

**Educational Supervisor's Structured Report: submission to the Annual Review of Competence Progression panel by the trainee's current educational supervisor, summarising the trainee's learning Portfolio since the previous assessment**  
*(indicative template –may vary by specialty/ Deanery)*

Name of person submitting report: Training unit  
Position

Trainee's name GMC number

**PMETB** Programme/Post approval number

Training number (if applicable)

**Previous annual assessments ands**

Dates Outcome

- 1.
- 2.
- 3.
- 4.
- 5.

**Previous placements in programme**

Training Unit Clinical supervisor Dates (to-from)

- 1.
- 2.
- 3.
- 4.
- 5.

**Current placement**

**Clinical supervisor**

**Dates of placement**

**Workplace based assessments (WPBAs) in current placement/s (only successful WPBAs should be included here)**

Assessment	Dates	Number	Outcome	Summary of comments
Mini-CEX				
DOPs				
CbD				
MSF (360 degree)				
Patient survey				
Other (please describe)				

**Experiential outcomes**

Activity	Date/s	Outcomes	Comment
1. log-book		Expected activity achieved/not achieved	
2. audits		completed/not completed/had impact/no impact	
3. research projects		work in progress/completed	
4. publications			
5. teaching			
6. management development			
7. presentations			
8. courses attended		relevant/not relevant/impact/no impact	

<u>Other outcomes</u>	Date/s	Outcome	Comment
1. reported adverse incidents		resolved/pending no case to find/accountable	
2. complaints		resolved/pending no case to find/accountable	
3. other		any further comments/observations	

I confirm that this is an accurate description/summary of this trainee's learning portfolio, covering the time period from \_\_/\_\_/\_\_\_\_ to \_\_/\_\_/\_\_\_\_

Signed by \_\_\_\_\_ Date \_\_\_\_\_  
(educational supervisor)

Signed by \_\_\_\_\_ Date \_\_\_\_\_  
(trainee)



## Form R: Registering for Postgraduate Specialty Training

(to be confirmed on appointment to/on entering specialty training and before a National Training Number (NTN) is issued, where this is appropriate. Must be updated and submitted annually with the Postgraduate Dean in order to renew registration for specialty training)

1. Full name:	2. Deanery:
3. Primary contact address in UK:  *email address (essential):	4. Home/other address:
5. Medical School awarding primary qualification: (name and county and date)	6. Immigration status (resident/settled/work permit required)
7. GMC registration no:	8. GDC registration no (if applicable):
9. National Training Number [NTN] (on first registration to be completed by the Postgraduate Deanery):  <b>I confirm that I have been appointed to a programme leading to award of a CCT subject to satisfactory progress</b> <input type="checkbox"/>	10. PMETB programme approval number (to be completed by Postgraduate Dean)
11. Specialty 1 for award of CCT: (as used to derive NTN except where core NTN allocated – e.g. CMT, CPT, CST)	12. Specialty 2 for award of CCT: (if appointed to a dual certification programme)
13. Royal College/Faculty assessing training for the award of CCT where trainee is undertaking a full prospectively approved programme:	14. Date of entry to grade/programme (dd/mm/yy)
15. Initial appointment to programme (full or part time – express part time training as a % of full time training)	16. Provisional date from deanery for award of CCT/CESR/CEGPR (dd/mm/yy)
17. Confirmation from trainee that he/she will be seeking entry to the register through Article 11 (CEPGR) or Article 14 (CESR)  <b>I confirm that I will be seeking specialist registration by application for a CESR or CEGPR</b> <input type="checkbox"/>  Expected date for completion of training:	18. I confirm that I have <i>not</i> been awarded a NTN but that I am undertaking a Fixed Term Training Appointment:  Confirmed <input type="checkbox"/> Specialty:

I confirm that the information recorded in Form R is correct.

Specialty Trainee (signature) \_\_\_\_\_

Date \_\_\_\_\_

Postgraduate Dean \_\_\_\_\_

Date \_\_\_\_\_

Annual Review of Competence Progression (ARCP) Outcomes

Deanery: \_\_\_\_\_ PMETB Training Programme Approval No. \_\_\_\_\_

Trainee: \_\_\_\_\_ Specialty \_\_\_\_\_ NTN \_\_\_\_\_

Members of the panel: 1 \_\_\_\_\_ 2 \_\_\_\_\_  
 3 \_\_\_\_\_ 4 \_\_\_\_\_  
 5 \_\_\_\_\_ 6 \_\_\_\_\_

**Date of Assessment** \_\_\_\_\_

**Period covered:** From \_\_\_\_\_ to \_\_\_\_\_

**Year / phase of training programme assessed (circle):** 1, 2, 3, 4, 5, 6, 7, 8 or other (state) \_\_\_\_\_

Approved clinical training gained during the period:

Placement / Post/ Experience	Dates: from	to:	In / out of Programme	FT / PT as % FT
1.				
2.				
3.				

Documentation taken into account and known to the trainee:

1. Structured report	<input type="checkbox"/>	2.	<input type="checkbox"/>
3.	<input type="checkbox"/>	4.	<input type="checkbox"/>

Recommended Outcomes from Review Panel

*Satisfactory Progress*

1. Achieving progress and competences at the expected rate (clinical)	<input type="checkbox"/>
Achieving progress and competences at the expected rate (academic)	<input type="checkbox"/>

*Unsatisfactory or insufficient evidence (trainee must meet with panel)*

2. Development of specific competences required – additional training time not required	<input type="checkbox"/>
3. Inadequate progress by the trainee – additional training time required	<input type="checkbox"/>
4. Released from training programme with or without specified competences	<input type="checkbox"/>
Released from academic programme	<input type="checkbox"/>
5. Incomplete evidence presented – additional training time may be required	<input type="checkbox"/>

*Recommendation for completion of training*

6. Gained all required competences (clinical)	<input type="checkbox"/>
Gained all required competences (academic)	<input type="checkbox"/>

*Outcomes for trainees out of programme or not in run-through training*

7. Out of programme experience for approved clinical experience, research or career break	<input type="checkbox"/>
8. Fixed-term specialty outcome – competences achieved identified above	<input type="checkbox"/>
9. Top-up training (outcome should be indicated in one of the areas above)	<input type="checkbox"/>

**Signed by: Chair of Panel** \_\_\_\_\_ **Signed by trainee:** \_\_\_\_\_

**Date** \_\_\_\_\_ **Date of next review** \_\_\_\_\_

**Supplementary Documentation for trainees with Unsatisfactory Outcome  
(trainee must be in attendance)**

Recommended outcome	Dates: from	to:	In / out of Programme	FT / PT as % FT
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Detailed reasons for recommended outcome

- 1.
- 2.
- 3.

Discussion with trainee

Mitigating circumstances

Competences which need to be developed

Recommended actions

Recommended additional training time (if required)

Date for next review

Signed by: Chair of Panel

Trainee

Date:

These documents should be forwarded in triplicate to the trainee's Training Programme Director (who must ensure that the trainee receives a copy through the further appraisal and planning process). Copies must also be sent to the Medical Director where the trainee works, as well as to the College or Faculty if the trainee is on a CCT programme.