

# Curriculum review

RCP Tutors & Associate Tutors

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Liz Berkin, Deputy Medical Director  
JRCPTB

# content outline

- background to the curriculum
- why review?
- reminder of current content
- new competences?
- procedures review
- OP clinic experience
- MRCPUK Part 1

# background

- GIM curriculum 2003
- CMT-based curriculum published 2006
  - follows on from Foundation (MMC)
  - generic and symptom competences
  - mapping to GMP & assessments
- revised 2009
  - mainly change of written presentation rather than content – generic now core competences
  - CMT ‘framework’ lines up with GIM

# curriculum change?

- was it correct in 2006?
- change of clinical practice
  - syndrome presentations
  - patient safety
  - procedure indications & techniques
- change of working practice
  - hours & shifts
  - AMU

does the curriculum drive skills or should clinical practice drive the curriculum?

# curriculum components

- common competences
- symptom competences
  - emergency (4)
  - top 20
  - other important (40)
- system (specialties)
- investigation
- procedures

# common competences

|  |  |
|--|--|
| <b>Audit</b>   | <b>Managing long term conditions and promoting patient self-care</b>       |
| <b>Breaking bad news</b>                             | <b>Personal Behaviour</b>  |
| <b>Clinical examination</b>                          | <b>Principles of medical ethics and confidentiality</b>                    |
| <b>Communication with colleagues and cooperation</b> | <b>Principles of quality and safety improvement</b>                        |
| <b>Complaints and medical error</b>                  | <b>Prioritisation of patient safety in clinical practice</b>               |
| <b>Decision making and clinical reasoning</b>        | <b>Relationships with patients and communication within a consultation</b> |
| <b>Ethical Research</b>                              | <b>Teaching and training</b>   |
| <b>Evidence &amp; Guidelines</b>                     | <b>Team working and patient safety</b>                                     |
| <b>Health promotion and public health</b>            | <b>The patient as central focus of care</b>                                |
| <b>History taking</b>                                | <b>Therapeutics and safe prescribing</b>                                   |
| <b>Infection control</b>                             | <b>Time management and decision making</b>                                 |
| <b>Legal framework for practice</b>                  | <b>Valid consent</b>   |
| <b>Management and NHS structure</b>                  |  |

# symptoms: top 4

cardio-respiratory arrest

shocked patient

unconscious patient

anaphylaxis

# top 20 symptoms

no lethargy / tiredness

|                             |                        |
|-----------------------------|------------------------|
| Abdominal Pain              | Fits / Seizure         |
| Acute Back Pain             | Haematemesis & Melaena |
| Blackout / Collapse         | Headache               |
| Breathlessness              | Jaundice               |
| Chest Pain                  | Limb Pain & Swelling   |
| Confusion, Acute / Delirium | Palpitations           |
| Cough                       | Poisoning              |
| Diarrhoea                   | Rash                   |
| Falls                       | Vomiting and Nausea    |
| Fever                       | Weakness and Paralysis |

# other important (1)

|  |                                  |
|--|----------------------------------|
| Abdominal Mass/ Hepatosplenomegaly             | Genital Discharge and Ulceration |
| Abdominal Swelling & Constipation              | Haematuria                       |
| Abnormal Sensation (Paraesthesia and Numbness) | Haemoptysis                      |
| Aggressive / Disturbed Behaviours              | Head Injury                      |
| Alcohol and Substance Dependence               | Hoarseness and Stridor           |
| Anxiety / Panic disorder                       | Hypothermia                      |
| Bruising and spontaneous bleeding              | Immobility                       |
| Dialysis                                       | Incidental Findings              |
| Dyspepsia                                      | Involuntary Movements            |
| Dysuria  | Joint Swelling                   |

# other important (2)

|  |   |
|--|---|
| Lymphadenopathy  | Pruritus  |
| Loin Pain  | Rectal Bleeding   |
| Medical Problems / Complications Following Surgical Procedures | Skin and Mouth Ulcers   |
| Medical Problems in Pregnancy                                  | Speech Disturbances   |
| Memory Loss (Progressive)                                      | Suicidal Ideation   |
| Micturition Difficulties                                       | Swallowing Difficulties   |
| Neck Pain  | Syncope & Pre-syncope   |
| Physical Symptoms in Absence of Organic Disease                | Unsteadiness / Balance Disturbance                                  |
| Polydipsia   | Visual Disturbance (diplopia, visual field deficit, reduced acuity) |
| Polyuria   | Weight Loss   |

# new competences?

- patient safety
- care of the dying patient & palliative care
- transition from paediatric to adult care
- obesity
- vulnerable person abuse
- back to work
- bio-ethics

# procedures

- altered working practice
  - trainees not exposed to many specialties
- altered clinical practice
  - patient safety

# current CMT procedures (18)

- Venepuncture
- Cannula insertion, including large bore
- Arterial blood gas sampling
- Lumbar Puncture
- Pleural tap and aspiration
- Intercostal drain insertion: Seldinger technique
- Ascitic tap
- Abdominal paracentesis
- Central venous cannulation
- Initial airway protection: chin lift, Guedel airway, nasal airway, laryngeal mask
- Basic and, subsequently, advanced cardiorespiratory resuscitation
- DC cardioversion
- Urethral catheterisation
- Nasogastric tube placement and checking
- Electrocardiogram
- Knee aspiration
- Temporary cardiac pacing by internal wire or external pacemaker
- Skin Biopsy

