JRCPTB

Joint Royal Colleges of Physicians Training Board

Curriculum for Genitourinary Medicine Training

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DRAFT

ROYAL COLLEGE of PHYSICIANS of EDINBURGH
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW
Royal College of Physicians

Contents

1. Introduction

The Shape of Training (SoT) review was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused, more general (especially in the early years) and with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission and the Francis report. With an ageing population, elderly patients exhibit co-morbidities and increasing complexity so acute medical and palliative medicine services need a revised approach to training the physician of the future in order to meet these needs.
A further driver for change was the GMC review of the curricula and assessment standards and introduction of the GPC framework. From May 2017, all postgraduate curricula should be based on higher level learning outcomes and must incorporate the generic professional capabilities. A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision making.
JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has produced a model for physician training that consists of an indicative seven year (dual) training period leading to a CCT in a specialty and internal medicine. Doctors will complete Internal Medicine Training (IMT) or Acute Care Common Stem (Acute Medicine), during which there will be increasing responsibility for the acute medical take and the MRCP(UK) Diploma will be achieved, before entering higher dual training in GUM and IM at ST4.
This model will enhance the training of GUM physicians by enabling the management of the acutely unwell patient with an increased focus on chronic disease management, comorbidity and complexity. Enhanced IM skills will better equip GUM physicians to work as members of the wider multidisciplinary team and alongside physicians in the acute hospital to most effectively manage patients with complex care needs and those approaching the end of their lives.
The curriculum for GUM incorporates and emphasises the importance of the generic professional capabilities. Common capabilities will promote flexibility in postgraduate training in line with the recommendations set out in the GMC's report to the four UK governments. We believe a flexible approach is essential to deliver a sustainable model for physician training agile enough to respond to evolving patient need.

The demand for well trained, pluripotent and flexible GUM clinicians is evident from many sources:

1. Levels of acute, complex, systemic STIs are rising (www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables).
2. HIV has become a chronic, manageable condition, hence the HIV positive cohort of patients, largely receiving their medical care through GUM consultant led teams, require management of co-morbidities and polypharmacy, and effective multidisciplinary and interdisciplinary team working. The number of HIV positive patients in care is rising year on year (www.gov.uk/government/statistics/hiv-annual-data-tables).
3. Despite medical advances STIs and HIV remain a deeply stigmatising diagnosis with vulnerable and marginalised patients disproportionately affected (www.avert.org/professionals/hiv-social-issues/stigma-discrimination)

4. The commissioning arrangements in England (where the vast majority of GUM specialist training occurs; 90% of training posts) and service delivery models have changed hugely in recent years. GUM doctors have needed to be resilient, flexible and develop generic professional and leadership skills effective from the start of their NHS consultant careers, both within and beyond their specialty (Health and Social Care Act 2012).
5. These new service delivery models are typically an integrated sexual health service with a workforce that is multi-professional and in many places nurse delivered. This workforce has many challenges including recruitment and appropriate education and training and was recently the subject of a Health Education England Workforce review. Thus consultants in GUM need to be able to lead such a team and this curriculum will equip them to be able to do so.
6. There is a need for more doctors to be trained as generalists with the ability to diagnose, treat and manage a wide range of medical conditions in an ageing population (SoT review).

2. Purpose

2.1 Purpose of the curriculum

The purpose of the Genitourinary Medicine (GUM) curriculum is to produce doctors with the generic and specialty specific skills to lead Internal Medicine (IM), GUM and HIV services. Upon successful completion of this training or recognition of equivalent training/experience they will be able to provide the highest standards of medical care for patients with sexually transmitted infections (STIs) and related conditions including their immediate contraceptive needs, genital dermatoses, sexual dysfunction and the medical care of HIV positive individuals. These doctors will have well developed communication skills and the ability to lead multi-professional teams and work collaboratively with other healthcare professionals within and beyond medicine to provide the holistic health care that patients with, or at risk from sexual ill-health require. Equally important is the prevention of sexually transmitted infections, HIV and unplanned pregnancy and these doctors will be able to provide and train others in appropriate interventions to promote sexual health. Doctors will also be able to diagnose, treat and manage a wide range of general medical conditions and be able to care for these patients in acute, on call or out-patient settings. Upon completion of this curriculum doctors will be eligible for a Certificate of Completion of Training (CCT) which facilitates dual entry onto the GMC specialist register in GUM and IM; an assurance that this doctor is at this point able to undertake high level independent practice as an NHS consultant in GUM and IM.

The curriculum will ensure that GUM CCT holders have the knowledge and skills required for effective leadership and delivery of integrated sexual health services where patients requiring interventions to prevent or manage STIs, HIV and related conditions and /or require provision of contraception, attend for care. Concurrently the trainees will build on their Internal Medicine training (IMT) and attain the experience and training required to demonstrate competence to deliver general medical care for acute and internal medical patients as inpatients and outpatients. This is required as our patients have increasingly complex co-morbidities and multi-system presentations and their care will be enhanced

by broad-based generalist training. Trainees will develop the experience and expertise required for attaining the full range of Generic Professional Competencies (GPCs).

In order to work effectively within integrated sexual health services delivering optimal care GUM doctors need to be able to safely and effectively deliver contraception including long-acting reversible methods (LARC) to their patients.

The curriculum for GUM has been developed with the support and input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the GUM Specialist Advisory Committee.

Scope of practice

GUM CCT holders are doctors who are exemplars of their specialty and generalist physicians who lead teams delivering specialist GUM & HIV medical care as well as having the ability to recognise and direct management of co-morbid general medical conditions in their patients. They have highly refined multi-disciplinary team working skills within and across medical practice that meet the complex needs of their patients. They are also fully training in Internal Medicine; skills which complement their specialist practice and also embed GUM within the physicianly specialties contributing to the general unselected medical take.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

2.2 High level learning outcomes – capabilities in practice (CiPs)

The capabilities in practice (CiPs) describe the professional tasks or work within the scope of GU medicine. 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 behaviours which should be demonstrated for an entrustment decision to be made. By the completion of training and award of a CCT, the doctor must demonstrate that they are capable of unsupervised practice in all CiPs.
The CiPs have 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 doctor in training's performance meets or exceeds the minimum expected level for completion of training, as defined in the curriculum.

The GUM CiPs comprise six specialty CiPs, six generic CiPs which are shared across all physician specialties and eight IM clinical CiPs shared across all group 1 specialties.

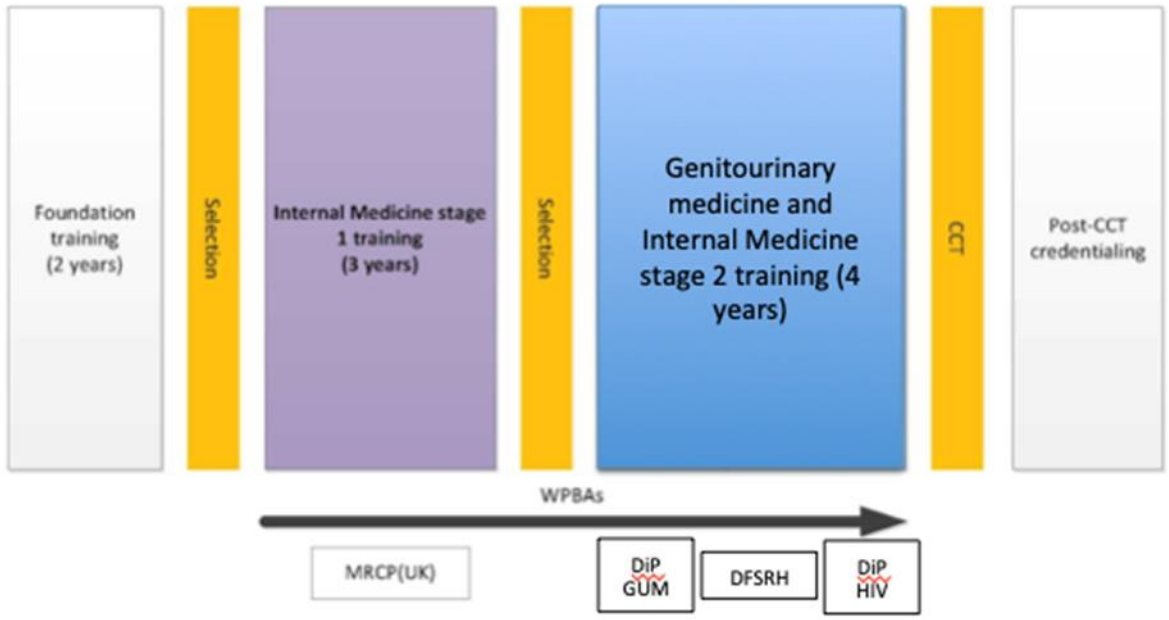
Learning outcomes – capabilities in practice (CiPs)

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
Clinical CiPs (Internal Medicine)
1. Managing an acute unselected take 2. Managing an acute specialty-related take 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
Specialty CiPs
1. Managing patients with non-complex GUM health presentations in out-patient or community settings 2. Managing patients with complex GUM health presentations in a specialist out-patient or community setting 3. Providing specialist care for individuals living with HIV in an out-patient or community setting 4. Providing specialist care for individuals with diagnosed HIV/AIDS in a hospital inpatient setting 5. Delivering interventions to prevent transmission of HIV, other blood borne viruses and STIs 6. Supporting early detection of STIs and HIV in all settings 7. Safeguarding of public health and delivering GUM/HIV services and information for specific populations in a range of settings

