JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Implementation
Endocrinology & Diabetes Mellitus Curriculum
Guidance for training programme directors, supervisors and trainees

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Contents

Introduction

This guide is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself. The curriculum, ARCP decision aid and this guide are available on the JRCPTB website.

The Rough Guide has been put together by members of the SAC with additional help from many external stakeholders especially trainees. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different about the 2022 curriculum?

Background

The 2007 (amendments 2010) curriculum adopted a competency based approach to training and assessment in which a large number of individual competencies were specified, and trainees were required to demonstrate evidence of competence in each. There have been two major drives to the need for change. Firstly the move away from the 'tick-box' approach associated with the current competency-based curricula to the holistic assessment of high level learning outcomes. The new curriculum has a relatively small number of 'capabilities in practice' (CIPs) which are based on the concept of entrustable professional activities (EPAs). Secondly, the GMC has mandated that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the Generic Professional Capabilities (GPC) framework.

The Internal Medicine clinical CiPs have been embedded in the specialty curriculum and all CiPs are mapped to the GPCs. The Endocrinology and Diabetes CiPs define the main areas of current specialty clinical practice and the enhanced role of the trainee and supervisor assessment, based on the concept of entrustable professional activities (EPAs) with a holistic assessment.

Duration of training

Endocrinology & Diabetes Mellitus higher specialty training and Internal Medicine stage 2 training will usually be completed in four years of full-time training. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

The 2022 Endocrinology & Diabetes Mellitus curriculum

The purpose of the curriculum is to produce doctors with the generic professional and specialty specific capabilities required to practice in Endocrinology & Diabetes Mellitus and Internal Medicine.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

The curriculum focuses on inpatient management (with emergency, inpatient and perioperative care a focus) but also patient empowerment through the outpatient setting (particularly education, enablement, self-care and choice). It recognises the need for involvement in disease prevention (from global health issues such as obesity and type 2 diabetes and screening for genetic conditions). It aims to address inequalities in health care. Whilst ensuring a broader base of knowledge, the curriculum helps develop skills to enhance super-specialist care via networks and Multidisciplinary Teams or meetings (MDTs of MDMs) for rarer conditions, to allow early recognition of these cases as consultants. Outpatient clinical experience is essential to ensure 'pattern recognition' of the common and rare conditions, but there is also an inclusion of other methods of enhancing training including MDTs and virtual learning, such as simulation (SIM) training.

By the end of their final year of training, the trainee will receive a dual CCT in Endocrinology & Diabetes Mellitus and Internal Medicine.

Capabilities in Practice (CiPs)

The **generic CiPs** cover the universal requirements of all specialties as described in the GPC framework. The generic CiPs are common across all physician specialties. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The **clinical CiPs** describe the capabilities required for Internal Medicine. The **specialty CiPs** describe the professional tasks or work within the scope of Endocrinology & Diabetes Mellitus.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice (level 4) in all clinical and specialty CiPs.

Capabilities in practice (CiPs)

Generic CiPs

1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focussed on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor to be assessed by DOPS

Internal Medicine Clinical CiPs

1. Managing an acute unselected take
2. Managing the acute care of patients within a medical specialty service
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions
5. Managing medical problems inpatients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills

Specialty CiPs

1. Providing diagnosis, management of diabetes mellitus as a long-term condition in outpatient, ambulatory or community settings
2. Providing diagnosis, support and management for people with diabetic foot disease
3. Providing diagnosis, support and management for women with diabetes and endocrine disorders in the perinatal period
4. Providing diagnosis, support and management of diabetes and endocrine disorders in adolescents and young adults (AYA)
5. Providing diagnosis, support and management for people with endocrine disorders in the outpatient and ambulatory settings
6. Providing support and management of diabetes and endocrine disorders in perioperative period
7. Providing support and management of people with diabetic and endocrine emergencies including management of these conditions during acute illness

