

JRCPTB

Joint Royal Colleges of Physicians Training Board



The Royal College of **Pathologists**

Pathology: the science behind the cure

**Rough Guide to Implementation
Infection Specialties curricula
Guidance for training programme directors,
supervisors and trainees
August 2021**



ROYAL COLLEGE
of PHYSICIANS
of EDINBURGH



ROYAL COLLEGE OF
PHYSICIANS AND
SURGEONS OF GLASGOW



Royal College
of Physicians

Contents

Introduction	3
What is different about the new curricula?	3
Background.....	3
Training pathways.....	4
Transition arrangements for trainees already in programme.....	4
The Infection Specialties curricula	4
Capabilities in Practice (CiPs).....	5
Syllabus.....	6
Evidence of capability.....	7
Assessment: What is required from trainees and trainers?	7
Introduction.....	7
What the trainee needs to do.....	7
What the Educational Supervisor (ES) needs to do.....	9
Types of Evidence	11
Annual Review of Competence Progression (ARCP)	14
Training programme	16
Combined infection training (CIT) (2 years duration).....	17
Higher Infection Training (HIT).....	17
Training resources links	20
Glossary of abbreviations	20

Introduction

This guide is for the infection specialties of Infectious Diseases (ID), Medical Microbiology (MM), Medical Virology (MV) and Tropical Medicine (TM). Its purpose is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curricula. It is intended to supplement rather than replace the curriculum document itself. The curricula, ARCP decision aid and this guide are available on the JRCPTB and RCPATH websites.

The Rough Guide has been put together by members of the Infection Specialties curriculum working group.

The curricula, ARCP decision aids, syllabuses and guidance documents relating to the four specialties are available on the following webpages:

[JRCPTB - Infectious Diseases and Tropical Medicine](#)

[RCPATH - Medical Microbiology](#)

[RCPATH - Medical Virology](#)

What is different about the new curricula?

Background

There have been two major drives to the need for change. Firstly the change from competency-based curricula to the holistic assessment of high level learning outcomes. The new curricula have 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](#).

Internal Medicine Training (IMT) replaced CMT in August 2019 and JRCPTB specialties have been divided into two groups: Group 1 specialties will require trainees to have completed three years of IMT and will dual train in internal medicine (IM) to CCT level. Group 2 specialties will select trainees who have completed two years of IMT and will not dual train in IM.

There are the following training pathways in infection:

- MM or MV single CCT (group 2)
- ID with MM or MV dual CCT (group 2)
- TM with MM or MV dual CCT (group 2)
- ID with Internal Medicine (IM) dual CCT (group 1)
- TM with IM dual CCT (group 1).

This model is considered to be the optimum way to deliver a pluripotential workforce. Those with CCTs in ID/IM are able to provide direct clinical care of patients with infections, as well as participating in acute medical services. Those with dual CCTs with MM or MV will not be expected to participate in acute medical takes at consultant level, but they may take on consultant roles whereby they provide direct patient care on infectious diseases wards, outpatient clinics, bedside infection consult services, and/or they may take on more laboratory based microbiology/virology consultant roles in spoke or hub centres.

Training pathways

Trainees will enter higher specialty training following Internal Medicine training (IMT) or Acute Care Common Stem – Internal Medicine (ACCS-IM) as follows:

- Entry to single CCT MM/MV training or dual CCT training in ID/TM with MM/MV (group 2 pathways) will be following completion of two years of IMT or three years of ACCS-IM
- Entry to ID/TM dual CCT training with IM will be following completion of three years of IM or four years of ACCS-IM (group 1).

Trainees will initially spend two years in combined infection training (CIT) where they will develop knowledge of laboratory work, engage with supervised clinical liaison and validation of results, and gain experience in direct clinical care. Following completion of CIT and the CICE/ FRCPath Part 1 examination (typically after 18-24 months of training), trainees will move onto Higher Infection 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).

Transition arrangements for trainees already in programme

Current trainees will remain on the 2015 curriculum and will not transfer to the new curricula prior to August 2022 at which point all trainees, except for those in their final year of training will transfer with a deadline of 31 August 2023.

The CiPs have been mapped to the previous curricula and can be used to assist with identifying any training needs. As the training programmes have not changed significantly it is expected that transition will be straightforward. Trainees will not be required to re-link evidence recorded against the previous curriculum/curricula in the ePortfolio.