2.3 Training pathway

Genitourinary medicine is a group 1 specialty and is entered following selection at ST4 on completion of three years of Internal Medicine (IM) stage 1 or Acute Care Common Stem –

Acute/Internal Medicine (ACCS-AM/IM) with full MRCP(UK) diploma. A trainee would then dual train with Internal Medicine stage 2 for four years before reaching CCT.
This will be integrated flexibly within the specialty training programme. Some GUM programmes will choose to run this as a separate year whilst others will integrate it within the specialty training. IMT stage 2 will include supporting the acute specialty take and the acute unselected take. GUM trainees will be expected to pass 3 knowledge based exams: the Diploma in sexual and reproductive health (DFSRH), the Diploma in Genitourinary medicine (Dip GUM) and the Diploma in HIV Medicine (Dip HIV), before they are awarded a certificate of completion of training (CCT) in GUM and GiM. See Figure 1 for structure of training and examinations.
Figure 1: The training pathway for GUM and achievement of a CCT; minimum of 48 months Specialty training to CCT:



2.4 Duration of training

Training in Genitourinary medicine 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 more rapidly than the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good physician (guidance on completing training early will be available on the JRCPTB website). There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)[1]. Upon successful attainment of these capabilities, the trainee will be recommended to the GMC for a CCT in GUM/GiM by the JRCPTB.

2.4 Flexibility and accreditation of transferrable capabilities

[1] A Reference Guide for Postgraduate Specialty Training in the UK

The curriculum supports flexibility and transferability of outcomes across related specialties and disciplines, reflecting key interdependencies between this curriculum and other training programmes, outlined below.

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. Additionally, all group 1 specialties share the internal medicine clinical capabilities.

- The implementation of this curriculum will be flexible and will allow competencies shared with other training programmes to be recognised and not repeated.
- The move to dual accreditation with IM greatly improves the inherent flexibility and transferability of the curriculum with other group 1 specialties as all IM and GPC competencies are transferable.
- In addition, as described above there are other physicianly specialties such as infectious diseases, dermatology, gastroenterology, geriatric and respiratory medicine where coverage of common curricular areas may be considered transferable. At the present time no established method or precedent exists but Training Programme Directors (TPDs) and SACs will review individual situations on a case-by-case basis and develop this process.
- Other specialty curricula where there are areas of commonality include gynaecology, sexual & reproductive health, and general practice. Although entry requirements differ (GUM requires IMT training including year 3 and full MRCP, for the others entry can be from the Foundation Programme), where trainees transferring from one to another can demonstrate competence in shared curricular areas the TPDs and SACs will recognise these and not require that training to be repeated. Of the curricula from different colleges with most commonality with GUM are the General Practice and Sexual & Reproductive Health (SRH) curricula. In 2017 the Education department at the Royal College of Physicians undertook an analysis of these 3 curricula to identify the main areas of commonality and of difference. This exercise broadly identified that the GP and SRH curricula cover screening for STIs & HIV and management of uncomplicated STIs and contraception, the SRH curriculum included this and all aspects of complex contraception and community gynaecology and the GUM curriculum included the basics of the GP curriculum, the DFSRH plus all aspects of complex STI and HIV care. Where these shared areas of training are identified in trainees wishing to transfer between curricula where the entry requirements are also met TPDs and SACs will review individual situations and identify aspects of training that do not require repetition but could be recognised as being achieved for the new curriculum already.
- Academic trainees will continue at present to train in academic tracks alongside the clinical training and areas of shared competence will be recognised by their TPDs with SACs reviewing and inputting as required.

2.5 Less than full time training

Trainees are entitled to opt for less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and

other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide.

2.6 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework[2] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of the GMC's Generic Professional Capabilities

[2] Generic professional capabilities framework

Good medical practice (GMP)[3] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

The nine domains and subsections of the GPC framework are directly identifiable in the IM curriculum. They are mapped to each of the generic and clinical CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

3 Content of Learning

The curriculum is spiral and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from needing direct supervision to able to be entrusted to act unsupervised.

3.1 Capabilities in practice

CiPs describe the professional tasks or work within the scope of the specialty and internal medicine. CiPs are based on the concept of entrustable professional activities[4] which use the professional judgement of appropriately trained, expert assessors as a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the knowledge, skills and attitudes which should be demonstrated. 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.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own

[3] Good Medical Practice
[4] Nuts and bolts of entrustable professional activities

treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.

In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP if capability is maintained (in line with standard professional conduct).

This section of the curriculum details the six generic CiPs, eight clinical CiPs for internal medicine (stage 2) and eight of specialty CiPs for Genitourinary medicine. The expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision are given for each CiP. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

3.2 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP there is a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	DipGUM	The Diploma in GU Medicine
DipHIV	The Diploma in HIV Medicine	DFSRH	FSRH Diploma
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within NHS organisational and management systems	
Descriptors	• Aware of and adheres to the GMC professional requirements • Aware of public health issues including population health, social detriments of health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching • Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of and processes for operational structures within the NHS Aware of the need to use resources wisely
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures Management course End of placement reports
2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements

	• Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX ALS certificate End of life care and capacity assessment End of placement reports
Category 2: Communication, teamworking and leadership	
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings • Communicates effectively with clinical and other professional colleagues • Identifies and manages barriers to communication (eg cognitive impairment, speech and hearing problems, capacity issues) • Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills • Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations • Shares decision making with children and young people • Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)*

	Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF PS End of placement reports ES report
Category 3: Safety and quality	
4. Is focussed on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: Wider professional practice	

5. Carrying out research and managing data appropriately	
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act a clinical supervisor to doctors in earlier stages of training
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO

	Relevant training course End of placement reports

3.3 Clinical capabilities in practice

The eight IM clinical CiPs describe the clinical tasks or activities which are essential to the practice of Internal Medicine. The clinical CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Clinical CiPs – Internal Medicine	
1. Managing an acute unselected take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Recognises need to liaise with specialty services and refers where appropriate
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements

	• national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
2. Managing an acute specialty–related take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Demonstrates appropriate continuing management of acute medical illness inpatients admitted to hospital on an acute unselected take or selected take
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention

	Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Demonstrates appropriate continuing management of acute medical illness inpatients admitted to hospital on an acute unselected take or selected take • Recognises need to liaise with specialty services and refers where appropriate Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions) • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement

Evidence to inform decision	MCR MSF ACAT Mini-CEX DOPS
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions)	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately manages comorbidities in outpatient clinic, ambulatory or community setting • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR ACAT mini-CEX PS Letters generated at outpatient clinics
5. Managing medical problems in patients in other specialties and special cases	
Descriptors	• Demonstrates effective consultation skills (including when in challenging circumstances) • Demonstrates management of medical problems in inpatients under the care of other specialties • Demonstrates appropriate and timely liaison with other medical specialty services when required
GPCs	Domain 1: Professional values and behaviours

	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR ACAT CbD
6. Managing a multi-disciplinary team including effective discharge planning	
Descriptors	• Applies management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations • Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover • Effectively estimates length of stay • Delivers patient centred care including shared decision making • Identifies appropriate discharge plan • Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR MSF ACAT Discharge summaries
7. Delivering effective resuscitation and managing the acutely deteriorating patient	
Descriptors	• Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious • Demonstrates the professional requirements and legal processes associated with consent for resuscitation

	• Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families • Demonstrates competence in carrying out resuscitation
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR DOPS ACAT MSF ALS certificate Logbook of cases Reflection Simulation training with assessment
8. Managing end of life and applying palliative care skills	
Descriptors	• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life • Demonstrates safe and effective use of syringe pumps in the palliative care population • Able to manage non-complex symptom control including pain • Facilitates referrals to specialist palliative care across all settings • Demonstrates effective consultation skills in challenging circumstances • Demonstrates compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills:

	• practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries
Evidence to inform decision	MCR CbD Mini-CEX MSF Regional teaching Reflection

3.4 Specialty capabilities in practice

The specialty CiPs describe the clinical tasks or activities which are essential to the practice of Genitourinary medicine. The CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Key

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	DipGUM	The Diploma in GU Medicine
DipHIV	The Diploma in HIV Medicine	DFSRH	FSRH Diploma
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Specialty CiPs
1. Managing patients with non-complex GUM/contraception presentations in out-patient or community settings

Descriptors	• Takes a comprehensive sexual and reproductive health history and performs risk assessment of male, female and transgender and non-binary individuals with empathy and sensitivity, respecting the patients' confidentiality • Performs HIV pre-test discussion • Demonstrates medical examination of the genitals, anus and rectum with valid consent and use of chaperones • Demonstrates appropriate sample taking and interpretation of laboratory tests for HIV, STIs, blood borne viruses, cervical cytology, pregnancy and pre-immunisation • Medically leads an integrated sexual health clinic providing care for asymptomatic patients and patients with uncomplicated STIs, genital lumps, vaginal discharge, urethral discharge, vulvovaginitis, balanitis and genital infestations • Prescribes emergency contraception if indicated • Assesses and meets patients' contraception needs using the full range of contraceptive methods
GPCs	Domain 1: professional values and behaviours Domain 2: professional skills: practical skills communication and interpersonal skills dealing with complexity and uncertainty clinical skills: history taking, diagnosis and medical management consent
Evidence to inform decision	Mini CEX CBD DOPS Dip GUM DFSRH MSF MCR ES report
2. Managing patients with complex GUM/contraception presentations in a specialist out-patient or community setting.	
Descriptors	• medically leads a clinic seeing symptomatic patients including those with complicated sexual health conditions, STIs, genital ulcers, systemic and extra-genital manifestations • clinically manages and uses tools to identify individuals who have experienced sexual assault, sexual exploitation, sexual abuse or gender-based violence and female genital mutilation (FGM) • supports HIV and Hepatitis B prevention for individuals at highest risk, including pre- or post-exposure prophylaxis if provided locally