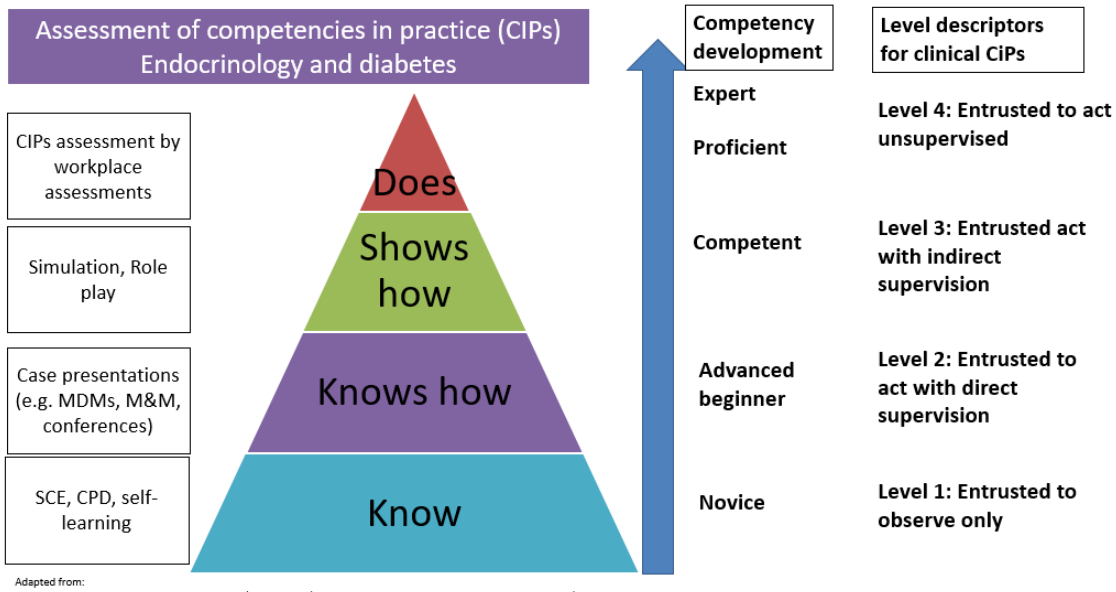
Please see the curriculum for details of each CiP.

Evidence of capability

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the trainee's capability (please see the CiPs tables and the assessment

blueprint). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multi-disciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

Evidence of progression across the years through the CiPs is essential. Trainees should move through stages of learning as reflected below. This includes reflection about 'doing it differently next time' and experience of putting that reflection in practice with future experience. Trainees can model their self-assessment of stage of CiP based on these principles.



Adapted from:

1. Miller GE. The assessment of clinical skills/competence/performance. *Acad Med.* 1990;65:S63–7. doi: 10.1097/00001888-199009000-00045.
2. Dreyfus S, Dreyfus H. A five stage model of the mental activities involved in directed skill acquisition. California University Berkeley Operations Research Center 1980.
3. JRCPTB, Curriculum for Endocrinology and Diabetes Training, Jan 2021

Presentations and Conditions

The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated. The presentation and conditions listed are either common or serious and trainees will be expected to know about these but they will not need to be signed off for individual items.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below level expected for the current year of

training. For the IM clinical and specialty CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each of these CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). The levels expected are given in the grid below and in the ARCP decision aid. A guide around using tools to assess CiPs is given below, but equivalence can be achieved through other means.

Table: Guide to assessing CiPs per domain of competency

Competency	**How to assess CIPs**
Knowledge	SCE, MCR, CBD
Patient care	Mini-CEX, CBD, MSF, OPCAT, simulation, patient survey, MCR
Procedures	DOPS
Professionalism	MSF self-assessment, MSF, declarations, Form R, Patient survey
Communication skills	Patient survey, MSF, MCR
Learning from own practice	Audit of own medical notes & entries, review and reflection of adverse incidents and patient safety or learning events, logbook, teaching observation
Learning from practicing within a system	MCR, MSF, reflections, QIPAT,

What the trainee needs to do

The requirements for supervised learning events (SLEs) and workplace based assessments (WPBAs) are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the **absolute minimums**. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development.