# *Foundation* procedures

- *Venepuncture*
- *Cannula insertion, including large bore*
- *Arterial blood gas sampling*
- Lumbar Puncture
- Pleural tap and aspiration
- Intercostal drain insertion: Seldinger technique
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# 'difficult' procedures

- *Venepuncture*
- *Cannula insertion, including large bore*
- *Arterial blood gas sampling*
- Lumbar Puncture
- Pleural tap and aspiration
- **Intercostal drain insertion: Seldinger technique**
- Ascitic tap
- **Abdominal paracentesis**
- **Central venous cannulation**
- Initial airway protection: chin lift, Guedel airway, nasal airway, laryngeal mask
- Basic and, subsequently, advanced cardiorespiratory resuscitation
- **DC cardioversion**
- *Urethral catheterisation*
- Nasogastric tube placement and checking
- *Electrocardiogram*
- Knee aspiration
- **Temporary cardiac pacing by internal wire or external pacemaker**
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# procedures

## proposed categories for CMT:

- essential

- clinical independence mandatory

- clinical independence desirable\*

\* *Trainees considering progression into an acute medical specialty are expected to develop clinical independence in these procedures where possible. If not able to gain clinical independence, then one or more of the following are acceptable: skills lab competent with certification, course competent with certification, some clinical experience with DOPS indicating, at a minimum, 'able to perform the procedure under direct supervision / assistance'*

- desirable

# essential procedures

## clinical independence essential

- ascitic tap
- lumbar puncture
- nasogastric tube placement and checking
- pleural tap and aspiration
- resuscitation (covered by valid ALS)

## clinical independence desirable\*

- CV cannulation using ultrasound guidance
- DC cardioversion
- intercostal drain insertion with ultrasound guidance using Seldinger technique

# desirable procedures

- abdominal paracentesis
- insertion of arterial lines
- insertion of long line via peripheral vein
- joint injections
- knee aspiration
- skin biopsy
- temporary cardiac pacing using internal wire?

# Foundation procedures

skills to be maintained:

- arterial blood gas sampling
- cannula insertion, including large bore
- electrocardiogram
- peak flow measurement
- urethral catheterisation
- venepuncture

# competence?

## WPBAs – DOPS

- formative then summative
- how many summative?
- specialty-specific DOPS exist
- no curriculum section or DOPS for CV cannulation

# outpatient experience

several issues have transpired to reduce exposure of Foundation and Core trainees to OP clinics



# outpatient experience

- shifts have lead to unpredictable availability for scheduled activity
- focus on acute care
  - rise in medical admissions
  - ED waiting targets
- GPs / patients expectation
- governance

# outpatient experience

- is not required at Foundation level
- is not crystal clear at CMT level
  - ARCP decision aid does not specify
  - curriculum mentions experience in clinics
- is required at ST3 level

CMT is delivering trainees inexperienced in OP work to ST3 posts

# how many clinics?

- shifts / AL / SL occupy 40% of time
    - can get to 60% of scheduled activity
    - equates to ~ 30 weeks per year
  - not all CMT posts offer OP experience
    - possibly half, equates to 15 clinics year
  - move away from large numbers to prove competence
    - minimum / indicative with competence assessment
- settled on 24 in 2 years

# competence in OP

The competent doctor will, without recourse to the usual acute care support services and team, and in the allotted time, be able to:

- assess the reason for the clinic review from referral letters, notes, patient / carer etc
- be able to focus on the issue(s) and any other important issues arising
- explore the patient's expectations and concerns
- undertake focussed examination as required
- review investigation results and need for further investigations and / or referrals, and make secure arrangements for these
- explain the outcomes of the review to the patient in a clear fashion, such that the patient can take forward any changes in the management plan
- make relevant notes in appropriate health care records
- communicate the salient facts of the consultation to the referring clinician
- be prepared to undertake further actions outside of the scheduled care setting eg obtain results and act on them, further communications etc.

# OP competence assessment

informal

- induction, discussion / support
- review of plans / tests / letters / patients

formal (formative then summative)

- CbD
- Mini-CEX
- Patient Survey & MSF
- PACES Stations 2 & 4

# MRCPUK progress

2007 CMT entrants 1<sup>st</sup> cohort that need MRCPUK to exit CMT

- must have MRCPUK to take up ST3 post
- 73% of ST3 applicants to RCP-coordinated specialties have MRCPUK
- deanery variation in MRCPUK at CT2 level
  - Part 2 written: 60 to 90%
  - PACES: 25 to 70%

therefore national concerns:

- gaps at ST3 level
- need for additional training at CMT level

# MRCPUK progress

- higher part 1 success rate if taken earlier
- increasingly some are taking in FY2
  - Foundation school policy & attitude
- average 1.7 attempts per part to pass
- 3 diets per year
- can take Pt 2 / PACES in either order
- need to have full exam by May of CT2 year in 2012

# MRCPUK progress

if no part 1 by end of CT1 the trainee will struggle to complete exam in 24 months

Part 1 in the month 11 ARCP decision aid

- will flag up a potential problem
- hopefully focus minds
- ARCP-2 outcome

# summary of requests

- procedures list
- OP experience
- MRCP Part 1 by month 11

request submitted to GMC in Feb  
clarification requested

hope to institute change from August 2011

# change process

- ad hoc requests sent by trainees / trainers
- formal request change form available
  - sent out Jan, return by March
- requests reviewed by SAC
  - discussion with stakeholders
    - TPDs, trainees, PG Deans, Heads of School, employers etc
    - for CMT - impact on ST3+, ACCS
- formal request to GMC (major or minor change)
- curriculum re-write (ARCP decision aid, WPBAs)
- communication, implementation, feedback