	• demonstrates assessment and referral of pregnancy, gynaecological and obstetric problems • identification, initial assessment and management and appropriate referral of psychosexual dysfunction and genital pain syndromes in men and women • clinically manages genital infections in pregnancy. Knowledge of investigation and management genital infections in newborn, infants and children • assesses and clinically manages sexual & reproductive health needs and child sexual exploitation in under 18s • shows awareness of confidentiality and ability to establish valid consent and Fraser competence • fits long-acting reversible contraception methods including subdermal implants, intrauterine devices and systems • clinically manages patients with genital dermatological conditions and awareness of when to refer to primary care or dermatology
GPCs	Domain 1: professional values and behaviours Domain 2: professional skills practical skills communication and interpersonal skills dealing with complexity and uncertainty clinical skills: history taking, diagnosis and medical management consent Domain 4: capabilities in health promotion and illness prevention Domain 5: capabilities in leadership and team working Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decision	Mini CEX CBD DOPS Dip GUM DFSRH Level 3 Safeguarding LoC SDI and IUD MCR MSF
3. Providing specialist care for individuals living with HIV in an out-patient or community setting.	
Descriptors	• recognises and assesses individuals with previously undiagnosed HIV infection in primary, secondary and tertiary settings

	• medically leads a clinic treating people living with HIV 1 and 2 including HIV-related medical conditions, prescribing and monitoring of prophylactic and antiretroviral therapies • uses knowledge of the epidemiology and natural history of HIV to prevent late diagnosis • recognises and assesses individuals with known and previously undiagnosed viral hepatitis in primary, secondary and tertiary settings • clinically manages the psychosocial aspects of care affecting people living with HIV • clinically manages the sexual and reproductive health care needs of people living with HIV • clinically manages transitional care of adolescents/young people with HIV, including those who were vertically infected
GPCs	Domain 1: professional values and behaviours Domain 2: professional skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills: ○ history taking, diagnosis and medical management ○ consent ○ humane interventions ○ prescribing medicines safely ○ infection control and communicable disease Domain 4: capabilities in health promotion and illness prevention Domain 6: capabilities in patient safety and quality improvement Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decision	Mini CEX CBD DOPS Dip HIV Dip GUM DFSRH MCR MSF ES report Letters generated at out-patient appointment
4. Providing specialist care for individuals with diagnosed HIV/AIDS in a hospital in-patient setting.	
Descriptors	• clinically manages unwell or immunosuppressed patients with complications of HIV as part of a multi-professional team • acts as a senior decision maker co-ordinating care for people living with HIV with complex multi-system conditions • deals with the additional confidentiality, legal and ethical aspects relating to HIV infection
GPCs	Domain 1: professional values and behaviours

	Domain 2: professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills: o history taking, diagnosis and medical management o consent o humane interventions o prescribing medicines safely o using medical devices safely o infection control and communicable disease Domain 4: capabilities in health promotion and illness prevention Domain 5: capabilities in leadership and team working Domain 6: capabilities in patient safety and quality improvement Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decision	Mini CEX CBD DOPS Dip HIV ALS Management course MCR MSF ES report
5. Delivering interventions to prevent transmission of HIV, other blood borne viruses and STIs.	
Descriptors	• demonstrates partner notification and effective interaction with sexual health advisers • utilises local and national data sources to influence specialist service delivery • demonstrates use of social determinants of health to influence specialist service provision • delivers interventions to prevent HIV, BBV and STI transmission including encouraging participation in vaccination programmes. • demonstrates knowledge of viral hepatitis A to E, including in persons living with HIV infection, the tests required to establish stage of infection, treatment strategies and when to refer, how to report notifiable viral hepatitis infections to public health, encourage screening and vaccination of contacts
GPCs	Domain 1: professional values and behaviours Domain 2: professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills:

	o history taking, diagnosis and medical management Domain 3: professional knowledge • professional requirements • national legislative requirements • the health service and healthcare system in the four countries Domain 4: capabilities in health promotion and illness prevention Domain 5: capabilities in leadership and team working Domain 6: capabilities in patient safety and quality improvement Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decision	Mini CEX CBD DOPS Dip GUM Dip HIV Management course MCR MSF ES report TO
6. Supporting early detection of STIs and HIV in all settings.	
Descriptors	• interacts with colleagues in acute, community and public health to promote testing for HIV and STIs • demonstrates working with HIV and sexual health third sector and voluntary sector groups to promote public participation
GPCs	Domain 1: professional values and behaviours Domain 2: professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills: o history taking, diagnosis and medical management o consent o humane interventions o infection control and communicable disease Domain 3: professional knowledge • professional requirements • national legislative requirements • the health service and healthcare system in the four countries Domain 4: capabilities in health promotion and illness prevention Domain 5: capabilities in leadership and team working Domain 6: capabilities in patient safety and quality improvement Domain 7: capabilities in safeguarding vulnerable groups Domain 8: capabilities in education and training Domain 9: capabilities in research and scholarship

Evidence to inform decision	Mini CEX CBD DOPS Dip GUM Dip HIV Management course MCR MSF ES report TO QIPAT GCP
7. Safeguarding of public health and delivering sexual health/HIV services and information for specific populations in a range of settings.	
Descriptors	• safeguarding of individuals and the wider public from the negative consequences of HIV infection and sexual ill-health • demonstrates use of information technology to maintain and improve public health • demonstrates engagement with colleagues in all sectors (including the media) to promote behaviours to reduce HIV infection and sexual ill health

GPCs	Domain 1: professional values and behaviours
	
	Domain 2: professional skills
	• practical skills
	• communication and interpersonal skills
	• dealing with complexity and uncertainty
	• clinical skills:
	  ○ history taking, diagnosis and medical management
	  ○ consent
	  ○ humane interventions
	  ○ prescribing medicines safely
	  ○ infection control and communicable disease
	
	Domain 3: professional knowledge
	• professional requirements
	• national legislative requirements
	• the health service and healthcare system in the four countries
	Domain 4: capabilities in health promotion and illness prevention
	Domain 5: capabilities in leadership and teamworking
	Domain 6: capabilities in patient safety and quality improvement
	Domain 7: capabilities in safeguarding vulnerable groups
	Domain 8: capabilities in education and training
	Domain 9: capabilities in research and scholarship

Evidence to inform decision	Mini CEX CBD Dip GUM Dip HIV Management course ES report TO QIPAT GCP
8. Ability to successfully lead, manage and work with specialist service commissioning in acute and community settings.	
Descriptors	• working with service commissioners to deliver cost-sensitive specialist services that meet local population demographics • demonstrates evidence-based approach using scientific method and critical analysis for specialist service development and quality improvement • develops and works as part of wider professional network in sexual health and HIV care • participation in multi-professional meetings to agree a consensus view to progress delivery of specialist services. • Participating in research, audit and delivering service innovation to improve clinical effectiveness
GPCs	Domain 1: professional values and behaviours Domain 2: professional skills • communication and interpersonal skills • dealing with complexity and uncertainty Domain 3: professional knowledge • professional requirements • national legislative requirements • the health service and healthcare system in the four countries Domain 4: capabilities in health promotion and illness prevention Domain 5: capabilities in leadership and team working Domain 6: capabilities in patient safety and quality improvement Domain 7: capabilities in safeguarding vulnerable groups Domain 8: capabilities in education and training Domain 9: capabilities in research and scholarship
Evidence to inform decision	ACAT Mini CEX CBD MCR MSF PS Dip GUM

	Dip HIV Management course ES report

3.4 Syllabus

The table below details the key topics which need to be covered to gain a CCT in Genitourinary Medicine:

Sexual and Medical History taking
Examination of the Genitals, Anus, Rectum and Systems review
Pathology of sexually transmitted infections
Bacterial genital infections
Genital ulceration and syphilis
Genital lumps, cancers and human papillomavirus (HPV) infection
Genital infestations
Sexual dysfunction
Sexual assault, sexual abuse and female genital mutilation
Genital infections in pregnancy
Genital infections in newborn, infants and children
Infective causes of vulvovaginitis and balanitis
Contraception
Gynaecology and Obstetrics
Dermatology
HIV testing and diagnosis
HIV epidemiology, natural history and general management of HIV 1 & HIV 2 infection
Prevention of HIV transmission including PEP, Prep and mother to child transmission
Complications of HIV
HIV in specialist groups-pregnancy, TB co-infection, IVDU
Antiretroviral therapy (ART)
Viral hepatitis including co-infection with HIV
Psychosocial aspects of HIV
Sexual and reproductive health in people living with HIV (PLWH)
Public health and epidemiology
Laboratory diagnosis of STIs, HIV and BBVs

3.5 Presentations and conditions

The table below details the key presentations and conditions of the specialty of Genitourinary Medicine. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate CiPs and GPCs. In this spiral curriculum, trainees will expand and develop the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate core bedside skills, including information gathering through history and physical examination and information sharing with patients, families and colleagues.