Each trainee must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received the minimum number of reports from consultant physician who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self- assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the Specialty Certificate Examination (SCE)
- a discussion about what resources are available to help with the programme
- develop a set of SMART Personal Development Plans (PDPs) for the training year
- a plan for using study leave
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including;

- develop a PDP including SMART objectives for the placement
- access to clinics and how to meet the learning objectives
- expectations for on-call
- expectations for inpatient experience
- expectations to gain experience in end-of-life care

Depending on local arrangements there should be regular meetings (we recommend approximately one hour most weeks) for personalised, professional development discussions which will include;

- writing and updating the PDP
- reviewing reflections and SLEs
- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a physician and career goals
- discussing things that went well or things that went not so well

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to

have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum
- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

What the Educational Supervisor (ES) needs to do

The educational supervisor and trainee should meet beforehand to plan what evidence will need to be obtained. This can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following anchor statements:

Below expectations for this year of training; may not meet the requirements for critical progression point
Meeting expectations for this year of training; expected to progress to next stage of training

Above expectations for this year of training; expected to progress to next stage of training

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include;

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the **IM clinical** and **specialty CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

Level 1: Entrusted to observe only – no provision of clinical care
Level 2: Entrusted to act with direct supervision: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3: Entrusted to act with indirect supervision: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4: Entrusted to act unsupervised

Only the ES makes entrustment decisions based on the information they receive. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP (recommended minimum 2W)
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Local Faculty Groups (LFG)

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of senior clinicians (medical and non-medical) who get together to discuss trainees' progress. The purpose is not only to make an assessment of a trainee but to determine and plan on-going training. It is recommended again as an optimal way of providing information about trainees' progress.

The LFG set-up will depend on the circumstances of the organisation. In smaller units the LFG make include all the physicians; while in larger units there may be several LFGs, each in a different department. In all circumstances, as a minimum, an LFG must be able to consider, direct and report on the performance of trainees in the acute medicine/on-call setting.

The LFG should meet regularly to consider the progress of each trainee and identify training needs, putting in place direction as to how these needs are to be met. This should be documented and communicated to trainee's Educational Supervisor and hence to the trainee. A mechanism for this to happen should be established.

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

There should be a range of professionals who fill this in. This should not be filled in by the educational supervisor. If there is an identified concern on a previous MSF or the initial responses, then further requests can be weighted towards individuals, to further explore this feedback. A typical distribution of colleagues for an MSF would include 3 consultants, junior doctors, inpatient and outpatient specialist nurses, other allied health professionals and admin staff. At least half the respondents should be from specialty. There would be an expectation of 48 responses over 4 years (with a roughly even split each year).

Multiple Consultant Report (MCR)

The MCR captures the views of consultant physician based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The ***minimum*** number of MCRs considered necessary is set out in the ARCP decision aid.

Consultant supervisors completing the MCR will use the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice. If it is not possible for an individual to give a rating for one or more area they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

The new curriculum places considerable weight of assessment from colleagues. The MCR should be completed by consultant physicians who have worked with closely with the trainee (but ideally not the educational supervisor unless no alternative assessor possible). There needs to be a minimum of one report where they have had experience of the trainee

in diabetes care, one in endocrine care (along with the general medical requirements) and these need to particularly comment on that experience. They need to have had repeated exposure to the trainee in clinical practice.

In later years, experience of the trainee in subspecialty clinics is important. A minimum of 4 assessors is acceptable but an optimal number would be six (and specific consultants may be agreed between the educational supervisor and trainee if necessary to clarify particular areas of the curriculum or feedback).

Supervised Learning Events

There has been a change from the 2010 curriculum with more of an emphasis on CBD and less on Mini-CEX (particularly at senior trainee level) in specialty but a range should be used to meet the individual training needs. The outpatient care assessment tool (OPCAT) will be a useful addition for these assessments (in outpatients and MDTs), at junior level, but at the time of writing has not been approved by the GMC. It is expected that these supervised learning events are spread out over the course of the year by a range of assessors, including both diabetes and endocrine. They should include evidence of subspecialty work (particularly towards the final 2 years of training). It is expected that these assessors are senior doctors experienced in training. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee. It is not expected that ACATs are performed in specialty (although still required in IMS2).

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Workplace-Based Assessments

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.l Although these are not essential requirements in the specialty decision aid, these can be used in areas such as dynamic function tests, diabetes technology set up.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led

(identifying appropriate teaching sessions and assessors). Evidence should be given of participation in a range of teaching eg med students, junior docs, AHP during all years of training.

