flexibility should be applied at their first ARCP.

ST1 RT trainees

Trainees either commenced their ST1 year in an EM post or in an Acute Medicine (AM) placement.

Emergency Medicine

Those trainees who started in EM in August 2007 have been able to access the Workplace Based Assessment (WPBA) documentation available on the CEM website from that date. It would therefore be expected that trainees should be able to produce, for their first ARCP, a full complement of EM WPBAs for this period.

This should consist of 2 Mini-Cexs, 2 DOPs and 2 CbDs. Some leniency may be used at the panel's discretion if the topics covered in these assessments do not exactly match the ones listed by the CEM, but this is a matter for the Educational Supervisor (ES) to decide when completing the Structured Training Report (STR) for that particular period of training.

Trainees are required to submit a STR, summarising their WPBAs for each period of training. As trainees do not always work directly with their ES,

it would be expected that the ES would complete the STR with the Clinical Supervisor (CS) who has completed the majority of their assessments or who has been allocated as their departmental supervisor.

All documents are available on the work place based assessment pages of the Training and Examinations section of the CEM website http://www.collemergencymed.ac.uk/CEM/

Acute Medicine

Trainees who started in an AM post did not have reasonable guidance on the number and frequency of assessments required until January 2008. It is therefore unreasonable to expect a trainee who started in AM in Aug 07 to have completed all of these assessments.

The AM assessments number approximately 36 in total, which the CEM believes is not achievable within a 6/12 AM post and the CEM therefore recommends that these should be spread out over the whole of the ACCS 2 years, as agreed with the inter-collegiate ACCS board. Assessments will need to be undertaken in AM related topics by trainers while the trainee is working in the posts in ICM, Anaesthesia and EM throughout the 2 year programme.

Trainees who started in AM in August 2007 should have begun to demonstrate some AM competencies during the second half of the year (i.e. from Jan 08 to July 08) whilst working in EM. It would not be unreasonable to expect trainees to have completed at least 1 AM assessment per month from and including January 2008, up to the date of their ARCP.

They will then have the remainder of their ACCS programme to demonstrate **all** of the AM competences in order to achieve level 1 competence in Acute Medicine. .

Only under exceptional circumstances should a C/ST1 RT trainee enter C/ST3 not having demonstrated all of the AM competences, as the demand on the trainee during C/ST3 would otherwise be too onerous to expect them to achieve any outstanding ACCS competences.

C/ST1 trainees, who entered AM in Aug 07, will therefore have 16 months to demonstrate all of the AM competences required, given that during August – December there was a lack of clarity.

ST2 RT trainees

Demonstration of ST1 competences

Trainees who entered ST2 training in 2007 would be expected to demonstrate that they have achieved competences in EM and/or AM by having previously completed approved SHO posts. Letters of appointment and assessments confirming satisfactory completion of posts should be available and included in the trainee's portfolio as evidence for PMETB. Failure to provide this evidence could mean that that the trainee runs the risk of PMETB requiring the CESR route to Specialist Registration.

It is quite possible that a ST2 trainee, due to the fact that the person specifications for 2007 were purposefully broad, may be missing some of the ST1 competences, particularly within Acute Medicine. Such trainees are unlikely (due to lack of advice) to complete many, if any, AM competences from Jan 08 to the ARCP. These trainees must be provided with the opportunity of acquiring AM competences during C/ST3 and this is possible as it is likely that one of the C/ST3 competences/experience (e.g. Paeds) was exchanged for an ACCS competency to enter the programme. It is suggested that this advice is provided by the ARCP panel and/or TPD at the earliest possible opportunity.

The trainee, rather than repeating the PEM (or T&O) experience should be gaining AM competences during this time. It would be quite acceptable for this 6/12 to be spent in an ED, with an AM focus (e.g. day release to AM takes and ward rounds) as the majority of the AM competences can be assessed in EM.

Although it would represent a significant commitment for trainees to demonstrate all of the AM competences during this 6 months, at least 50% of them should be achieved allowing 3/12 of ST4+ (HST) experience for the remainder to be gained.

It should be acceptable to use this 3/12 as part of the 6/12 ST4+ (HST) experience agreed with PMETB towards acquiring these competences, without extending total training time. Again this time could be spent in the ED with a focus on AM with a day release programme.

Demonstration of ST2 competences

The assessments required for the ST2 year were available from Aug 07 and therefore should be produced on a pro-rata basis for Anaesthesia and ICM up to the ARCP date.

There may be some regional differences in the evidence produced for these critical care competencies and it is up to the local ARCP panel

(which includes Anaesthesia and ICM panel members) to decide if the evidence produced is of sufficient standard to allow progression.

The trainee should not be disadvantaged by any assessment process that is not in complete agreement with the Intercollegiate ACCS Board given that this is a new and evolving programme.

ST3 RT trainees

A significant number of RT trainees would have entered ST3 training in 2007 with missing ACCS competences. Their initial focus should be to demonstrate the competences required for their ST3 year, although it is assumed many will already be able to demonstrate these competences from previous experience, hence their appointment to ST3.

It may be possible to use the second 6/12 of the ST3 year to demonstrate /acquire missing competences, whilst still remaining in the ED and completing the ST3 competences. This is particularly true for AM (see ST2 above), but it would not be expected that trainees would acquire all these competences in 6/12 and may require some time allocated for this during ST4+ (HST).

Missing competences in Anaesthesia and ICM will require a period of attachment in that specialty. The CEM has agreed with PMETB that during the transition years trainees can be 'seconded' to Anaesthesia and/or ICM to gain these competences.

The duration of each secondment is dependant upon the acquisition of competences and is not time dependant. It may be possible for a trainee to gain the required competencies during a 3/12 attachment in each area, making a total of 6 months for anaesthesia and critical care, achievable in the headroom period agreed with PMETB during HST, in which case the CCT would not be delayed.

However, if the competences have not been gained during the 6/12 headroom period, then the CCT would need to be extended accordingly (in a process similar to the old RITA E). Any seconded time out of the ED will clearly have an impact on service and covering this time with a LAT should be discussed with the HOS and Postgraduate Dean.

The CEM is aware of examples where ST3 trainees have been allowed day release in the second half of ST3 (having completed their musculo-skeletal (MSK) or Paediatric EM (PEM)) to gain Anaesthesia and ICM competences, which can be finalised at a latter date. This is perfectly

acceptable to the Training Standards Committee and the Education & Examination committee.

We have also published a framework of training for CT3 trainees for both PEM and MSK as some difficulties have arisen in brining these specialties 'in house' for training. The framework for PEM specifies the different options of environment in which the trainee is able to gain exposure to Paeds EM. We are conscious that for this first year there will be some problems in the amount of time the ST3 trainee is able to spend seeing Paediatric cases, but would hope that some sensible judgement can be made by the PEM ARCP panel member as to what constitutes ST3 PEM competences to get through to ST4, bearing in mind some of these competences can be acquired in ST4+ (HST).

It is hoped in England, Wales and Northern Ireland that by the time we completely uncouple CT1-3 from ST4-6, (the intake in 2008-09) we will have more clearly defined those core PEM competencies required for completion of CCT as distinct to those competencies that can acquired in ST4+ (HST).

ST4 RT trainees

Trainees who entered ST4 in 2007 should have all of the ACCS, PEM and MSK competences, as evident by letters of completion of SHO posts in their portfolios. Trainees should be able to readily produce this evidence for successful application to PMETB via the CCT route. Failure to produce this evidence may result in the trainee having to take the CESR route to the specialist register.

However a number of trainees may be missing one or more ACCS or ST3 competences. Trainees progressing from ST3 to ST4 in 2008 may not have passed the MCEM parts B&C (or equivalent).

ST3 RT trainees who enter ST4 in 2008 will have until the end of their ST4 year to pass the full MCEM (or equivalent), under the agreement reached with the Training Standards Committee and Education & Examinations Committee in 2007.

Trainees who are missing ACCS or ST3 competencies may use the 6/12 headroom in ST4+ (HST) to gain these.

For AM, MSK and PEM, trainees can be based in the emergency department and have a specialty focus and day release programme (see individual competencies above). Trainees must complete the required amount of WPBA expected for each specialty and this includes those in AM.

Trainees are advised to start early with their AM assessments as these can be demonstrated whilst in EM and do not need to be left until time is allocated for AM focused training at some later date.

Anaesthesia and ICM competences can only really be demonstrated outside of the ED and the 6/12 headroom can be counted towards this. If a trainee fails to demonstrate the required competencies during this time the ARCP panel may agree to extend the training period accordingly and inform the Training Standards Committee of the adjustment in the CCT date.

Specialist Registrars (SpRs)

There is no (legal) requirement for old style SpRs to demonstrate any WPBAs as they are not subject to the same assessment system as agreed with PMETB. However the TSC and E&E would strongly recommend that they do complete some WPBAs as this method of assessment will be required for revalidation and the FCEM OSCEs are really adapted WPBAs (with the CTR a version of case based discussion).

It is up to local panels to agree on the type and number of assessment required from this type of trainee, dependant on the individual trainees learning styles and needs.

'Failure to progress'.

If an ARCP panel feel that a trainee has not produced sufficient evidence to demonstrate that they are at the correct level of training, then the panel can hold that trainee at that level until the requirements are fulfilled (similar to the old 'RITA E' process).

At the end of this period the ARCP panel should review progress and if satisfactory confirm with the CEM how long the CCT should be extended by.

It is up to the local EM Programme/School and STC as how these trainees are accommodated in the rotation whilst gaining these competencies providing all training is in PMETB approved posts. The current recommendations in the Gold Guide are that up to one year can be used to demonstrate missing competences, but normally this would be no more than 6 moths and would always be agreed with the PG dean.

TSC and E&E
April 2008