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether care is focused mainly on curative intent or whether the main focus is on symptomatic relief. It also covers broader aspects of care, including involvement of other professionals or services.

Particular presentations, conditions and issues are listed either because they are common or serious (having high morbidity, mortality and/or serious implications for treatment or public health). Rarer conditions are listed as awareness of their presentation is important.

For each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Our approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Specialty and topic	Presentations	Conditions/Issues
GUM STI	Genital discharge	Diagnosis, Investigation and treatment
		Bacterial vaginosis, candida, chlamydia, gonorrhoea, mycoplasma, ureaplasma, trichomonas
	Genital ulcers	Herpes, syphilis, LGV, fixed drug eruption
	Genital lumps	HPV, Molluscum, Malignancy Syphilis, systemic GC
	Rash, itching	Secondary syphilis, Scabies, pediculosis Prevention, sexual behaviour, partner notification
	Pelvic pain Lower urethral symptoms/perianal pain Painful testes	PID, chronic prostatitis, trauma, use of sex toys, fisting Torsion, Epidymo-orchitis
GUM Dermatology	Oro-genital ulcers Pruritus Pale itchy genitalia	Behcet's disease Cutaneous reaction to drugs Dermatitis, eczema Lichen sclerosis, Lichen planus, balanitis, psoriasis, zoon's,
	Tumours of skin	Kaposi's sarcoma Squamous cell carcinoma Basal cell carcinoma
	Skin rash	

		Skin in systemic disease eg systemic gonococcal infection
GUM Gynaecology	Disorders of menstruation, Post coital bleeding IMB Bleeding in early pregnancy Pelvic pain FGM	Polycystic ovary, menopause, infections, malignancy Ectopic, trophoblastic tumour, infections
GUM Rheumatology	Reactive arthritis	Chlamydia, Gonorrhoea, Non-specific urethritis
GUM Sexual assault		CSE, domestic violence Safeguarding Prophylaxis for HIV, Hep B Post coital contraception Referral and timing for forensic examination
GUM Contraception		COC, POP, barrier methods (condoms-male and female, diaphragm/cap), contraceptive patch and vaginal ring, LARC such as Depo – provera, Sayana press, sub-dermal implant, Copper coil, Hormonal coil, Emergency contraception tubal occlusion, vasectomy Counselling for sterilisation
GUM Heath promotion	Prevention	HIV discussion and testing Vaccination – Hep A, B, HPV, Pneumonia, Flu PrEP PEP Cervical cytology
GUM Sexual dysfunction	Genital pain syndrome Sexual dysfunction	Vulvodynia Premature ejaculation Erectile dysfunction

System Specialty and system/topic	Presentations	Conditions/Issues
HIV - HIV1 and HIV 2	Asymptomatic or may present with any condition listed below	Primary HIV infection Early asymptomatic infection Late HIV infection including AIDS, with advanced

		immunosuppression, with or without symptoms
HIV - Cardiology	Breathlessness Weight loss Chest pain Limb swelling	Pericardial effusions – viral, TB, lymphoma, KS Coronary heart disease Cardiac involvement of infectious diseases including infectious endocarditis, myocarditis Non-bacterial thrombotic endocarditis Dilated cardiomyopathy Primary pulmonary hypertension Cardiac failure Hyperlipidaemia Hypertension Venous thromboembolic disease Cardiac risk assessment in over 40s
HIV - Dermatology	Generalised lymphadenopathy Rash Mouth ulcers Pruritus Blisters Skin lesions Nail changes Pigmentation	Viral: primary HIV infection, HSV, VZV, molluscum contagiosum, HPV, oral hairy leucoplakia Bacterial: cellulitis, folliculitis, ecthyma, impetigo, bacillary angiomatosis, non-tuberculous mycobacteria Fungal: tinea, candidiasis, cryptococcosis, penicilliosis, pityriasis versicolor Infestations: scabies including Norwegian Parasitic: cutaneous leishmaniasis Inflammatory: seborrhoeic dermatitis, psoriasis, eczema, eosinophilic folliculitis, nodular prurigo Malignancies Adverse drug reactions including hyperpigmentation of nails/skin Other: Ichthyosis
HIV - Endocrinology	Weight loss Polyuria and polydipsia Sexual dysfunction Fatigue Amenorrhoea	Metabolic syndrome Diabetes mellitus type 1 and 2 Primary adrenal failure Disorders of the pituitary gland Gonadal disease Pancreatic disorders Drug induced Cushing's syndrome Malabsorption Lipodystrophy Dyslipidaemia

HIV - Gastroenterology	Weight loss Diarrhoea Swallowing difficulties Jaundice Anaemia Abdominal pain Abdominal swelling Abdominal mass Dyspepsia Rectal bleeding Haematemesis and melaena Nausea and vomiting	Opportunistic infections: cryptosporidium, microsporidium, non-tuberculosis mycobacteria, tuberculosis, CMV, giardiasis, amoebiasis, leishmaniasis, disseminated histoplasmosis, isospora belli, cyclospora cayetanensis Oesophageal candidiasis Intestinal microbial dysbiosis Malignancies
HIV - Haematology	Bruising/spontaneous bleeding Lymphadenopathy Splenomegaly Breathlessness Blood dyscrasias including: anaemia, leukopenia, thrombocytopaenia	Direct effect of HIV on bone marrow Thrombotic thrombocytopenic purpura and immune thrombocytopenic purpura Infections including parvovirus (B19) Haemophagocytic lymphohistiocytosis Drug induced bone marrow suppression G6PD deficiency Polyclonal increase in immunoglobulins Venous and arterial thromboembolic disease Malignancies Blood transfusion and alternatives
HIV - Hepatology	Hepatosplenomegaly Abdominal swelling Jaundice Weight loss Haematemesis and melaena Anorexia	Alcoholic liver disease Non-alcoholic fatty liver disease Drug induced hepatitis Viral Hepatitis –A,B,C,D,E including screening and vaccination Screening for fibrosis/cirrhosis and hepatocellular carcinoma End stage liver disease Secondary sclerosing cholangitis
HIV - Musculo skeletal/Rheumatology	Pain and swelling of joints Back pain/neck pain Rash Weakness Fractures	Avascular necrosis Infection Metabolic bone disease including osteopaenia/osteoporosis (FRAX score) Diffuse infiltrative lymphocytosis syndrome Osteoarthritis Crystal-related arthropathies Spondyloarthritides including reactive arthritis
HIV - Nephrology/Urology	Dysuria Loin pain Proteinuria Polyuria	Acute kidney injury Chronic kidney disease HIV associated nephropathy

	Haematuria Micturition difficulties Electrolyte abnormalities Raised serum creatinine Erectile dysfunction	Glomerular diseases: drugs, infections, systemic disease Tubular diseases: Fanconi syndrome Tubulointerstitial diseases: drugs, infections, immune-mediated Thrombotic microangiopathies Drugs and the kidney Systemic disorders affecting the kidneys Urinary tract infection Urinary tract obstruction Malignancies Managing erectile dysfunction
HIV - Nervous system	Headache Confusion Focal neurological signs Visual disturbance Seizures Hearing loss Speech disturbance Abnormal sensation Memory loss/intellectual decline Bladder/bowel disturbances Abnormal behaviour Tremors Weakness/paralysis	Opportunistic infections: toxoplasmosis, cryptococcal meningitis, progressive multifocal leukoencephalopathy (JC virus), CMV (encephalitis, polyradiculopathy, mononeuritis multiplex) Encephalitis: HIV, HSV, VZV Neurosyphilis Trypanosoma cruzi: space occupying lesions, encephalitis, meningo-encephalitis Peripheral neuropathy: drug induced, HIV, Guillain-Barré syndrome Autonomic neuropathy Dementia Acute stroke and TIA Malignancies
- Eye	Loss/blurring of vision, Floaters	Retinitis-CMV, VZV, HSV Ocular syphilis Ocular toxoplasmosis, KS, malignancies
HIV - Oncology	Weight loss Focal neurological signs Rectal bleeding Lymphadenopathy Night sweats Headache Breathlessness Haemoptysis Lethargy Masses Skin changes	Kaposi's sarcoma: cutaneous and visceral Systemic AIDS related non-Hodgkin lymphoma: diffuse large B-cell lymphoma, Burkitt lymphoma Other lymphomas: primary CNS lymphoma, primary effusion lymphoma, plasmablastic lymphoma, cutaneous T-cell lymphoma Multicentric Castleman's disease Hodgkin lymphoma HPV related cancers: cervical, penile, anal and oral