In addition, trainees should aim to take a lead on a patient education course for diabetes and observe steroid education and have the additional support of a teaching course.

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor.

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via this link.

There is an expectation that at least one specialty audit or quality improvement project will be completed in the first 2 years of training and one in the second 2 years of training. One audit should aim to complete an audit cycle (with reaudit loop) or, if not achievable within the time window, a plan formulated for the completion. Although the completion of the loop is not an absolute requirement at ARCP, it should be noted that this is a common question at consultant interview and good practice.

Examination

Trainees are required to pass the Specialty Certificate Examination (SCE) in Endocrinology & Diabetes Mellitus by completion of training to be awarded the CCT. Information is available on the MRCP(UK) website www.mrcpuk.org.

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events.

Some examples of personal reflections include:

- MDT participation – preparation, referrals, case presentations, educational benefit, interprofessional difficulties
- audit/QIPAT - see above

- teaching – see above
- clinical research, ethics and economics – recruitment, trial management, data analysis, presentation, project planning
- medical leadership, management and governance – rota management, staff induction, departmental meetings, network meetings, shadowing senior managers, recruitment, development of business cases, risk management, governance, developing guidelines
- clinical practice – difficult conversations and/or cases, management outside of standard guidelines, critical incidents
- Completion of personality type indicator to help identify individual's strengths, preferences and self-perceptions eg MBTI or Belbin

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that trainees do not need to present every piece of evidence listed and the list is not exhaustive and other evidence may be equally valid.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

It is recognised that ST4 trainees may have had little or no experience of outpatient diabetes and endocrine clinics. Using educational tools and on-line resources to ensure exposure to common conditions and consultations prior to starting can enhance this learning experience and these are being developed for sharing.

Ahead of the meeting review:

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Agree with the placement CSs how other support meetings will be arranged. Including;
  - Arrangements for LFGs or equivalent
  - Arrangements for professional development meetings

At the meeting the following need to be considered:

- Review the placements for the year
- Review the training year elements of the generic educational work schedule or its equivalent

- Construct the personalised educational work schedule for the year or its equivalent
- Construct the annual PDP and plan relevant training courses
- Discuss the trainee's career plans and help facilitate these
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss the teaching programme
- Discuss cross regional opportunities such as MDTs and cross specialty experiences (eg transplant clinics, thyroid one-stop)
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including the professional development meetings and the interaction with the placement CSs
- Planning of SLEs and WPBA
- Arrangements for MSF
- Review the ARCP decision aid
- Arrangements for Interim Review of Competence Progression (IRCP)
- Arrangements for ARCP and the writing and discussion of the ESR
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- Prepare for the meeting
- Make sure that knowledge of the curriculum is up-to-date
- Set up a plan for the training year

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered;

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- Review the training placement elements of the generic educational work schedule or its equivalent
- Construct the personalized educational work schedule for the placement or its equivalent
- Construct the set of placement-level SMART objectives in the PDP
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
- Arrangements for MSF
- Review the ARCP decision aid
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

Professional Development Meetings

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the trainee's PDP

- Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- Provide support around other issues that the trainee may be encountering

Transition arrangements for trainees already in programme

The GMC published a new policy statement on the transition of learners to a new curriculum. The policy statement sets out the GMC's requirements for doctors in training

who are working towards a CCT to move to the most recent GMC approved curriculum and programme of assessment. The transition should be completed as soon as it is feasibly possible, taking account of patient and trainee safety whilst also balancing the needs of the service. Some cohorts of trainees may experience a greater impact than others and require longer to prepare for the transition. Doctors in their final year of training (pro rata for less than full time trainees), or for whom it would not be in the interests of patient safety or impractical to support to move to a new curriculum, will normally remain on the curriculum in place prior to the new approval.

JRCPTB has produced guidance for physician trainees on its website here.

Annual Review of Competence Progression (ARCP)

Introduction

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

Endocrinology & Diabetes Mellitus training and the ARCP

The change from the tick-box style competencies to the high-level Capabilities in Practice (CiPs) will have a major impact on how trainees are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in trainees failing to achieve a standard ARCP outcome by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: “Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other

information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?"

Relationship with Educational Supervisor (ES)

It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Clinical supervisor (CS)

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR). The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because

- Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- They allow the excuse for trainees to receive targeted and constructive feedback from a senior colleague.

