Gastroenterology ARCP Decision Aid – *August 2014*

The table below sets out the targets that have to be achieved for a satisfactory ARCP outcome at the end of each training year. Requirements for advanced specialist areas follow. This document replaces previous versions from August 2014.

Blueprint Sections	Assessment	ST3	ST4	ST5	ST6	ST7
	External					
	SCE		Specialist Exam [a]			
	Supervised learning events					
Common Competencies	mini-CEX [b] / CbD [b]	Ten of the common competencies do not require linked evidence but any concerns must be reported in the appraisal documentation and educational supervisors report [h]				
	Evidence of engagement [c]	30%	50%	80%	90%	100%
Basic and Applied Science	mini-CEX [b] / CbD [b]					
	Evidence of engagement [c]	30%	50%	80%	90%	100%
Upper GI tract disorders	mini-CEX [b] / CbD [b]					
	Evidence of engagement [c]	30%	50%	80%	90%	100%
Intestinal disorders	mini-CEX [b] / CbD [b]					
	Evidence of engagement [c]	30%	50%	80%	90%	100%
Hepatology	mini-CEX [b] / CbD [b]	3 mini-CEX and 6 CbD				
	Evidence of engagement [c]	30%	50%	80%	90%	100%

Nutrition	mini-CEX [h] /CbD [h]/DOPs	3 mini-CEX, 6 CbD and 3 DOPs				
Total SLEs (mini-CEX / CbD) per year		6	6	6	6	6
	Workplace based assessments					
Endoscopy	Formative DOPS [d] Summative DOPS [d]	Formative x 10 in each modality	F-DOPS S-DOPS	F-DOPS S-DOPS	F-DOPS S-DOPS	F-DOPS S-DOPS
	DOPS [d]	2	2	2	2	2
Generic skills	MSF [e]	Satisfactory		Satisfactory		
	Audit assessment [f]	1	1	1	1	1
	Patient survey [g]		Satisfactory		Satisfactory	
Multiple Consultant Report (MCR)		4-6	4-6	4-6	4-6	4-6
Educational Supervisor Report		Satisfactory	Satisfactory	Satisfactory	Satisfactory	Satisfactory

Notes:

a) Specialist Exam: Can be attempted in ST4 onwards, must be achieved for attainment of CCT.

b) Six SLEs in total (mini-CEX; CbD) per year to cover curriculum requirements, to be guided by the core outcomes blueprint grid. One SLE in each major domain 1-5 covered during placement, with endoscopic procedures assessed more frequently. If progression is inadequate, as evidenced by SLEs/WBA's and supervisor report, then ARCP outcome 2 or 3.

c) Indication of percentage of curriculum to be explored. Will help to identify gaps in training in particular nutrition / hepatology where experience may be focused into a specific training period.

d) Endoscopy: should have a formal formative DOPS x 10 in all procedures being practiced each year (since all procedures will be directly supervised this is easily accomplished). Summative DOPS for JAG accreditation can be taken when appropriate. Other procedures should be assessed by a total of DOPS x 2 annually.

e) MSF should be carried out at end of years 1, 3, and as required. If there are no concerns, two MSFs over the specialty training would be satisfactory. If there are areas for improvement, there is the option to add in further MSFs as necessary.

f) There should be evidence of audit undertaken on an annual basis, which has been assessed by the ES.

g) A patient survey should be carried out during years 2, 4, and as required. If there are no concerns, two Patient Surveys over the period of specialty training would be satisfactory.

h) **Common competencies**

Evidence such as reflective logs, courses, teaching and SLEs should be used to demonstrate exploration of these curriculum competencies. The following common competencies will be repeatedly observed and assessed but do not require linked evidence in the ePortfolio:

- History taking
- Clinical examination
- Therapeutics and safe prescribing
- Time management and decision making
- Decision making and clinical reasoning
- Team Working and patient safety
- Managing long term conditions and promoting patient self-care
- Relationships with patients and communication within a consultation
- Communication with colleagues and cooperation
- Personal Behaviour

Advanced Specialist areas

1. Hepatology

Blueprint section	Assessment	Induction [1]	Month 6	Month 12
Liver transplantation	SCE, CbD, mini-CEX, MSF[2]			
Acute liver failure	SCE, CbD, mini-CEX			
Hepatitis C	SCE, CbD, mini-CEX			
Hepatitis B	SCE, CbD, mini-CEX			
Complications of cholestatic liver disease	SCE, CbD, mini-CEX			
Vascular liver disease	SCE, CbD, mini-CEX			
Pregnancy associated liver disease	SCE, CbD, mini-CEX			
Liver tumours **Benign** **Hepatocellular** **Cholangio Ca**	SCE, CbD, mini-CEX			
Intensive care	SCE, CbD, mini-CEX, MSF[2]			
Competency progression[3]				
Audit [3]	AA			
Total assessments required			5	10
Endoscopic management of varices	Log book, DOP's		10 [5]	20 [5]

[1] Sum of relevant assessments undertaken prior to Advanced Specialist training
[2] MSF should be directed to intensive care or multi disciplinary assessment of malignancy or need for transplantation
[3] Review of evidence produced suggesting satisfactory progression (Y/N/ action required)
[4]Evidence of audit involvement should be assessed at month 6 for inception and month 12 for completion
[5] Endoscopic DOP's should include variceal banding, injection of Histoacryl glue / thrombin, use of APC for those wishing to undertake endoscopy as a consultant

It is strongly suggested that a log book be kept by the trainee to demonstrate exposure to the breadth of the curriculum in terms of cases seen in clinic, on the wards, and in an ITU setting

2. Inflammatory bowel disease

Blueprint section	Assessment	Induction [1]	Month 6	Month 12
Principles	SCE, mini-CEX			
Diagnosis	SCE, CbD			
Management **Routine** **Surgical** **Biological**	Modified ACAT, CbD, mini-CEX, log book			
Team working	MSF[2]			
Complex disease	CbD, log book			
Disease in pregnancy	SCE, mini-CEX, CbD,			
Nutrition in IBD	SCE, mini-CEX, CbD, log book			
IBD in adolescence	SCE, mini-CEX, CbD			
Competency progression[3]				
Total assessments required **mini-CEX / CbD**			5	10
Colonoscopy in patients with IBD	DOPS		Log book >30	Log book >60
Audit [4]				

[1] Assessments involving IBD cases should be reviewed on commencement of Advanced Specialist training
[2] MSF undertaken between months 4 and 8 using members of MDT and supervisors
[3] Review of evidence produced suggesting satisfactory progression (Y/N/ AR action required)
[4] Evidence of audit involvement should be assessed at month 6 for inception and month 12 for completion

It is strongly advised that a logbook is kept recording all cases seen in clinic / on wards for review during advanced specialist training.

3. Nutrition

Blueprint section	Assessment	Induction [1]	Month 6[3]	Month 12
Enteral nutrition	CbD, mini-CEX,			
Parenteral nutrition	CbD, mini-CEX			
Intestinal failure-general	CbD, mini-CEX			
Short bowel **-IBD** **-ischaemia** **-jejunostomy/high output stoma** **-jejunum in continuity with colon**	CbD, mini-CEX,			
	MSF[2]			
pancreatitis	CbD			
Post-op. complications/ management	CbD, mini-CEX			
Enteric dysmotility	CbD, mini-CEX			
Eating disorders	CbD, mini-CEX			
Abdominal malignancy/chemo-radiotherapy	CbD, mini-CEX			
Ethical/legal issues	CbD			
Total assessments required **mini-CEX / CbD**			8	16
Insertion and removal of parenteral feeding lines	DOPS		8 (logbook)	16 (logbook)
Audit [4]				

[1] Assessments involving nutrition cases should be reviewed on commencement of advanced specialist training
[2] MSF undertaken between months 4 and 8 using members of MDT and supervisors
[3] Review of evidence produced suggesting satisfactory progression (Y/N/ AR action required)
[4] Evidence of audit involvement should be assessed at month 6 for inception and month 12 for completion

It is strongly advised that a log book is kept recording all cases seen in clinic / on wards and procedures performed for review through advanced specialist training

4. Advanced Endoscopy

Blueprint section	Assessment	Induction [1]	Month 6	Month 12
Endoscopic ultrasound	DOPS, CbD, MSF	Accredited in diagnostic upper gastrointestinal endoscopy and preferably flexible sigmoidoscopy prior to training	cancers of oesophagus, stomach or rectum, >25; sub-epithelial lesions, >15; pancreatico-biliary, >25 and FNA, >15 (50% solid pancreatic lesions); >20 DOPS luminal, > 10 subepithelial; > 20 pancreatico-biliary; 10 CbD; 1 MSF	cancers of oesophagus, stomach or rectum, 75; sub-epithelial lesions, 40; pancreatico-biliary, 75 and FNA, 50 (50% solid pancreatic lesions); >40 DOPS luminal, > 20 subepithelial; > 40 pancreatico-biliary; 20 CbD
ERCP	DOPS, CbD, MSF	> 20 procedures; 7 DOPS	>120 procedures; 50 DOPS; 10 CbD; 1 MSF	>250 procedures; 100 DOPS; 20 CbD

[1] Sum of relevant assessments undertaken prior to advanced specialist training.

Completion of this period of training does not necessarily confirm eligibility to practice in this specialist area independently