The Infection Specialties curricula

The purpose of the curricula is to produce doctors with the generic professional and specialty specific capabilities required to practice as consultants for the four infection specialties. 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.

Capabilities in Practice (CiPs)

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

The **specialty CiPs** describe the laboratory and clinical tasks or activities which are essential to the practice of the infection specialties. The specialty CiPs have also been mapped to the GPC domains and subsections to reflect the professional generic capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each of the CiPs, the trainee's performance meets or exceeds the minimum expected level of performance expected for completion training. Seven of the eight specialty CiPs are common to all four specialties, the eighth is specific to Tropical Medicine training.

The IM **clinical CiPs** describe the capabilities required for Internal Medicine for trainees who are dual training in ID/TM with IM.

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. Each set of descriptors can be found in the relevant sections of the curricula.

All trainees will need to achieve the following generic and infection specialty 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
Specialty CiPs

1. Able to provide clinical leadership and support to the laboratory
2. Able to use the laboratory service effectively in the investigation, diagnosis and management of infection
3. Able to advise on infection prevention, control and immunisation
4. Able to manage and advise on important clinical syndromes where infection is in the differential diagnosis
5. Able to lead and advise on treatment with and stewardship of antimicrobials
6. Providing continuity of care to inpatients and outpatients with suspected or proven infection
7. Able to manage and advise on imported infections
8. Able to deliver equitable and high quality care in resource poor settings [Tropical Medicine only]

Group 1 training pathways ID/TM with IM will also acquire the IM clinical CiPs:

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 in patients 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

The curricula set out the key topics for each specialty. A more detailed syllabus is available to guide trainees and trainers [please see links above].

Evidence of capability

The curricula 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 blueprints). 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.

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 specialty CiPs, a judgement will be made as to the level of supervision the trainee requires (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 (see section on ES report) and in the ARCP decision aids.

What the trainee needs to do

Trainees will need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs) as well as the summative examinations set out in each curriculum. The requirements 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 indicative minimums. SLEs 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 the required number of Multiple Consultant Report (MCR) are received from consultants who are familiar with their work.

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. This includes the induction meeting with the ES and/or CS to plan the training year, and regular professional development meetings.

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
- review the placements for the year
- a plan for taking the FRCPATH/CICE examination(s)
- 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
- discuss the teaching programme
- discuss procedural skill requirements
- discuss arrangements for LTFT if required
- discuss any career opportunities to go out of programme (eg for research or training)
- use of the various assessment/development tools
- review the ARCP decision aid
- planning of SLEs and WPBAs
- pastoral support

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement, (these topics could be covered in the ES induction meeting depending on local arrangements for supervision), including;

- access to clinics, laboratories etc, and how to meet the learning objectives
- expectations for on-call
- expectations for acquiring inpatient and consults experience
- expectations to gain experience in end-of-life care

At the end of these meetings 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

Professional Development Meetings

Depending on local arrangements there should be regular professional development meetings 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
- 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

Trainee Self-assessment and preparation for ARCP

Trainees are required to undertake 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 ES 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 professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

Educational supervisors of dual trainees who do not themselves practise in both specialties must take particular care to ensure that they obtain and consider detailed feedback from clinical supervisors who are knowledgeable about the trainees' performance in the other specialty and include this in their educational reports. It is recommended that the educational supervisor report is completed by a trainer with a CCT in that specialty

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 **specialty CiPs and IM clinical 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. 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.

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

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

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- 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.

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.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) 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 four per year.

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

Supervised Learning Events

Acute Care Assessment Tool (ACAT)

The ACAT is used to provide feedback on a trainee's performance when undertaking acute care. Its main focus is on multi- tasking, prioritisation and organisational skills. It should not be used to produce a "multiple Case Based Discussion". Each ACAT should cover the care of a minimum of five patients.

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.

Evaluation of Clinical Events (ECE)

Provides a method of assessing the trainee in the performance of their duties in complex tasks, often involving teamwork or interacting with other professional staff. Examples include clinicopathological evaluation and reporting of diagnostic material, presentation of a case at a multidisciplinary team meeting, or contributing to quality assurance and audit processes in both clinical and laboratory settings.

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).

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.

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](#).

Outpatient Care Assessment Tool (OPCAT)

The Outpatient Care Assessment Tool (OPCAT) has been introduced to help with the assessment of outpatient capability. The OPCAT is designed to be used in a single clinic whether that is face to face or virtual and may be used during a direct observation if the trainer is present or as an assessment at the end of a clinic. There is no minimum number of patients that should be seen although for a post clinic assessment it would be unusual if the trainee has seen fewer than three patients. It is unlikely that a single assessment could provide all the evidence required for an educational supervisor to make an entrustment decision on outpatient capability. The assessment of overall progress can also take into

account the multiple consultant reports as part of the holistic assessment of the trainees' capabilities.

The OPCAT is not a GMC approved tool at present so is not mandatory but it is recommended as a method for obtaining structured feedback on outpatient capability.

Examinations

Combined Infection Certificate Examination(CICE)/FRCPATH Part 1/FRCPATH Part 2

The CICE/FRCPATH Part 1 is a curriculum requirement for all infection trainees. The FRCPATH Part 2 is required for trainees undertaking training in MM and MV either as a single CCT or dual CCT programme. Information about the examination is available on the RCPATH website www.rcpath.org.

It is advisable that the CICE/FRCPATH Part 1 examination is attempted for the first time towards the end of year 2 of CIT, or early in the first year of Higher Infection training (HIT).

For dual trainees in ID/MM or ID/MV the CICE/FRCPATH Part 1 should ideally be obtained by the end of the third year of training, to allow time to obtain FRCPATH Part 2. For trainees dual training in ID/IM the CICE examination must be obtained by CCT date.

Diploma of Tropical Medicine and Hygiene (DTM&H)

Trainees in ID and in TM are recommended to take the DTM&H offered by the London School of Hygiene and Tropical Medicine or the Liverpool School of Tropical Medicine. Information about the Diploma, including guidance for candidates, is available on the following websites; www.lshtm.ac.uk and www.lstmed.ac.uk. Attendance at a DTM&H course is mandatory for TM trainees, but it is not mandatory to have passed the summative assessment of the course.

Diploma of HIV Medicine (Dip HIV Med)

Trainees in ID and TM are recommended to take the Dip HIV Med offered by the Worshipful Society of Apothecaries of London. Information about Dip HIV Med, including guidance for candidates, is available on the Worshipful Society of the Apothecaries website; <http://www.apothecaries.org/>

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 curriculum requirements and the decision aids 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 receives a non-standard outcome inappropriately.

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.

Completing reports

When completing reports such as MCR/ESRs, consultants should explain their judgement and reference evidence that has been reviewed. It is important that they make statements 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*. A comment is not required for each descriptor but these provide a guide for the senior doctor doing the assessment. The ES will use MCR reports and other evidence to inform their report for the ARCP panel, again with reference to the evidence provided.

Constructive comments are also of course valued by the trainee so they know if they are progressing along the “normal” trajectory or if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

It is essential that the trainee reviews their ePortfolio on a regular basis throughout the year and ensures that all requisite information is available in a logical and accessible format with workplace based assessments and reflections being done contemporaneously for each placement/experience.

Prior to the ARCP, 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 Aids

ARCP decision aids are provided for each training pathway and are available on the JRCPTB and RCPATH websites [see links above].

Training programme

The following provides a guide on how training programmes should be focussed in each training year in order for trainees to gain the experience and develop the capabilities to the level required.

Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person.

Combined infection training (CIT) (2 years duration)

The aim of CIT is to produce a doctor who is familiar with laboratory practice in the diagnosis and management of infection as well as familiar with the clinical presentations and management of infections. CIT is common to all infection training programmes. In order to acquire the requisite capabilities, the indicative two year training period should be organised as follows:

- Indicative six months of clinical microbiology and virology training associated with a diagnostic laboratory to diagnose and manage infection. An indicative two months of this period (whole time equivalent) should be spent under the clinical supervision of a consultant virologist, where possible working in a specialist virology centre or unit.
- Indicative six months of clinical infection consult duties
- Indicative six months of appropriate infection related clinics where the major focus of the clinic is managing patients with infection. A combination of clinics could include:
 - HIV clinic
 - OPAT clinic
 - Bone infection clinic
 - Viral hepatitis clinic
 - General Infectious Disease (ID) clinic
 - Travel clinic (pre-travel advice and/or returning traveller clinic)
 - TB clinic (supervised by ID or chest physician)
 - GUM clinic
 - Chronic Fatigue Syndrome clinic
- Indicative six months of clinical inpatient care of patients with infection. During this period the trainee should have continuity of care of patients with infection and should be under the clinical supervision of an Infectious Disease consultant who is taking clinical responsibility for the patients (up to two months of this experience could be obtained at a specialised inpatient HIV unit).

There is flexibility in how the above training experiences are delivered.

Higher Infection Training (HIT)

The training experience for higher speciality training will differ according designated final CCT(s).

Higher infection training (HIT) towards dual CCT in ID with IM (indicative two years) or TM with IM (three years duration):

Internal medicine training is integrated into specialty training in Group 1 specialities. Trainees will undertake an indicative 12 months of internal medicine integrated flexibly into the training programme. This may be delivered as a six month block during CIT and a further six months in HIT. There must be an indicative three months of IM [or intensive four weeks

in AMU] in the final year of training to ensure IM capabilities are at level 4 at the time of CCT. The requirements for IM are set out in the IM stage 2 curriculum, ARCP decision aid and rough guide.

Examples of clinical experience for HIT in infectious diseases include:

- Inpatient work looking after a broad range of ID inpatients.
- Ward consults with suspected infection-related problems
- Outpatient clinics as in CIT (above)
- Infection Prevention and Control (e.g. management of suspected high consequence infections, outbreak investigations, root cause analyses, policies and guidelines)
- Antimicrobial stewardship
- Management of infections in immunocompromised hosts (HIV and non-HIV)
- Experience in Public Health
- Experience in Paediatric Infections
- Experience in GUM

Higher infection training (HIT) towards dual CCT in ID with MM/MV (three years duration) or TM with MM/MV (four years):

- Experience is expected to be obtained in a variety of settings. An indicative one year should be spent in MM/MV and one year in ID. There should be an indicative 12 months of direct patient care during HIT.
- Examples of clinical experience for HIT are the same as above plus:
 - Laboratory work, quality assurance, laboratory management
 - Experience of specialised laboratory services
- Refer to the relevant curricula for more details of capabilities required for each CCT.

Additional requirements for Tropical Medicine:

Doctors undertaking TM training will require the following:

- An indicative 12 months of HIT in a UK tropical centre (Hospital for Tropical Diseases in London, or Liverpool School of Tropical Medicine/Royal Liverpool Hospital) focussing on the diagnosis and management of imported infections.
- An indicative 12 months working as a clinician in a resource poor tropical medicine setting approved by the SAC. This experience will enable trainees to meet the learning outcome of delivering equitable and high quality care in a resource limited setting.
- Tropical medicine trainees will complete a full-time course in Tropical Medicine (such as a Diploma in Tropical Medicine and Hygiene - DTM&H) to ensure they have the knowledge to meet the learning outcome of delivering equitable and high quality care in

a resource limited setting. The course should be approved by the SAC for Infectious Diseases and Tropical Medicine.

- Refer to the relevant curricula for more details of capabilities required for each CCT.

HIT towards single CCT in MM or MV (two years duration)

- Trainees will be primarily supervised by consultants trained in microbiology/virology.
- Examples of clinical experience for HIT are as in ID with MV/MM above but with no mandatory inpatient work:
- Refer to the relevant curricula for more details of capabilities required.

Training resources links

[JRCPTB - Infectious Diseases and Tropical Medicine](#)

[RCPATH - Medical Microbiology](#)

[RCPATH - Medical Virology](#)

[JRCPTB - background information](#)

[JRCPTB - trainer resources](#)

[LearnInfection](#)

[British Infection Association](#)

[Health Infection Society](#)

[British Society for Antimicrobial Chemotherapy](#)

[British HIV Association](#)

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
CICE	Combined Infection Certificate Examination
CIP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
DOPS	Direct Observation of Procedural Skills
ECE	Evaluation of clinical events
EPA	Entrustable Professional Activity
ES	Educational Supervisor
GPC	Generic Professional Capabilities
GMC	General Medical Council
HoS	Head of School
JRCPTB	Joint Royal Colleges of Physicians Training Board
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
PS	Patient Survey
RCPATH	Royal College of Pathologists
SLE	Supervised Learning Event
WPBA	Workplace Based Assessment

JRCPTB

Joint Royal Colleges of Physicians Training Board