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as "good trainee". It is important that they make meaningful

comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the "normal" trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

- All appropriate certificates have been uploaded to the personal library and are clearly signposted
- An appropriate amount of reflection has been documented
- As a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio
- MSF has been completed and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF
- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
- The trainee has self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have either been achieved fully and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed. If

members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should examine more detail in the ePortfolio and review more of the SLEs and other subsidiary information.

ARCP Decision Aid for <insert specialty>

This decision aid provides guidance on the requirement to be achieved for a satisfactory ARCP outcome at the end of each training year. The training requirements for Internal Medicine (IMS2) are set out in the IMS2 ARCP decision aid. The ARCP decision aids are available on the JRCPTB website. All numbers are indicative minimums https://www.jrcptb.org.uk/training-certification/arcp-decision-aids

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Educational supervisor (ES) report	Indicative one per year to cover the training year since last ARCP (up to the date of the current ARCP)	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms will meet all requirements needed to complete training
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings.	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training. ES confirms demonstration of overall improvement from previous year	ES to confirm trainee meets expectations for level of training ES confirms demonstration of improvement from previous year (unless already competent)	ES to confirm trainee meets expectations for level of training ES confirms demonstration of improvement from previous year (unless already competent)
Specialty capabilities in practice (CiPs)	See grid below of levels expected for each year of training. Trainees must complete self-rating to facilitate discussion with	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm level 4 in all CiPs by end of training

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	ES. ES report will confirm entrustment level for each CiP				
Multiple consultant report (MCR)	Indicative minimum number. Each MCR is completed by a consultant who has supervised the trainee's clinical work. The ES should not complete an MCR for their own trainee	4-6	4 -6	4 - 6	4 - 6
Multi-source feedback (MSF)	Indicative minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical). MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF	1 This must include a range of workforce from General Internal Medicine (GIM) and specialty.	1 This must include a range of workforce from GIM and specialty.	1 This must include a range of workforce from GIM and specialty.	1 This must include a range of workforce from GIM and specialty.

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Supervised Learning Events (SLEs): Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)	Indicative minimum number to be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs as required to evidence CIPs. SLEs should be undertaken throughout the training year by a range of assessors and diabetes and endocrinology. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee	6 CBDs or mini-Cex (with a minimum of 4 CBDs)	6 CBDs or mini-Cex (with a minimum of 4 CBDs)	6 CBDs or mini-Cex (with a minimum of 4 CBDs)	6 CBDs or mini-Cex (with a minimum of 4 CBDs)
SCE		Opportunity to attempt at this stage	Must have attempted at this stage	Should have ideally passed at this stage	Must have passed to obtain CCT
Advanced life support (ALS)		Valid	Valid	Valid	Valid
Patient Survey (PS)			1		1

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Audit/Quality improvement (QI) project	Project to be assessed with quality improvement project tool (QIPAT)	1 completed Audit or Quality Improvement Project in either ST4 or 5	1 completed Audit or Quality Improvement Project in either ST4 or 5	2nd completed Audit or Quality Improvement Project in ST6 or 7	2nd completed Audit or Quality Improvement Project in ST6 or 7
Simulation	Simulation Teaching is increasingly used in various endocrinology centres and trainees must explore opportunities to enhance their training by accessing available resources.	Optional Evidence can be used towards SLEs	Optional Evidence can be used towards SLEs	Optional Evidence can be used towards SLEs	Optional Evidence can be used towards SLEs
Teaching attendance	Indicative **minimum** hours per training year.	Attended a specialist training course (b) Attendance at regional specialty study days expected. Minimum 60 hours of regional specialty education (covering a broad range of subject areas) expected over ST4 and ST5 spread roughly evenly.	Attended a specialist training course such as an annual DUK or BES meeting or other accredited CPD events. Attendance at regional specialty study days expected. Minimum 60 hours of regional specialty education (covering a	By this stage, attended specialist training courses in diabetes and endocrinology. Attendance at regional specialty study days expected. Minimum 60 hours of specialty education (covering a broad range of subject areas) expected	Continued attendance at national meeting and regional specialty study days Attendance at regional specialty study days expected. Minimum 60 hours of specialty education (covering