		Common cancers: breast, bowel, skin, prostate, lung, testicular, hepatocellular Paraneoplastic conditions Complications: SVC obstruction, hypercalcaemia, spinal cord compression
HIV - Pregnancy		Pre-conceptual advice Undetectable=Untransmittable National regulations for fertility treatment for individuals with blood borne viruses Prescribe appropriate ART MDT working Post-natal care including data regarding breastfeeding
HIV - Psychiatry	Aggressive or disturbed behaviour Anxiety Low mood Alcohol and substance dependence Treatment refusal Self-harm	Alcohol and substance misuse/chem sex Anxiety disorders Psychoses Schizophrenia Depression Bipolar disorder Dementias Suicide and self-harm
HIV - Respiratory	Fever Cough Haemoptysis Breathlessness Chest pain Weight loss Pleural effusion/empyema Wheeze	Bacterial pneumonia Opportunistic infections – Pneumocystis jiroveci, CMV, tuberculosis, non-tuberculous mycobacteria, aspergillus, cryptococcus, histoplasmosis, nocardia Influenza Asthma COPD Lymphocytic interstitial pneumonia Primary pulmonary hypertension Malignancies Vaccinations
HIV - Antiretroviral therapy (ART)	Drug side effects Drug allergies Drug-drug interactions Poisoning	Adverse drug reactions Immune reconstitution inflammatory syndrome Practice safe/rational prescribing including generic drugs Use national/local guidelines for appropriate and safe prescribing Drug-drug interactions Effect of drugs on renal markers Renal dose adjustments for drugs Prescribing in special populations eg malignancy, TB, HBV/HCV co-infection

		Resistance tests Tropism tests HLAB*5701 testing
HIV - Public health and health promotion		Sexual behaviour Alcohol Smoking Mental health Substance abuse/ChemSex Obesity Exercise Non-communicable diseases Tackling stigma related to HIV
HIV – Sexual Health	See GUM – STI section	See GUM – STI section

3.6 Practical procedures

There are a number of procedural skills in which a trainee must become proficient.

Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should receive training in procedural skills in a clinical skills lab if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. The table below sets out the minimum competency level expected for each of the practical procedures.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct).

Practical procedure **Mandatory**	**ST4**	**ST5**	**ST6**	**ST7**
Female genital examination including bimanual examination, and speculum insertion		Competent to perform unsupervised	Maintain	Maintain

Male examination with proctoscopy and sample collection		Competent to perform unsupervised	Maintain	Maintain
Liquid nitrogen cryotherapy		Competent to perform unsupervised	Maintain	Maintain
Point of care testing for HIV infection		Competent to perform unsupervised	Maintain	Maintain
Female cervical cytology sampling		Satisfactory supervised practice	Competent to perform unsupervised	Maintain
Light microscopy for detection of sexually transmitted infections		Satisfactory supervised practice	Competent to perform unsupervised	Maintain
Dark ground microscopy		Satisfactory supervised practice	Competent to perform unsupervised	Maintain
Insertion of sub-dermal contraceptive implant		Observe colleague	Observe colleague or satisfactory supervised practice	Competent to perform unsupervised
Insertion of intrauterine device and system		Observe colleague	Observe colleague or satisfactory supervised practice	Competent to perform unsupervised
Preparation and administration of intramuscular vaccination	Satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Preparation and administration of	Satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain

intramuscular antibiotics				
Practical Procedure **Recommended**				
Genital skin or punch biopsy		Observe colleague	Satisfactory supervised practice	Competent to perform unsupervised

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries'. A training programme director (TPD) will be responsible for coordinating the specialty training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Progression through the programme will be determined by the Annual Review of Competency Progression (ARCP) process and the training requirements for each indicative year of training are summarised in the ARCP decision aid (available on the JRCPTB website).

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the curriculum requirements are met and also that unnecessary duplication and educationally unrewarding experiences are avoided.

Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person. It will be best practice for trainees to have an educational supervisor who practises internal medicine for periods of IM stage 2 training. Educational supervisors of IM trainees who do not themselves practise IM must take particular care to ensure that they obtain and consider detailed feedback from clinical supervisors who are knowledgeable about the trainees' IM performance and include this in their educational reports.

All training in GUM and GIM should be conducted in institutions which have been approved by the GMC for training, with appropriate standards of clinical governance and which meet the relevant Health and Safety standards for clinical areas. It is expected that trainees will maintain an e portfolio of evidence of their clinical and training activity.

During the 4 year training programme the trainee will undertake the equivalent of 12 months of internal medicine (IMT stage 2 curriculum). This will enable a dual accreditation CCT in GIM alongside GUM. This training can be integrated flexibly into the 4 years of specialty training, either as one or several blocks or alongside the training throughout the 4 years, as long as there is a minimum of 3 months of internal medicine within the last year of training. IM stage 2 competencies can be gained during inpatient care of HIV patients however there is an expectation that a dedicated period of time in an attachment that allows other general medical competencies to be gained, will be also required. Due to the aging cohort of HIV patients, a period in Geriatrics would be recommended however this is not mandated.

IMT Stage 2 will include participating in the acute medical 'take'. An indicative number of patients to be managed by the trainee during unselected medical 'take' would be 750, with a minimum of 100 patients managed in the last year of training (ST7). In order for the trainees to maintain skills in acute medicine, it is recommended that the acute medical take be a part of the trainee's routine workload throughout the training programme however this is not mandated. If a trainee works 40 weeks per year, with a fortnightly acute medical admissions shift, admitting 10 patients per shift, this will equate to 800 admissions (200 per annum for each year of training).

Acute take may be undertaken during daytime and/or overnight depending on local need. Ward-rounds with a senior consultant to review admitted patients and also necessary ward work, will need to be built into the rota. Great care in rota planning will be needed to ensure this workload does not impact on specialty training.

The trainee may also be required to take part in GUM or HIV specialty on call during the day and/or overnight, but this is not mandated and can flexibly take place at any time during the 4 year training programme.

During stage 2 of IM training, it will be expected that the trainee will undertake an indicative 20 outpatient clinics in a specialty other than GUM. These could be completed during one year of training (3-4 clinics per week) or spread more evenly over the 4 years of training. Wherever possible the clinics should have educational value relevant to specialty training, in particular supporting management of acute and chronic presentations of HIV infection, including management of patients at both ends of life (adolescent and ageing). The exposure to medical specialist skills should be as varied as possible and should facilitate completion of e-portfolio requirements and CiPs. Special interests of trainees should be taken into account wherever possible.

Trainees should be exposed to the full range of urgent and emergency consultations in GUM. This can be obtained through on-call responsibilities during the standard working day and /or out of hours. It would be expected that trainees would be a referral point for emergency consultations throughout their training.

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.

4.1.1 Mandatory training requirements for Genitourinary Medicine (GUM) specialist trainees

Indicative progress through training for GUM

For the following statements a 'clinic' or session is expected to be of 3.5-4hrs duration with time for patient-related administrative tasks such as letters and management of results included within this time.
Outpatients:
-At least 1 general HIV clinic per week throughout specialist GUM training.
-5 to 6 clinics a week comprising general GUM and/or specialist GUM and/or specialist HIV clinics or equivalent ward time managing HIV inpatients. One of these sessions per week may be allocated for attending specialist non-GUM training e.g. dermatology, gynaecology, public health and laboratory attachment
1 session per week CME.
2 session per week comprising clinical or departmental administration and/or management or audit/quality improvement activities and/or departmental research and/or private study.

ST4 and/or ST5
The aim of these two years is to lay the groundwork of knowledge and skills for the following specialist curriculum and GPC syllabus requirements:
•Epidemiology, diagnosis and clinical management of common genitourinary infections.
•Diagnosis and management of the complications of common genitourinary infections
•Human Immunodeficiency Virus (HIV); see detailed explanation below
o HIV testing
o Experience of PEP and Prep
o HIV OPD , with own patient cohort under direct consultant supervision
o HIV inpatient management or can defer to ST6 or ST7
o Assessing newly diagnosed PLWH
o Monitoring asymptomatic PLWH
o Instituting and monitoring first-line ARV treatment
•Contraception
•Pathology including laboratory diagnosis of STIs, HIV and BBVs (see below)
•Research methods, including statistics, with a view to initiating a research project
•Audit and or quality improvement project
•Start management training
•Public health
•Gynaecological module
•Teaching/training
•Depending on individual needs, parts of this programme can be deferred to ST 6 or ST7

ST6 and/or ST7
In these years the basic competencies in knowledge and skills will be consolidated in:
•Epidemiology, diagnosis, and clinical management of genitourinary infections and their complications

•Continue weekly HIV clinic and gain further HIV experience in the following areas:
o Assessing HIV patients with treatment failure including management of poor adherence
o Supervised experience of the use of new ARV classes
o Supervised experience of therapeutic drug monitoring
o Supervised experience of complex drug interactions in patients with co-morbidities
o Supervised experience of the management of Hepatitis B and C coinfection in PLWH
•Experience of at least one specialist HIV clinic (e.g. antenatal clinic, injecting drug users, Prison healthcare in PLWH, TB co-infection, metabolic, renal, neurology).
•Management of ARV toxicity
•HIV inpatient management (or can complete earlier in ST4 or ST5)
•Dermatology module
•Audit including completing at least one audit cycle or a quality improvement project
•Continue developing management skills
•Public health experience
•Teaching/training

The remainder of the time must be divided into:
•Developing special interests (e.g. vulval, adolescent, HIV specialist clinics, HIV/STI prison healthcare, service development, teaching)
And/or
•Research

•Overseas experience can be incorporated in this period but is not mandatory.
All out of programme experience must be prospectively approved by the Local rotation TPDs and HEE. Please see the JRCPTB website (www.jrcptb.org.uk) and section 4.7 of this curriculum for details.

4.1.2 Gynaecology training

Aims of gynaecology training

To ensure trainees have the knowledge, skills and attitudes required to identify and appropriately manage common gynaecological and obstetric conditions presenting to GUM/HIV departments.

Duration and organisation of training

By the end of training, trainees must complete the theoretical and practical training required to obtain the Diploma of the Faculty of Sexual and Reproductive Health (DFSRH), which is a mandatory requirement. Trainees must also observe gynaecological and obstetric practice, enabling them to have a broad understanding of this speciality and its application in GUM clinical practice. This can be obtained as follows:

1. Before entering GUM specialty training
Trainees who have completed a minimum of three months in a F1, F2, ST1 or ST2 post in gynaecology or obstetrics and gynaecology, before embarking on GUM specialty training, can use this experience to meet the training objectives.
During that time trainees should have monitored their knowledge and competence using their portfolio and have had this countersigned by their educational superviser. At the start

of GUM specialty training, trainees will meet with their Unit Training Director to review competencies to date against objectives in the curriculum and identify how best to complete any additional training identified.

2. During GUM specialty training
Trainees without sufficient previous experience in gynaecology and obstetrics to meet the training objectives should undertake a programme of gynaecological training, preferably during the first two years of specialist training in GUM. This will be attained through half or full day release or through single or multiple attachments.

In order to meet the syllabus objectives training will include attendance at a wide range of obstetric and gynaecology clinics and services. These could include clinics in general gynaecology, gynaecological endocrinology, uro-gynaecology, infertility, early pregnancy assessment units (EPU), also known as early diagnostic units (EDU), antenatal clinics, termination of pregnancy clinics, colposcopy, gynaecological oncology and vulval clinics. Emergency presentations must be observed by shadowing the on-call gynaecology team during daytime working hours; out of hours attachments are not compulsory.

The minimum number of clinics/sessions that trainees are expected to attend is not stipulated but must be sufficient to complete all the competencies. An indicative programme would be the following clinics: 4 general under the supervision of a named consultant, 4 antenatal,2 of which may be HIV/ANC, 3 colposcopy, 2 endocrine, 1/2 uro-gynaecology, 2 infertility, 2 endometriosis, 2 gynaecology oncology, 4 vulval, 2 termination of pregnancy, 2 menopause, plus FGM if available. A programme to observe emergency presentations could include three EPU/EDU sessions, an equivalent to 2 days shadowing emergency on call plus observing a wide range of in-patient attendances. Where units do not divide clinics into these specialist services, the trainee must ensure that the wide range of experience is achieved thorough general clinics and ward/emergency care attachments.

4.1.3 Pathology training

Aims of pathology training

To ensure that trainees have the knowledge, skills and attitudes required to manage pathology requests and interpretation of results related to STIs, HIV and BBVs, in addition to knowledge of specimen collection and an ability to develop working relationships with laboratory staff.

Duration and organisation of training

Some pathology training is available in the genitourinary medicine clinic. Self-directed learning and attendance at courses/lectures may be required to gain factual knowledge. In addition a week attending the local or regional microbiology and virology laboratories will be required to observe techniques, gain an understanding of laboratory procedures including quality assurance, the optimum way in which specimens should arrive in the laboratory and handling of results.

4.1.4 Dermatology training

Aims of dermatology training

To ensure that trainees have the knowledge, skills and attitudes required to identify and appropriately manage common dermatological conditions seen in patients presenting to GUM and HIV departments.

Duration and organisation of training

Trainees' specific training requirements should be identified in partnership with their Unit Training Director to determine the best way to meet the dermatology learning objectives. These can be obtained as follows:

1. Before entering GUM specialty training

Trainees who have completed a minimum of a three month post in dermatology during F1, F2, or CMT/IMT, before embarking on GUM specialty training, can use this experience to meet the learning objectives. During that time trainees should have monitored their knowledge and competence using their portfolio and have had this signed off by a designated dermatology superviser. At the start of GUM specialty training, trainees will meet with their Unit Training Director to review competencies to date against objectives in the curriculum and identify how best to complete any additional training identified.

2. During GUM specialty training

Trainees without sufficient previous experience in dermatology to meet the training objectives should undertake a programme of dermatology training, preferably during the latter two years of specialist training in GUM. This will be attained through half or full day release or through single or multiple attachments.

In order to meet the dermatology learning objectives, trainees will attend a variety of related outpatient clinics and attend dermatology ward rounds and dermatology histopathology meetings.

Outpatient clinics could include general dermatology as well as more specialist genital dermatology clinics, which may be run by dermatologists, GU physicians or gynaecologists depending on local services. Experience of genital malignancies may require trainees to attend gynaecology oncology, urology and plastic surgery clinics.

A minimum number of clinics/ sessions that trainees are expected to attend are not stipulated although approximately 10 should complete all the competencies.

It is recommended that trainees are proficient at performing genital biopsies although this requirement is no longer mandatory.

4.1.5 HIV training

Duration and organisation of training

During the first 2 years of training emphasis for HIV training should be on HIV testing, assessment of ARV naïve individuals, instituting first-line ARV therapy, and management of post exposure prophylaxis.

In years 3 and 4, this work should be continued and experience widened to include management of regimen failure, management of toxicity and diagnosis of HIV complications.

Competence in these clinical areas should, in the most part, be gained through direct clinical experience and directed self-learning.

It is also important that trainees have supervised experience of unselected assessment of acutely unwell HIV positive individuals.

4.1.5.1 In-patient training

To gain knowledge and skills in the investigation, diagnosis, and management (including appropriate referral) of patients with complex HIV/AIDS-related presentations, trainees will need time attached to an HIV in-patient service. Such experiential learning should be supplemented by directed self-learning, supported with more formal teaching. Attachments should in most instances be for a minimum of 3 months and can be at any time during GUM training. This also represents a period when trainees might usefully experience other important facets of their training for example complex ARV prescribing, treatment of different patient groups eg IVDU, adolescents, pregnant women, TB coinfected patients and experience of patients with hepatitis co-infection.

The recommended characteristics of an in-patient unit are:
•an average of 10 in-patients per month. If fewer in-patients are anticipated a longer period of attachment is acceptable if the case-mix enables the trainee to see the wide range of OI and malignancies in the curriculum.
•On-site access to intensive care
•Multi-professional management of complex antiretroviral prescribing
•Management of patients with viral hepatitis co-infection
•Management of pregnant HIV positive women
•Well-defined, specialist cancer referral protocols

Trainees should complete a logbook documenting their experience of in-patients and complex antiretroviral management.
During the period of attachment trainees should, under supervision, be responsible for the initial assessment of HIV positive individuals presenting acutely unwell. This does not have to be out of hours. Ideally, involvement in the care of patients requiring in-patient care should occur throughout the period of training and not be solely restricted to the period of attachment to an in-patient unit.

In view of the decrease in clinical exposure within smaller HIV outpatient units due to the decreased incidence of OIs/cancers and the rationalisation of in-patient services to HIV centres, the TPD must ensure that if the training is not available within the host training centre, that the training programme includes secondment to an in-patient unit at another HIV centre. From the BHIVA audit of current network arrangements it appears that secondment of trainees, where necessary, will mostly be achievable within the same clinical network. If not, this will need to be funded by the deanery and be included in the trainee's the job description. A secondment must be of sufficient duration to meet the training objectives; three months is an indicative period. The Diploma in HIV must be obtained by the end of training in order to achieve CCT.

4.1.6 Palliative and end of life care

Palliative and end of life care is a core component of the Internal Medicine (IM) curriculum and trainees will continue to develop their knowledge and skills throughout specialty training. Palliative and end of life care is one of the eight clinical Capabilities in Practice

(CiPs), with specialist palliative care experience recommended. There is sometimes the opportunity to experience this during ward attachments to an HIV in-patient unit. If not, experience of end of life care can be achieved during attachments to routine medical teams (eg geriatric medicine, oncology, respiratory medicine) and ICU but trainees may have the opportunity to undertake a palliative medicine attachment to a specialist palliative care setting (or range of settings), which would enhance a trainee's ability to gain knowledge and skills in managing palliative and end of life patients beyond experience in an IM or other speciality environment.
During a palliative medicine placement, trainees will have a clinical supervisor and will be encouraged to undertake relevant workplace based assessments to evidence entrustment decisions for CiP8. Depending on the setting in which they are based, trainees will have the opportunity to provide direct care to hospice/specialist palliative care unit inpatients, work in day hospice and outpatient settings, undertake domiciliary visits and work with hospital and community palliative care teams. During an attachment, trainees are likely to participate in the specialty palliative care on call.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities described in the syllabus through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn.

Work-based experiential learning - The content of work-based experiential learning is decided by the local faculty for education but includes active participation in:

Medical clinics including specialty GUM, RSH & HIV clinics
The educational objectives of attending clinics are:

- To understand the management of chronic diseases
- Be able to assess a patient in a defined time-frame
- To interpret and act on the referral letter to clinic
- To propose an investigation and management plan in a setting different from the acute medical situation
- To review and amend existing investigation plans
- To write an acceptable letter back to the referrer
- To communicate with the patient and where necessary relatives and other health care professionals.

These objectives can be achieved in a variety of settings including hospitals, day care facilities and the community. The clinic might be primarily run by a specialist nurse (or other qualified health care professionals) rather than a consultant physician. After initial induction, trainees will review patients in clinic settings, under direct supervision. The degree of responsibility taken by the trainee will increase as competency increases. Trainees

should see a range of new and follow-up patients and present their findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.

The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be a minimum of two hours.

Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

Reviewing patients with consultants
It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WBA such as an ACAT, mini-CEX or CBD). This may be accomplished when working on a take shift along with a consultant, or on a post-take ward round with a consultant.

Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments
Every patient seen, on the ward or in outpatients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading, reflection on clinical problems and WBAs. Cases should be anonymously recorded in the e-portfolio.

Ward rounds by more senior doctors
Every time a trainee observes another doctor seeing a patient or their relatives there is an opportunity for learning. Ward rounds (including post-take) should be led by a more senior doctor and include feedback on clinical and decision-making skills.

Multi-disciplinary team meetings
There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning.

Trainees have supervised responsibility for the care of inpatients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

Palliative and end of life care

Trainees undertaking a palliative medicine attachment will see palliative care patients with a range of life-limiting illnesses, including cancer, frailty, multi-morbidity, dementia and organ failure. They will gain expertise in:

- Managing difficult physical symptoms;
- Managing psychological, spiritual and existential distress for patients and those close to them;
- Addressing complex social issues for patients at the end of life (including facilitating preferences for place of care and death);
- Managing challenging symptoms in the dying patient;
- Identifying those in need of proactive or enhanced bereavement support;
- Managing palliative care patients out of hours, including in non-acute settings (hospice and community).

Trainees will also have the opportunity to:

- Enhance skills in recognising the patient with limited reversibility of their medical condition and the dying patient;
- Improve understanding of the range of interventions that can be delivered in acute and non-acute settings (e.g. community, hospice or care home);
- Increase confidence in developing and communicating appropriate advance care plans, including DNACPR and treatment escalation decisions;
- Increase confidence in providing a senior opinion where there is conflict regarding a patient's goals of care;
- Increase confidence in working in an advisory/liaison role, e.g. in hospital or community, providing advice to other multi-professional teams.

Formal postgraduate teaching

The content of these sessions are determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings. Many of these are organised by the Royal Colleges of Physicians.

Suggested activities include:

- a programme of formal bleep-free regular teaching sessions to cohorts of trainees (eg a weekly training hour for IM teaching within a training site)
- case presentations
- research, audit and quality improvement projects
- lectures and small group teaching
- Grand Rounds
- clinical skills demonstrations and teaching
- critical appraisal and evidence based medicine and journal clubs
- joint specialty meetings
- attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.

Learning with peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions.

Independent self-directed learning

Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- reading journals
- achieving personal learning goals beyond the essential, core curriculum

Formal study courses

Time to be made available for formal courses is encouraged, subject to local conditions of service. The study leave lists have been constructed by the relevant Heads of Speciality Schools/Training Programme Directors with oversight and approval of the Post Graduate Deans. Those courses identified as mandatory should assist educational supervisors to ensure that the trainee is meeting the requirements mandated by the curriculum.
The optional courses are complementary to the curriculum, the Head of School or Training Programme Director being of the opinion that attendance at these events is of benefit to the trainee. It is not expected that the lists are exhaustive and there is no expectation that the trainee should complete all the optional events for their given programme. The list should act as a guide for the trainee and educational supervisor to plan and schedule attendance at some of these events across the entire duration of training.

Mandatory

Basic Life Support course
Advanced Life support course
Regional Training Days
Level 3 child protection course
Clinical Leadership and Management Course
e Knowledge Assessment (eKA) for DFSRH
Course of 5 for DFSRH
Practical training for DFSRH
Practical training for the insertion of contraceptive implants
Practical training for the insertion of intrauterine devices and systems
HIV in-patient training

Optional

<u>All medical specialties</u>
Exam preparation course relevant to level of training
Developing skills for educational supervision
National Conference or course attendance relevant to curricular progression
National Courses and Events for Critical Appraisal Training
National Courses and Events relating to Human Factors Training
National Statistical analysis courses
Courses to prepare for consultant interview (last two years of training)
National courses in relation to research methodology
Teaching course
<u>Specific to GUM training</u>

British Association for Sexual Health and HIV (BASHH) Masterclass in HIV
HIV trainees club meeting
ABC of sexual dysfunction course
BHIVA - General Medicine for HIV Physicians course
Adult Sexual Assault Examination and Aftercare (2 days)
BHIVA Conference
BASHH Spring Meeting
BASHH Doctors-in-training day
BASHH OGM
BASHH Midlands Meeting
BASHH STIs and HIV Course (10 days)
BSIG Microscopy courses (2 days)
Revision course for Diploma in Genitourinary Medicine OSCE (1 day)
Revision course for Diploma in HIV Medicine (1 day)
BASHH Genital Dermatology course (1 day)
HIV Drug Resistance workshop
DFSRH sexual and reproductive health meetings/update days
FSRH Annual Scientific Meeting

4.3 Academic training

Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent.

All trainees are encouraged to gain experience in research and teaching during their specialty training. Some will wish to develop their skills further, for example by undertaking a Masters level degree with a period of out of programme experience.
Some will want more in depth research experience and to complete a postgraduate research degree (eg PhD, MD) as part of a research training. For those contemplating an academic career, the Integrated Academic Training Pathway offers a structured way of combining academic and clinical training. The four nations have different arrangements for academic training and doctors in training should consult the LETB or deanery for further guidance.

Academic trainees can be recruited at any point in the internal medicine training programme. Academic clinical fellow (ACF) or equivalent posts are available as part of the Integrated Academic Training Pathway and offer a 3-year training post with 25% time reserved for academic work (research and/or teaching). Most fellows will apply for an externally-funded research training fellowship during this time, and take OOPR to complete a PhD/MD. On completion, fellows complete the balance of their training in a clinical training post, or an academic clinical lecturer (ACL) post. Fellows who do not take up an externally funded fellowship during their ACF will still complete training, switching to a clinical training post for the final year. Trainees interested in this path should discuss this with the TPD and academic training lead at an early stage.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the

facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the Deanery as to what is appropriate together with guidance from the appropriate SAC that the proposed period and scope of study is sensible.

4.4 Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the postgraduate dean in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

4.5 Acting up as a consultant

A trainee coming towards the end of their training may spend up to three months “acting-up” as a consultant, provided that a consultant supervisor is identified for the post and satisfactory progress is made. As long as the trainee remains within an approved training programme, the GMC does not need to approve this period of “acting up” and their original CCT date will not be affected. More information on acting up as a consultant can be found in the Gold Guide.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:

- assess trainees’ actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development
- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- identify trainees who should be advised to consider changes of career direction.

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of

training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different individual types of assessment. A range of assessments is needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (eg through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgement in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees continually to gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all SLEs and WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment 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

Towards the end of the training year, trainees will make a self-assessment of their progression for each CiP and record this in the eportfolio with signposting to the evidence to support their rating.

The educational supervisor (ES) will review the evidence in the eportfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in the ES report, with commentary.

For **generic CiPs**, the ES will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For **clinical and specialty CiPs**, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Level descriptors for clinical and specialty CiPs

Level	Descriptor
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**

The ARCP will be informed by the ES report and the evidence presented in the eportfolio. The ARCP panel will make the final summative judgement on whether the trainee has

achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

5.4 Critical progression points

There will be a key progression point on entry and on completion of specialty training. Trainees will be required to be entrusted at level 4 in all CiPs in order to achieve an ARCP outcome 6 and be recommended for a CCT.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

The outline grids below set out the expected level of supervision and entrustment for the IM clinical CiPs and the specialty CiPs and include the critical progression points across the whole training programme.

Table 1: Outline grid of levels expected for Internal Medicine clinical capabilities in practice (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

IM Clinical CiP	CRITICAL PROGRESSION POINT	ST4	ST5	ST6	ST7	CRITICAL PROGRESSION POINT
1. Managing an acute unselected take					4	
2. Managing an acute specialty-related take			3		4	
3. Providing continuity of care to medical inpatients					4	
4. Managing outpatients with long term conditions					4	
5. Managing medical problems in patients in other specialties and special cases					4	
6. Managing an MDT including discharge planning					4	
7. Delivering effective resuscitation and managing the deteriorating patient					4	
8. Managing end of life and applying palliative care skills					4	

Table 2: Outline grid of levels expected for Genitourinary medicine specialty capabilities in practice (CiPs)

Levels to be achieved by the end of each training year 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

	IM Stage 1				Selection	GUM Specialty + IM Stage 2				CCT
Specialty CiPs	**IM1**	**IM2**		**IM3**		**ST4**	**ST5**	**ST6**	**ST7**	
Managing patients with non-complex sexual & reproductive health presentations in out-patient or community settings.						2	3	3	4	
Managing patients with complex sexual & reproductive health presentations in a specialist out-patient or community setting.							2	3	4	
Providing specialist care for individuals living with HIV in an out-patient or community setting.						2	3	3	4	
Providing specialist care for individuals with diagnosed HIV/AIDS in a hospital in-patient setting.							2	3	4	
Delivering interventions to prevent transmission of HIV, other blood borne viruses and STIs.						2	3	3	4	
Supporting early detection of STIs and HIV in all settings.						2	3	3	4	
Safeguarding of public health and delivering sexual health/HIV services and information for specific populations in a range of settings.							2	3	4	
Ability to successfully lead, manage and work with specialist service commissioning in acute and community settings							2	3	4	

5.5 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Examinations and certificates

- Advanced Life Support Certificate (ALS)
- The Diploma in GU Medicine (DipGUM)
- The Diploma of HIV Medicine (DipHIV)
- The Diploma of the Faculty of Sexual and Reproductive Health (DFSRH)
- Letter of Competence in subdermal implants (LoC SDI)
- Letter of Competence in intrauterine techniques (LoC IUT)

5.8.1 Information about DipGUM, DipHIV, DFSRH

Weblink for more information including guidance for candidates

- DipGUM and DipHIV - www.apothecaries.org
- DFSRH/Loc SDI/LoC IUT - www.fsrh.org/education-and-training

The Worshipful Society of the Apothecaries has developed the Diploma of GU Medicine and the Diploma HIV Medicine, which are blueprinted to the GUM curriculum. The convenors and external advisers of both exams are co-opted members to the GUM SAC, which meets 3 times a year. The Faculty of Sexual and Reproductive Healthcare have developed the DFSRH, Loc SDI and LoC IUT. During the course of training, the successful completion of the Diplomas in GUM and HIV Medicine (Society of Apothecaries of London) and the Diploma of the Faculty of Sexual and Reproductive Healthcare are required. Trainees are required to complete these knowledge-based exams in accordance with the schedule stipulated in the ARCP decision aid-Dip GUM by the end of year 3 (ST6) of GUM training and the DFSRH and Dip HIV by completion of training.

It is envisaged that by the end of ST6, all trainees will have had adequate opportunities to be proficient in the management of the range of common GUM presentations, and have had appropriate exposure to allied disciplines and to specialist training opportunities so as to develop the knowledge, skills and attitudes required of specialists in most aspects of STI and sexual health care. The JRCPTB acknowledges that for most trainees, HIV training continues throughout the training programme and that appropriate levels of expertise may only be developed later in the training programme.

The DFSRH is a recognised assessment of basic competence in sexual and reproductive health (SRH) provision, supported by the FSRH. It builds on a Department of Health (DoH) supported ‘E-learning for Health’ (eLFH) contraceptive module and is taught and assessed within contraception services that are recognised for training. Assessment is competency based and conducted by trained supervisors within contraceptive or integrated sexual and

reproductive health clinics. The DFRSH maps closely to the contraception elements of the GUM curriculum. Some elements of GUM contraception training (eg LARC insertion, management of the contraceptive needs of HIV positive patients) are beyond the curriculum of the DFSRH and are assessed separately by obtaining the LoC SDI, LoC IUT and within the Dip HIV examination. By testing trainees' knowledge and assessing their skills, the Diploma demonstrates that they can provide safe and effective sexual and reproductive health care in community, primary and secondary care settings.

Workplace-based assessment (WPBA)

- Direct Observation of Procedural Skills (DOPS) – summative

Formative assessment

Supervised Learning Events (SLEs)

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)

WPBA

- Direct Observation of Procedural Skills (DOPS) – formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the eportfolio and on the JRCPTB website (www.jrcptb.org.uk).

Assessment should be recorded in the trainee's eportfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Acute Care Assessment Tool (ACAT)

The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take. It is primarily for assessment of their ability to prioritise, to work efficiently, to work with and lead a team, and to interact effectively with nursing and other colleagues. It can also be used for assessment and feedback in relation to care of individual patients. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT.

Case-based Discussion (CbD)

The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and

application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, and discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

mini-Clinical Evaluation Exercise (mini-CEX)
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

Direct Observation of Procedural Skills (DOPS)
A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative).

Multi-source feedback (MSF)
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administrative staff, and other allied professionals. Raters should be agreed with the educational supervisor at the start of the training year. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Patient Survey (PS)
The PS addresses issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

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 review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the same quality improvement project by more than one assessor.

Teaching Observation (TO)
The TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO 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).

Multiple Consultant Report (MCR)
The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisors report (ESR)
The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

5.6 Decisions on progress (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the clinical and specialty CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year or training. The requirements for each year of training are set out in the ARCP decision aid (www.jrcptb.org.uk).

The ARCP process is described in the Gold Guide. Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's eportfolio.

As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal eportfolio review either with their educational supervisor or arranged by the local school of

medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the JRCPTB website www.jrcptb.org.uk.

5.7 Assessment blueprint

The tables below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

KEY

ACAT	Acute care assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
TO	Teaching observation	DipGUM	The Diploma in GU Medicine
DipHIV	The Diploma in HIV Medicine	DFSRH eKA	e Knowledge assessment component of FSRH Diploma
LoC SDI	Letter of competence subdermal implants	Loc IUT	Letter of competence intrauterine techniques
BO5	Best of five	OSCE	Objective structured clinical examination

Blueprint for assessment mapped to CiPs

Learning outcomes	**ACAT**	**CbD**	**DOPS**	**MCR**	**Mini -CEX**	**MSF**	**PS**	**QIPAT**	**TO**	**DipGUM BO5**	**DipGUM OSCE**	**DipHIV BO5**	**DipHIV OSCE**	**DFSRH eKA**	**LoC SDI**	**LoC IUT**
Generic CiPs																
Able to function successfully within NHS organisational and management systems				√		√										
Able to deal with ethical and legal issues related to clinical practice		√	√	√	√	√				√	√	√	√			
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement				√		√	√				√		√		√	√
Is focussed on patient safety and delivers effective quality improvement in patient care				√		√		√			√		√	√	√	√

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO	DipGUM BO5	DipGUM OSCE	DipHIV BO5	DipHIV OSCE	DFSRH eKA	LoC SDI	LoC IUT
Carrying out research and managing data appropriately				√		√										
Acting as a clinical teacher and clinical supervisor				√		√			√							
Clinical CiPs																
Managing an acute unselected take	√	√		√		√										
Managing an acute specialty-related take	√	√		√		√										
Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	√		√	√	√	√							√			
Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions	√			√	√		√			√	√	√	√	√		
Managing medical problems in patients in other specialties and special cases	√	√		√												
Managing a multi-disciplinary team including effective discharge planning	√			√		√					√		√			
Delivering effective resuscitation and managing the acutely deteriorating patient	√		√	√		√										
Managing end of life and applying palliative care skills		√		√	√	√										
Practical procedural skills			√								√		√		√	√
Managing patients with non-complex GUM/ contraception presentations in out-patient or community settings		√	√	√	√	√	√			√	√	√	√	√		
Managing patients with complex GUM/contraception presentations in a specialist out-patient or community		√	√	√	√	√	√							√	√	√
Providing specialist care for individuals living with HIV in an out-patient or community setting.	√	√	√	√	√	√	√			√	√	√	√			
Providing specialist care for individuals with diagnosed HIV/AIDS in a hospital in-patient setting.	√	√	√	√	√	√	√					√	√			
Delivering interventions to prevent transmission of HIV, other blood borne viruses and STIs.		√			√			√	√	√	√	√	√	√		

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO	DipGUM BO5	DipGUM OSCE	DipHIV BO5	DipHIV OSCE	DFSRH eKA	LoC SDI	LoC IUT
Supporting early detection of STIs and HIV in all settings.		√			√			√	√	√	√					
Safeguarding of public health and delivering sexual health/ HIV services and information for specific populations in a range of settings.		√			√			√	√	√	√	√	√			
Ability to successfully lead, manage and work with specialist service commissioning in acute and community settings.	√	√		√	√	√	√									

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning[5].

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in

[5] Improving feedback and reflection to improve learning. A practical guide for trainees and trainers

which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[6].

6.1.1 Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements. Trainees on a dual training program may have a single educational supervisor responsible for their internal medicine and specialty training, or they may have two educational supervisors, one responsible for internal medicine and one for specialty.

6.1.2 Clinical supervisor

Consultants responsible for patients that a trainee looks after, provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide an MCR for the trainee to inform the Educational Supervisor's report.

The educational and (if relevant) clinical supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors (as well as the trainee). These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[7]. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

[6] Promoting excellence: standards for medical education and training
[7] Recognition and approval of trainers

6.1.3 Trainees

Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.2 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the eportfolio

Induction Appraisal

The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

Mid-point Review

This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP).At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal

Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be

recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed. Supervisors should also identify areas where a trainee has performed about the level expected and highlight successes.

7 Quality Management

The organisation of training programs is the responsibility of the deaneries. The deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees into the specialty
- allocate trainees into particular rotations appropriate to their training needs
- oversee the quality of training posts provided locally
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training.

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by deaneries or by the colleges or both.

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB and the SAC. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

The JRCPTB has a role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. The SACs are actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its specialties and subspecialties to provide meaningful quality management. The datasets include the GMC national Training Survey (NTS) data, ARCP outcomes, examination outcomes, new consultant survey, penultimate year assessments (PYA)/external advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences.

8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an eportfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the eportfolio

On enrolling with JRCPTB trainees will be given access to the eportfolio. The eportfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainee's main responsibilities are to ensure the eportfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use eportfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

Deaneries, training programme directors, college tutors and ARCP panels may use the eportfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous eportfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace-based assessments (including MSF) should be recorded in the eportfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the eportfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other eportfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-

assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

9 Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

Deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- Deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every three years
- Deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every three years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. Deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
- monitoring of College Examinations

- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.