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
			broad range of subject areas) expected over ST4 and ST5 spread roughly evenly.	over ST6 and ST7 spread roughly evenly.	a broad range of subject areas) expected over ST6 and ST7 spread roughly evenly. 120hrs of specialist study over 4 years.
Teaching skills	Need to attend formal teaching course during HST and evidence of teaching during each year of training. In addition, trainees need to have evidence of being involved in delivering patient education.	Evidence of participation in teaching of med students, junior docs, AHP. TO to be completed by ST4 or ST5 Certification (or aligned feedback) to lead/ teach on an accredited diabetes patient education and empowerment programme eg DAFNE or equivalent to be completed in ST4 or ST5	Evidence of participation in teaching of med students, junior docs, AHP. TO to be completed by ST4 or ST5 Formal qualification to lead/ teach on an accredited diabetes patient education and empowerment programme eg DAFNE or equivalent to be completed in ST4 or ST5	Evidence of participation in teaching of med students, junior docs, AHP. TO to be completed by ST6 or ST7	Evidence of participation and satisfactory feedback in teaching of med students, junior docs, AHP. TO to be completed by ST6 or ST7 (2 overall in training) Teaching course completed by the end of ST7.

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Leadership and Management experience:	There is a range of ways that a trainee can meet this outcome, one of which may be attendance at a relevant course.	Experience of presenting at diabetes and endocrine Multi-disciplinary meetings (eg pump, thyroid, adrenal, pituitary or other)	Experience of presenting at diabetes and endocrine Multi-disciplinary meetings (eg pump, thyroid, adrenal, pituitary or other)	Leading or chairing skills or other experience of management (such as rota coordination) demonstrated from ST6	Completing a leadership and management course by end of training or equivalent experience within local training programme.
Research:	Evidence of research awareness, critical appraisal of literature and analysis. Presentation of poster at a meeting expected in training. Networking and sharing experience is an important part of the specialty.	Evidence of literature search and critical appraisal of research or guidelines presented at a meeting or journal club (locally) in St4 or 5	Evidence of literature search and critical appraisal of research or guidelines presented at a meeting or journal club (locally) in St4 or 5.	Evidence of presentation of literature review, poster, or publication submitted (regionally or nationally) in ST6 or 7	Evidence of presentation of literature review, poster, or publication submitted (regionally or nationally) in ST6 or 7

Levels to be achieved by the end of each training year and at critical progression points for specialty CiPs

Level descriptors

Level 1: Entrusted to observe only – no clinical care

Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

Specialty CiP	**ST4**	**ST5**	**ST6**	**ST7**	**CRITICAL PROGRESSION POINT**
1. Providing diagnosis and management of diabetes mellitus as a long-term condition in outpatient, ambulatory or community settings	**2**	**3**	**3**	**4**	
2. Providing diagnosis, support and management for people with diabetic foot disease	**2**	**2**	**3**	**4**	
3. Providing diagnosis, support and management for women with diabetes and endocrine disorders in the perinatal period	**2**	**2**	**3**	**4**	
4. Providing diagnosis, support and management of diabetes and endocrine disorders in adolescents and young adults (AYA)	**2**	**2**	**3**	**4**	
5. Providing diagnosis, support and management for people with endocrine disorders in the outpatient and ambulatory settings	**2**	**3**	**3**	**4**	
6. Providing support and management of diabetes and endocrine disorders in the perioperative period	**2**	**3**	**3**	**4**	
7. Providing support and management of people with diabetic and endocrine emergencies including management of these conditions during acute illness	**2**	**3**	**3**	**4**	

Training programme

Delivery of the Programme will be facilitated through the local deaneries and NHS trusts, with annual progression demonstrated through the ARCP process. The trainee will have a clinical and educational supervisor (best practice would be a single educational supervisor who also practises internal medicine for IMS2 where possible).

Endocrinology and diabetes is a group 1 specialty, dually training with Internal Medicine. Trainees enter IM stage 2 at ST4 level, having done a year of intensive IM training in their ST3 year. The indicative period of further IM training during IM stage 2 is one year out of four. It is likely that training programs will need to be redesigned to enable trainees to acquire all the required competencies in the available training time.

Competence is assessed through CiPs (as described above). Acquiring additional skills such as in virtual consultation, engaging in MDTs, advice and guidance, and delivery of education, are emphasised.

Educating other health care professionals and patients is a key skill within the specialty. Trainees are recommended to be formally qualified in accredited structured education programmes such as DAFNE or equivalent empowerment programme for type 1 diabetes (and Type 2). Acquisition of a doctor's qualification is recommended. Other courses, such as diabetes pump course, steroid education (and sick day) experience, diabetes technology course, or equivalent experience, is likely to offer valuable additional skills. If unable to attend in person, there are on-line options. These will be important in clinical practice as a consultant but are not a mandatory requirement. Leading a group, developing a patient education tool or leaflet or assisting in an education course should all be considered as valuable opportunities.

As a predominantly clinic-based specialty, it is expected that much of the training is acquired in clinics under supervision, progressing to independent capabilities. The level of autonomy will depend on progress made and set in conjunction with supervisors. Whilst training is based on competency, there would need to be an indicative number of clinics (or equivalent experience) likely to be needed to have acquired competence. This may equate to an equivalent number of specialist patients seen in other settings, such as leading on specialty ward rounds, virtual advice and guidance or community clinics. It is felt that trainees should achieve a minimum of 3 specialty clinics a week average through their training programme, with approximately half of those as general specialty clinics and half as specialist or subspecialty clinics (or including subspecialist patients). This would equate to a minimum of 504 clinics over 4 years (or equivalent experience) as a guide and trainees would be encouraged to keep a record of the number of clinics experienced. It would be expected that trainees see an average of at least 5 patients per clinic (more in general specialty clinics, perhaps less in subspecialty clinics such as neuroendocrine, thyroid eye, insulin pump, transition). This recognises that when in specialty 'blocks'

an expectation of at least 5 clinics a week would be expected, but accounting for general medicine in a 42 week year, the average will be lower. There is recognition that the first year of training, full lists may not be achievable but this should be the aim by completion of the first year in most clinics. Defining competence through the CiPs should be evidenced with experience through clinics, inpatient experience, MDTs and virtual experience as well as training events. This will be discussed, after self-rating, with the educational supervisor through meetings as described above.

There is a range of ways that competence can be met – outpatient clinic exposure important, regular case meetings (when presenting), specialist ward rounds, active engagement in MDTs and these can sometimes be interchangeable with clinics if felt to offer the same educational experience. Virtual consultations with primary care, including taking part in advice and guidance and community clinics are new skills to help deliver population based medicine.

Simulation (SIM) training

This is a new addition to the curriculum decision aid and whilst not an essential requirement, it is a useful educational tool with a growing emphasis over time to support training. There are various options for exploring this further and the aim will be that these are highlighted on a shared education portal being developed. Examples where SIM training can be useful include early knowledge training, emergency scenarios as part of an MDT experience or human factors in training (including situation awareness, decision making skills, team working and communication skills).

Personal Teaching attendance and skills

It is important that a range of study days, courses and training events are utilised. However there is an expectation that regional study days are attended and that trainees are active in helping prepare, deliver and engage in these events. The number of hours should be evenly distributed across the years but there is an acceptance that this is not an exact science. It is expected that these teaching events should be a mix of formulations, but a significant amount should be in person (rather than virtual) where possible. These teaching sessions are also a useful environment to practice teaching skills. Regional teaching is only one source as part of a package of learning resources.

The calculated time for **minimum** in regional study time considers delivery of local training programmes. There are various regional models but, as an example, many do this by full days on alternate months and would equate to about 180 hours over 4 years for local training programmes. There may be delivered over 2 years to allow the cycle to be repeated twice. Unavoidable absences locally could be compensated by joining another regions teaching. The decision aid has suggested a minimum of 120 hours over the 4 year training programme, which should include covering the curriculum and additional learning needs. Although the minimum suggested is 60 hours over 2 years, most training programmes will be delivering 80-100 hours over 2

years. The minimum requirement equates to roughly 2/3 of regional training opportunities (similar to old curriculum).

Training is delivered in many different ways but there are advantages of locally delivered education, including local networking, presenting and in depth discussion in a smaller group. An example of a 2 year teaching framework that covers the breadth of the curriculum is included below.

Year	Days	AM	PM
Year 1	1	Diabetes prevention and newly diagnosed diabetes	Thyroid
	2	Patient education and empowerment and Race/ethnicity/culture	Pituitary
	3	Managing diabetes in the ambulatory setting	Pancreas
	4	Managing diabetes in special situations and Disabilities and learning difficulties	Neuroendocrine tumours
	5	Managing diabetes in hospital inpatients	Calcium and metabolic bone disorders
	6	Managing diabetes in frailty and Managing diabetes towards the end of life	Reproductive disorders
Year 2	7	Population health management	Sexual differentiation and gender dysphoria
	8	Micro and macrovascular complications of diabetes	Obesity
	9	Adrenals	Underweight disorders or eating disorders
	10	Managing lipid disorders	Managing spontaneous hypoglycaemia
	11	Managing electrolyte abnormalities	Endocrine disorders in people living beyond cancer
	12	Diabetes technologies	Endocrine disease in systemic disorders, Familial disorders and genomics

Attending and presenting at regional, national and international conferences is strongly encouraged. Depending on the training trajectory, certain conferences in addition to the core specialty meetings will be supported for subspecialty interests. This should be discussed with the educational supervisors. Reflection on teaching events is strongly encouraged. It is also important for local training programmes to gather feedback to improve the engagement with teaching over time.

Management experience

In the modern NHS, consultants add value by being effective managers, from managing small teams to leading larger scale projects. Workforce surveys show that a significant proportion of Diabetes and Endocrinology trainees will take on a management role as a consultant. Trainees are required to gain management experience throughout their training through similar processes as acquisition of clinical competencies.

MDT working is essential for safe, effective and efficient care delivery, across specialties and care providers. Trainees through their training should be more than passive observers. It is important for them to gain skills in leading MDTs with varying degrees of supervision, leading up to unsupervised practice. Trainees should also acquire skills necessary to use technology to enable remote working as necessary. Experience participating and running an MDT is an important skill to acquire. It is considered that trainees will have experience attending, participating and potentially leading MDTs in various subspecialties such as diabetes, pump + technology, adrenal, pituitary, thyroid, neuroendocrine amongst others.

Experience in senior leadership is useful for future career development and consultant interviews. Whilst a management course will give a broad overview of the NHS and consolidate knowledge, this may be delivered through local training programmes or equivalent experience through exposure in the hospital setting. This can be a standalone course or modular course through training as long as approved course locally. Non clinical topics such as morbidity and mortality, finance, human factors in health care, service delivery, business case writing, large data handling, listening intelligence, and various aspects of communications skills can be incorporated into local training.

Research

This specialty has traditionally had a strong research base and further degrees and academic paths are symbiotic to training. Being able to interpret evidence and translate that into clinical practice is a fundamental skill in this specialty. Evidence of research awareness, critical appraisal of literature and analysis, presentation of local, regional or national projects is expected and publishing in peer review journals encouraged. Networking and sharing experience is an important part of the specialty.

It is considered that this broad training base will allow further development of interests as a consultant, with the necessary skills to be able to pursue a range of possible career paths.

Training resources links

Diabetes UK:
https://www.diabetes.org.uk/

Society for Endocrinology:
https://www.endocrinology.org/

Association of British Clinical Diabetologists (ABCD)
https://abcd.care/

Young Diabetologists and Endocrinologists' Forum (YDEF)
https://www.youngdiabetologists.org.uk/

Royal College Physicians

https://www.rcplondon.ac.uk/
https://www.rcpe.ac.uk/

Training resource Hub (being developed by joint societies) – to include links to SIM training, courses, other training models and practical resources.

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
CBME	Competency Based Medical Education
DME	Director of Medical Education
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
GPC	Generic Professional Capabilities
GMC	General Medical Council
HoS	Head of School
ICU	Intensive Care Unit

JRCPTB	Joint Royal Colleges of Physicians Training Board
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MMC	Modernising Medical Careers
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
PS	Patient Survey
SLE	Supervised Learning Event
WPBA	Workplace Based Assessment

JRCPTB

Joint Royal Colleges of Physicians Training Board

ROYAL COLLEGE *of* PHYSICIANS *of* EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians