

Curriculum for Neurology Training

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FIRST DRAFT FOR CONSULTATION

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1. Introduction

The burden of neurological disease in the United Kingdom is high and increasing. 12.2 million people in the United Kingdom live with a neurological disorder. One million are disabled by their condition, 350 000 of whom require help with activities of daily living. For 2.2 million, their condition worsens over time and for 7.4 million their deficits are intermittent (1).

In a patient survey published in 2019 (2), one in three patients waited over a year to see a neurologist and only 30% of patients felt involved in decision making about their care. The prevalence of neurological disease and the capricious nature of many of the conditions explains the associated 700,000 emergency admissions and 11 million bed-days each year. The very serious nature of these diseases is also reflected in the increasing mortality rate associated with neurological conditions in the UK, in contrast to all-cause mortality(3).

It is also of relevance that in the most recent WHO International Classification of Disease (ICD-11) stroke has been classified as a neurological disease, rather than a cardiovascular disease (4). This is of particular importance to patients who live with neurological disability after a stroke, the nature of which is the same or very similar to that caused by other diseases involving the brain.

The reforms associated with Shape of Training coupled with the needs of patients with neurological disease led the Neurology Specialist Advisory Committee (SAC) of the JRCPTB and the Association of British Neurologists (ABN) and the Association of British Neurologists Trainees (ABNT) to engage with the neurology community to determine how training in neurology should change to develop neurology consultants who can deliver the highest quality patient care.

This revision of the neurology curriculum reflects this burden of disease but also the dramatic developments in the diagnosis and management of acute and chronic neurological diseases to ensure patients, and their families, and the doctors providing their care, are well served by neurology training in the future.

In the reforms of Shape of Training, neurology is joining the other major specialties in Group 1, incorporating in to specialist training an additional year of internal medicine. Furthermore, the neurology curriculum will incorporate the three capabilities described in the new stroke curriculum, which will be necessary for doctors to contribute to the care of stroke patients.

2. Purpose

2.1 Purpose of the curriculum

The curriculum will outline the training required for neurologists to deal with the growing number of neurological diseases that can be treated and require long-term management, and patients who present acutely to neurology, stroke, and general medical services.

This curriculum will ensure that trainees acquire the necessary competencies by describing the skills and knowledge required at each stage of training, and suggesting the likely duration of training in neurology, stroke and sub-specialist areas of the neurology curriculum. The curriculum will also describe the assessment tools to be used, such as mini-CEX, CbD and MSF.

The curriculum will reflect the demand for trained neurologists in three distinct areas of practice: acute (including inpatients), outpatients, and ambulatory care.

The demands on acute neurology services are increasing in two contrasting areas: the acute general neurology and stroke services in secondary care, and the tertiary neurology services that also deliver thrombolysis and thrombectomy for stroke. As treatments for acute neurological diseases, including stroke, are so time critical, it seems highly likely that neurologists, who will be dual-trained in internal medicine, will be asked to take on more acute work, to help develop services which are focussed on the acute presentations of all conditions involving the nervous system. The skills and knowledge required will be reflected in the new curriculum.

Currently the vast majority of people with neurological diseases present to Neurologists as outpatients. There are 10 million people in the UK with a progressive or intermittent neurological condition and a further 2.2 million with a stable neurological condition but with changing needs (1). The breadth and complexity of neurological diseases means that periods of dedicated training in outpatients in subspecialty areas of neurology are of the utmost importance. As well as the more common diseases which now have complex treatments, there are many rare immune-mediated, paraneoplastic, infectious and metabolic diseases for which a delay in diagnosis can have profound implications.

The assessment and management of chronic disability is often best done in the community where an assessment of the patient can be combined with an evaluation of their psychosocial predicament, their environment and the suitability of their accommodation. In addition, there are many conditions that lend themselves to assessment in ambulatory care units and community clinics, including chronic headache, pain, Parkinson's disease and secondary progressive Multiple Sclerosis, to name just a few. The broad range of neurological and general medical training in the new curriculum will make neurologists of the future particularly well suited to work in the community.

The curriculum also needs to reflect the organisational skills needed to work effectively with Clinical Nurse Specialists, Physiotherapists and Speech Therapists in order to run efficient patient-centred ambulatory care services.

Specialty training in Neurology will begin following completion of the Internal Medicine Stage 1 curriculum. Training will be provided in a variety of settings using a range of methods including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

Attendance at courses, a minimum of two every year, tailored to the training requirements of the doctor, will be an important part of training. The programme will also support preparation for the Specialty Certificate Examination (SCE) by encouraging the use of the eBrain practice questions, attendance at SpR training days, and attendance at appropriate courses.

The purpose statement for this curriculum has been endorsed by the GMC’s Curriculum Oversight Group (COG) and was commended 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 specialty CiPs incorporate the core capabilities that all trainees must achieve in order to practice as a general neurologist in an acute (including inpatients), outpatient and ambulatory setting. Each neurology CiP refers to a group of neurological disorders with a combined estimated prevalence of more than 100,000 in the UK.

Following the successful completion of a training programme in neurology, a doctor will be able to do the following:

- Provide inpatient and outpatient services for patients presenting with neurological conditions, including stroke
- Appropriately request and interpret diagnostic tests including structural and functional imaging techniques, neurophysiology, histopathology and gene analysis
- Interpret psychological and neurological symptoms, including psychiatric complications of neurological disease and presentations with functional neurological symptoms
- Work effectively with colleagues in allied medical specialties such as neurosurgery, neurorehabilitation, neuro-ophthalmology and audiovestibular medicine and with professions allied to medicine such as physiotherapy and psychology.
- Constructively engage with national, regional and local organisations in planning the management and prevention of neurological disease.

Engage with university employees to promote academia and high quality research Learning outcomes – Capabilities in Practice (CiPs)

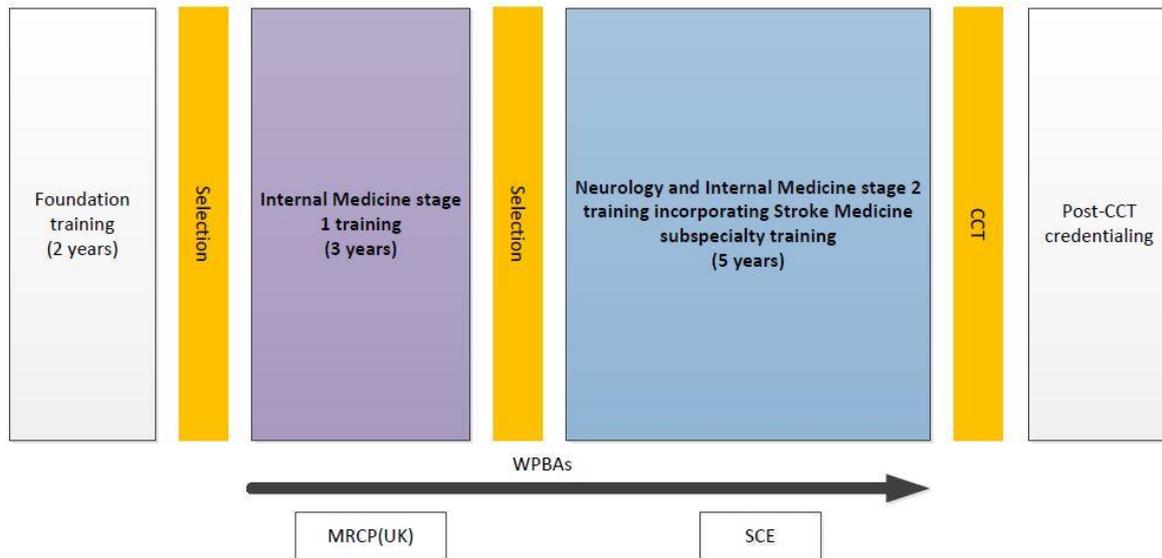
Generic CiPs

- | |
|--|
| <ol style="list-style-type: none"> 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)
<ol style="list-style-type: none"> 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
Neurology Specialty CiPs
<ol style="list-style-type: none"> 1. Managing disorders of cognition and consciousness 2. Managing headache and pain 3. Managing seizures and epilepsy 4. Managing inflammatory and infectious disorders 5. Managing movement disorders 6. Managing neuromuscular disorders 7. Managing traumatic brain injury and patients requiring neurorehabilitation 8. Managing neuropsychiatric disorders, and functional neurological disorders
Stroke Sub-specialty CiPs
<ol style="list-style-type: none"> 1. Managing the care of acute stroke patients, including hyperacute care and cerebral reperfusion strategies. 2. Managing the primary and secondary prevention of stroke and Transient Ischaemic Attack 3. Managing early and late stroke rehabilitation in hospital and community settings

2.3 Training pathway

Training starts with stage 1 Internal Medicine Training (IMT), during which there will be a gradually increasing responsibility for the acute medical take, and during which the MRCP(UK) Diploma should be attained. There will then be competitive entry into neurology training during which one further year of Internal Medicine will be completed, three months of which will be in the final year of training.



2.4 Duration of training

The new curriculum, with dual training in neurology and internal medicine and sub-specialty accreditation in stroke medicine will be organised over five years of training. As with other group 1 specialties, training in Neurology will comprise an indicative 3 years of IM Stage 1 followed by competitive selection for entry in to specialist training. This will be followed by 5 years of specialty training incorporating IM Stage 2 and Stroke Medicine 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 with the Reference Guide for Postgraduate Specialty Training in the UK (5)

2.5 Flexibility and accreditation of transferrable capabilities

The curriculum 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. In addition, the IM generic CiPs will be shared across all curricula and the IM clinical CiPs will be shared across all group 1 specialties, supporting flexibility for trainees to move between these specialties without needing to repeat all aspects of training.

The curriculum will allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities, and these skills will be transferable across other specialties. Notwithstanding the fact that completion of the curriculum is based on the acquisition of competencies there is no expectation that academic trainees will be able to

complete the curriculum in a shorter clinical training programme, particularly as competencies in Internal medicine and stroke will be compulsory for completion of training.

The frequency with which general medical problems manifest in the nervous system suggests that a period of training in neurology will lead to the acquisition of valuable and easily transferrable skills in general medicine.

Finally the frequency with which neurological problems occur in diseases of the heart, kidney, liver and lungs, either as a complication of the disease or of the treatment, means that skills learnt in neurology training will be of relevance to training in each of the major specialties, particularly the other Group 1 specialties.

2.6 Less than full time training (LTFT)

This curriculum allows for flexible training. Less-than-full-time trainees should undertake a share of out-of-hours duties (including on-call and other out-of-hours commitments) in proportion to that of their full-time colleagues. Training will be of a duration commensurate with their sessional commitment, in accordance with the Gold Guide, and as for all trainees based primarily on the acquisition of competencies.

2.7 Generic Professional Capabilities (GPC's) and Good Medical Practice (GMP)

The GMC has developed the Generic Professional Capabilities (GPC) framework (6) 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



Good Medical Practice (GMP,⁷) 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 deficits are identified only 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 being entrusted to act without supervision.

3.1 Capabilities in Practice (CiPs)

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 (8) 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 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 a 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 gives details of the six generic CiPs, eight clinical CiPs for internal medicine (stage 2), eight specialty CiPs for Neurology and three CiPs for Stroke 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	Audit	Audit Assessment
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
		OPCAT	Outpatient care assessment tool

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

GPCs	<ul style="list-style-type: none"> • 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
Evidence to inform decision	<p>Domain 1: Professional values and behaviours</p> <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries <p>Domain 9: Capabilities in research and scholarship</p> <p>MCR</p> <p>MSF</p> <p>Active role in governance structures</p> <p>Management course</p> <p>End of placement reports</p>

2. Able to deal with ethical and legal issues related to clinical practice

Descriptors	<ul style="list-style-type: none"> • 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	<p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries <p>Domain 4: Capabilities in health promotion and illness prevention</p> <p>Domain 7: Capabilities in safeguarding vulnerable groups</p> <p>Domain 8: Capabilities in education and training</p> <p>Domain 9: Capabilities in research and scholarship</p>
Evidence to inform decision	<p>MCR</p> <p>MSF</p> <p>CbD</p> <p>DOPS</p> <p>Mini-CEX</p> <p>ALS certificate</p> <p>End of life care and capacity assessment</p> <p>End of placement reports</p>

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	<ul style="list-style-type: none"> • Communicates clearly with patients and carers in a variety of settings
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<p>GPCs</p>	<ul style="list-style-type: none"> • 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 <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>)
<p>Evidence to inform decision</p>	<p>Domain 5: Capabilities in leadership and teamworking</p> <p>MCR MSF PS End of placement reports ES report</p>

Category 3: Safety and quality
4. Is focussed on patient safety and delivers effective quality improvement in patient care

<p>Descriptors</p>	<ul style="list-style-type: none"> • 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
<p>GPCs</p>	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills</p>

Evidence to inform decision

- 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
- 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
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6. Acting as a clinical teacher and clinical supervisor

Descriptors	<ul style="list-style-type: none"> • 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 (CiPs)

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	<ul style="list-style-type: none"> • 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
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<p>GPCs</p>	<ul style="list-style-type: none"> • 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 <p>Domain 1: Professional values and behaviours Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty <p>clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>)</p> <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislation • the health service and healthcare systems in the four countries <p>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</p> <ul style="list-style-type: none"> • patient safety • quality improvement
<p>Evidence to inform decision</p>	<p>MCR MSF CbD ACAT Logbook of cases Simulation training with assessment</p>
<p>2. Managing an acute specialty-related take</p>	
<p>Descriptors</p>	<ul style="list-style-type: none"> • 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

GPCs

- 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

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

<p>GPCs</p>	<ul style="list-style-type: none"> • Recognises need to liaise with specialty services and refers where appropriate Appropriately manages comorbidities in medical inpatients (unselected take, selected acute take or specialty admissions) • Demonstrates awareness of the quality of patient experience <p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislation • the health service and healthcare systems in the four countries <p>Domain 4: Capabilities in health promotion and illness prevention</p> <p>Domain 5: Capabilities in leadership and teamworking</p> <p>Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> • patient safety • quality improvement
<p>Evidence to inform decision</p>	<p>MCR MSF ACAT Mini-CEX DOPS</p>
<p>4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long term conditions)</p>	
<p>Descriptors</p>	<ul style="list-style-type: none"> • 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
<p>GPCs</p>	<ul style="list-style-type: none"> • Demonstrates awareness of the quality of patient experience <p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

Evidence to inform decision	<ul style="list-style-type: none"> • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislation • the health service and healthcare systems in the four countries <p>Domain 5: Capabilities in leadership and teamworking</p> <p>MCR ACAT mini-CEX PS Letters generated at outpatient clinics</p>
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5. Managing medical problems in patients in other specialties and special cases

Descriptors	<ul style="list-style-type: none"> • 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	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>)
Evidence to inform decision	<p>Domain 7: Capabilities in safeguarding vulnerable groups</p> <p>MCR ACAT CbD</p>

6. Managing a multi-disciplinary team including effective discharge planning

Descriptors	<ul style="list-style-type: none"> • 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
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GPCs	<ul style="list-style-type: none"> Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
Evidence to inform decision	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> practical skills communication and interpersonal skills dealing with complexity and uncertainty clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 5: Capabilities in leadership and teamworking</p> <p>MCR</p> <p>MSF</p> <p>ACAT</p> <p>Discharge summaries</p>

7. Delivering effective resuscitation and managing the acutely deteriorating patient

Descriptors	<ul style="list-style-type: none"> 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
GPCs	<ul style="list-style-type: none"> Demonstrates competence in carrying out resuscitation <p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> practical skills communication and interpersonal skills dealing with complexity and uncertainty clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> professional requirements national legislation the health service and healthcare systems in the four countries <p>Domain 5: Capabilities in leadership and teamworking</p> <p>Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> patient safety quality improvement <p>Domain 7: Capabilities in safeguarding vulnerable groups</p>

Evidence to inform decision	MCR DOPS ACAT MSF ALS certificate Logbook of cases Reflection Simulation training with assessment
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8. Managing end of life and applying palliative care skills

Descriptors	<ul style="list-style-type: none"> 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 pain, breathlessness, agitation and distress 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: <ul style="list-style-type: none"> practical skills communication and interpersonal skills dealing with complexity and uncertainty clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) Domain 3: Professional knowledge <ul style="list-style-type: none"> 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 (CiPs)

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

Please note, neurology training also includes stroke. This curriculum should be read in conjunction with the Stroke Sub-specialty Curriculum. However, for convenience the Stroke sub-specialty CiPs are included here.

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.

As with the generic CiPs 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. The following is a list of those descriptors that may be appropriate.

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion Logbook of cases Minutes of an MDT meeting	DOPS	Direct observation of procedural skills Log of procedures performed
GCP	Good Clinical Practice Evidence of application for ethical and R&D approval		Publication e.g. case reports and audits Engagement with management and administrative work (anonymised minutes of meetings, PDSA cycles followed, changes in rotas etc.) Courses attended e.g. management courses, leadership courses
Mini-CEX	Mini-clinical evaluation exercise Simulation training with assessment	MCR	Multiple consultant report End of placement reports Educational supervisor's report Clinical supervisor's report
MSF	Multi-source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation Student feedback Certificates and diplomas in teaching Teaching material e.g. slides, e-modules, and podcasts.

Evidence of literature search and critical appraisal of research
 Use of clinical guidelines
 Quality improvement and audit
 Evidence of research activity
 Letters generated at outpatient clinics
 End of life care assessment
 Mental capacity assessment
 Safeguarding assessment

Reflections on regional training days.

OPCAT Outpatient Care Assessment Tool

Specialty CiPs	
1. Managing disorders of cognition and consciousness	
Descriptors	<p>Understands the anatomy and pathophysiology of the clinical manifestations of disorders of cognition and consciousness, including the relevance of systemic and psychiatric comorbidity.</p> <p>Able to construct a history by consulting all relevant sources, including relatives, witnesses and other healthcare professionals.</p> <p>Able to examine patients using appropriate techniques and rating scales.</p> <p>Able to select, request and interpret relevant investigations to inform diagnostic thinking and management, including neuropsychological assessments, brain imaging, electroencephalography, sleep studies, brain biopsy and the analysis of cerebrospinal fluid.</p> <p>Able to work independently and as part of a multidisciplinary team to implement appropriate treatments and interventions for patients with impaired cognition or consciousness, in accordance with national guidance.</p> <p>Able to anticipate, recognise and manage complications in accordance with legal principles including the monitoring of change over time and the effect of interventions, ceilings of care, and medical and psychosocial complications.</p> <p>Able to work with and appropriately refer to other relevant professionals with apposite expertise in medicine, nursing, professions</p>

	allied to medicine, law and advocacy, at every stage of a patient's journey.
GPCs	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> • 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) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislation • the health service and healthcare systems in the four countries <p>Domain 5: Capabilities in leadership and teamworking</p> <p>Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> • patient safety • quality improvement <p>Domain 7: Capabilities in safeguarding vulnerable groups</p>
Evidence to inform decision	<p>MCR</p> <p>ACAT</p> <p>OPCAT</p> <p>MSF</p> <p>Mini-CEX</p> <p>CbD</p> <p>Reflection</p>
2. Managing headache and pain	
Descriptors	<p>Understands the anatomy and pathophysiology of headache and pain, including the relevance of systemic disease and psychiatric comorbidity.</p> <p>Able to construct a relevant history by consulting all relevant sources, including relatives and witnesses and other healthcare professionals, in order to recognise common and rare headache and pain syndromes, including musculoskeletal disorders.</p> <p>Able to examine patients including fundoscopy, visual fields and eye movements, using appropriate techniques and rating scales.</p> <p>Able to select, request and interpret investigations including imaging of the brain and spine, neurophysiological investigations, visual fields and optical coherence tomography, and use them effectively to identify the</p>

	<p>common and rare causes of headache and pain and their response to intervention.</p> <p>Able to work independently and as part of a multidisciplinary team to implement appropriate treatment, monitor and record their effect, and institute changes when necessary, in accordance with national guidance.</p> <p>Able to anticipate, recognise and manage complications including the physical, psychosocial, vocational and domestic consequences of living with pain and the side effect of medication.</p> <p>Able to work with and appropriately refer to other relevant professionals including specialists from other medical and surgical disciplines and professions allied to medicine.</p>
GPCs	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <p>Domain 3: Professional knowledge</p> <p>Domain 4: Capabilities in health promotion and illness prevention</p> <p>Domain 7: Capabilities in safeguarding vulnerable groups</p>
Evidence to inform decision	<p>CbD</p> <p>OPCAT</p> <p>Mini-CEX</p> <p>MSF</p> <p>DOPS</p> <p>MCR</p> <p>PS Patient survey</p>
3. Managing seizures and epilepsy	
Descriptors	<p>Understands the underlying anatomy and pathophysiology of seizures and epilepsy, including the relevance of physical, neurodevelopmental and psychiatric comorbidity.</p> <p>Able to construct a history by consulting all relevant sources, in order to distinguish epileptic seizures from syncope, dissociative attacks, cataplexy and parasomnias and to identify and localise different seizure types.</p> <p>Able to examine patients presenting with transient loss of consciousness, seizures and epilepsy.</p> <p>Able to select, request and interpret investigations including ECG, EEG and video EEG, polysomnography, genetic testing, MRI and functional imaging techniques, and use them effectively to identify the common and important epilepsy syndromes and their mimics.</p>

	<p>Able to work independently and as part of a multidisciplinary team to manage patients with epilepsy including the use of anti-epileptic drugs (AEDs) in acute and chronic presentations including switching AEDs and making personalised AED decisions that take into account co-morbidity, concomitant medication, and patient choice.</p> <p>Able to anticipate, recognise and communicate appropriately the physical and psychosocial consequences of living with epilepsy, including drug side-effects on the patient and foetus, driving restrictions, safety advice and sudden unexpected death in epilepsy (SUDEP).</p> <p>Able to work with and appropriately refer to other relevant professionals during the course of the illness, in particular when managing epilepsy in women (including pregnancy), people with intellectual disability, teenagers transitioning from paediatric services, and those who may benefit from surgery.</p>
GPCs	<p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> • Communication and interpersonal skills • Dealing with complexity and uncertainty • History taking, diagnosis and medical management <p>Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> • Patient safety • demonstrate effective multidisciplinary and interprofessional team working • Quality Improvement <p>Domain 7: Capabilities in safeguarding vulnerable groups</p> <ul style="list-style-type: none"> • understand the needs and support required for people with learning disabilities • understands the implications and consequences of living with epilepsy including the social, financial, and psychological constraints <p>Domain 9: Capabilities in research and scholarship</p>
Evidence to inform decision	<p>CbD OPCAT Mini-CEX MSF MCR Patient survey</p>
4. Managing inflammatory and infectious disorders	
Descriptors	Understands the underlying anatomy and pathophysiology of inflammatory and infectious diseases of the nervous system, including

	<p>the treatments and their side effects, and the relevance of comorbidity and a compromised immune system</p> <p>Able to construct a history by consulting all relevant sources to include past medical history, lifestyle, travel, occupation and sexual activity.</p> <p>Able to examine patients using appropriate techniques and rating scales</p> <p>Able to select, request and interpret relevant investigations in order to diagnose and manage infectious and inflammatory disorders of the nervous system.</p> <p>Able to work independently and as part of a multidisciplinary team to treat and implement appropriate interventions for acute, persistent, and progressive presentations, in keeping with national guidance.</p> <p>Able to anticipate, recognise and manage complications of the disease process and its treatment, including secondary infectious, inflammatory and degenerative processes.</p> <p>Able to work with and appropriately refer to other relevant professionals during the course of the illness including specialists from other medical and surgical disciplines and professions allied to medicine.</p>
<p>GPCs</p>	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills Domain 3: Professional knowledge Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team working</p>
<p>Evidence to inform decision</p>	<p>ACAT OPCAT CbD Mini-CEX SCE MCR MSF Reflections</p>
<p>5. Managing movement disorders</p>	
<p>Descriptors</p>	<p>Understands the underlying anatomy and pathophysiology of movement disorders including the relevance of comorbidity.</p>

	<p>Able to construct a history by consulting all relevant sources for patients presenting with Parkinsonism, tremor, chorea, dystonia, tics, myoclonus, drug-induced and sleep-related movement disorders.</p> <p>Able to examine patients using appropriate rating scales for patients presenting with Parkinsonism, tremor, chorea, dystonia, tics, myoclonus and drug-induced movement disorders.</p> <p>Able to select, request and interpret relevant investigations including genetic tests and brain imaging.</p> <p>Able to work independently and as part of a multidisciplinary team to manage and treat movement disorders including the motor and non-motor symptoms and the selection of patients for advanced therapies, in accordance with national guidance.</p> <p>Able to anticipate, recognise and manage complications including motor, cognitive and behavioural complications.</p> <p>Able to work with and appropriately refer to other relevant professionals to manage the cognitive and neuropsychiatric complications of movement disorders and contribute to planning palliative and advanced care.</p>
GPCs	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <p>Domain 5: Capabilities in leadership and team working</p>
Evidence to inform decision	<p>ACAT</p> <p>OPCAT</p> <p>CbD</p> <p>Mini-CEX</p> <p>MSF</p> <p>MCR</p>
6. Managing neuromuscular disorders	
Descriptors	<p>Understands the anatomy and pathophysiology of neuromuscular disorders, including the relevance of comorbidity</p> <p>Able to construct a history by consulting all relevant sources including the patient, relatives and witnesses, and other healthcare professionals</p> <p>Able to examine patients with neuromuscular disorders using appropriate techniques, including those with disorders of eye movement, swallowing, breathing, mobility, and autonomic function.</p>

	<p>Able to select, request and interpret relevant investigations for neuromuscular disorders, including neurophysiology, genetic, metabolic and antibody testing, imaging, and histopathology.</p> <p>Able to work independently and as part of a multidisciplinary team to implement appropriate treatment, interventions and standards of care for acute, persistent, and progressive presentations of neuromuscular disorders in accordance with national guidance.</p> <p>Able to anticipate, recognise and manage complications including the common medical, legal, vocational, and psychosocial consequences of neuromuscular disorders, and the transition from paediatric to adult services.</p> <p>Able to work with and appropriately refer to other relevant professionals during the course of neuromuscular illness, particularly regarding resuscitation, feeding, ventilation, advanced decisions and driving, with the involvement of patients and their families, or their advocates.</p>
GPCs	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <p>Domain 3: Professional knowledge</p> <p>Domain 4: Capabilities in health promotion and illness prevention</p> <p>Domain 5: Capabilities in leadership and team working</p> <p>Domain 6: Capabilities in patient safety and quality improvement</p> <p>Patient safety</p> <p>Domain 7: Capabilities in safeguarding vulnerable groups</p> <p>Domain 9: Capabilities in research and scholarship</p>
Evidence to inform decision	<p>ACAT</p> <p>OPCAT</p> <p>CbD</p> <p>GCP</p> <p>Mini-CEX</p> <p>MSF</p> <p>MCR</p> <p>PS Patient survey</p> <p>SCE</p>
7. Managing traumatic brain injury and patients requiring neurorehabilitation	
Descriptors	<p>Understands the anatomy and pathophysiology of brain injury and mechanisms of recovery during rehabilitation</p> <p>Able to construct a history by consulting all relevant sources including eye-witnesses, family and carers as well as information from healthcare professionals regarding previous treatment, interventions, complications and previous rehabilitation</p>

	<p>Able to examine patients with traumatic brain injury and complex neurological disability using appropriate rating scales and techniques, including assessment of behaviour, cognition, capacity, mobility, spasticity and sphincter function.</p> <p>Able to select, request and interpret relevant investigations including imaging, neurophysiology, urodynamics, diagnostic trials of intrathecal, intramuscular and oral therapy, and detailed clinical assessments of cognitive function and conscious level.</p> <p>Able to work independently and as part of a multidisciplinary team to provide treatment and implement appropriate intervention, set goals and follow up using agreed pathways in accordance with national guidance.</p> <p>Able to anticipate, recognise and manage complications including medical, domestic, ethical, legal, vocational, behavioural and psychosocial complications of severe neurological disability.</p> <p>Able to work with and appropriately refer to other relevant professionals regarding resuscitation, feeding, ventilation, pain control, management of the upper motor neurone syndrome, advanced decisions, and palliation.</p>
GPCs	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills Domain 3: Professional knowledge Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups</p>
Evidence to inform decision	<p>ACAT OPCAT CbD Mini-CEX MSF DOPS MCR PS</p>
8. Managing neuropsychiatric disorders, and functional neurological disorders	
Descriptors	<p>Understands how to identify and diagnose functional neurological disorders on positive grounds</p>

	<p>Able to recognise that functional disorders commonly co-exist with, or can be a precursor to, other neurological conditions and that psychological and social factors may affect the presentation and management of common neurological disorders</p> <p>Able to communicate a diagnosis of a functional neurological disorder in a manner that contributes constructively to the management of the patient</p> <p>Able to describe the elements of further management of functional neurological disorders and their comorbidities and refer appropriately to psychiatry, psychology, other medical disciplines and other professions allied to medicine.</p> <p>Able to identify the main features of common psychiatric disorders and describe how they interact with neurological disorders as comorbidities or intrinsic features of the disorder</p> <p>Able to identify the spectrum of psychosis presenting in neurological and psychiatric conditions</p> <p>Able to initiate treatment of common psychiatric disorders and acute confusion and demonstrate an understanding of how to use the mental health and mental capacity acts</p>
GPCs	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <p>Domain 3: Professional knowledge</p> <p>Domain 5: Capabilities in leadership and team working</p> <p>Domain 6: Capabilities in patient safety and quality improvement</p>
Evidence to inform decision	<p>CbD</p> <p>OPCAT</p> <p>Mini-CEX</p> <p>MSF</p> <p>MCR</p> <p>PS</p>

Sub-specialty Stroke CiPs (reprinted from the Stroke Sub0specialty Curriculum)

1. Managing the care of acute stroke patients, including hyperacute care and cerebral reperfusion strategies.	
Descriptors	<ul style="list-style-type: none"> • Demonstrates ability to conduct an up-to-date hyper-acute stroke clinical assessment efficiently with appropriate use of imaging to safely deliver cerebral reperfusion strategies where indicated • Demonstrates ability to carry out up-to-date specialist assessment, investigation and treatment of patients with stroke or mimic syndromes relevant to the patient's age, comorbidities and clinical presentation • Demonstrates knowledge of anatomy, physiology, blood supply and

	<p>apply pathophysiology of these to common and rarer causes of TIA and minor stroke</p> <ul style="list-style-type: none"> • Able to apply principles of early stroke team multi-professional assessment to understand the physical and psychological and social impact of stroke on patients and work collaboratively with the stroke unit multidisciplinary team to guide management strategies including positioning, hydration, nutrition, continence, risk factor modification and participation in rehabilitation • Able to use up-to-date knowledge of evidence, guidelines, appropriate monitoring and measurement scales (including NIHSS and mRS) to guide management and anticipate early complications e.g. malignant MCA syndrome • Appropriate management of comorbidities and risk factors relevant to stroke. •
GPCs	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills Domain 3: Professional knowledge 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</p>
Evidence to inform decision	<p>ACAT Acute care assessment tool CbD Case-based decision Mini-CEX Mini-clinical evaluation exercise Mini-IPX Mini-Imaging Interpretation Exercise MSF Multi source feedback QIPAT Quality improvement project assessment tool DOPS-Cerebral Reperfusions Direct observation of procedural skills MCR Multiple consultant report PS Patient survey Educational Supervisor report</p>
2. Managing the primary and secondary prevention of stroke and Transient Ischaemic Attack	
Descriptors	<ul style="list-style-type: none"> • Demonstrates ability to conduct an urgent acute clinical evaluation and prioritise safely: initiating appropriate, timely and effective investigations and interpret and communicate the results • Able to provide an accurate diagnosis and appropriate comprehensive management of patients with suspected TIA or minor stroke including identification of vascular risk factors and lifestyle modification • Demonstrates recognition of conditions that mimic TIA and stroke and how to effectively manage these or make an appropriate referral • Awareness of up-to-date primary and secondary prevention treatment strategies for TIA and minor stroke (including knowledge

	<p>and application of national guidance)</p> <ul style="list-style-type: none"> • Ability to prioritise referrals received through different mechanisms (e.g. electronic, virtual, telephone, in person) and by all healthcare professionals • Provide appropriate driving, vocational and social advice for patients with TIA or stroke working in partnership where necessary with the stroke multi-disciplinary team (e.g. with occupational therapy, driving centre assessment etc) • Appropriate management of comorbidities and risk factors relevant to TIA and minor stroke in an outpatient clinic (e.g. hypertension, dyslipidaemia and cardiogenic causes etc) •
GPCs	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills Domain 3: Professional knowledge Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship</p>
Evidence to inform decision	<p>ACAT Acute care assessment tool CbD Case-based decision Mini-CEX Mini-clinical evaluation exercise Mini-IPX Mini-Imaging Interpretation Exercise MSF Multi source feedback QIPAT Quality improvement project assessment tool MCR Multiple consultant report PS Patient survey Educational Supervisor report</p>
3. Managing early and late stroke rehabilitation in hospital and community settings	
Descriptors	<ul style="list-style-type: none"> • Discusses patterns of recovery relevant to stroke subtypes and other factors to guide planning and expectations for an individual's recovery • Ensures rehabilitation is individualised, patient focussed and recognises how the consequences of stroke disability can impact on participation in rehabilitation • Co-ordinates the multi-disciplinary team to optimise post stroke recovery, participation in goal setting, measurement of rehabilitation outcome, and participation in national audit • Demonstrates good communication and understanding with patients and families and identifies carer's long term needs and participation in goal planning • Appropriately manages common post stroke complications (seizures, thromboembolism, dysphagia, dehydration, shoulder girdle dysfunction, spasticity) and takes into account how these may affect participation in rehabilitation

	<ul style="list-style-type: none"> • Demonstrates an understanding of medico-legal issues relating to clinically assisted nutrition and hydration in patients lacking capacity • Demonstrates an understanding of the diverse factors that can influence outcome including problems often associated with non-dominant hemisphere stroke (e.g. agnosias), neuropsychiatric consequences, post stroke pain and spasticity • Contributes to and leads effective discharge planning to support transition to the community and facilitate life after stroke, including engaging with social services that may help optimise on-going recovery and/or provide support including impact on function, vocation and driving.
GPCs	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills Domain 3: Professional knowledge 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</p>
Evidence to inform decision	<p>ACAT Acute care assessment tool CbD Case-based decision GCP Good Clinical Practice Mini-CEX Mini-clinical evaluation exercise MSF Multi source feedback QIPAT Quality improvement project assessment tool MCR Multiple consultant report PS Patient survey Educational Supervisor report</p>

3.5 Presentations and Conditions

The table below details the key presentations and conditions of Neurology. 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 i.e. high morbidity, mortality and/or serious implications for treatment or public health.

For each presentation and condition 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.

System/Specialty and subspecialty	Presentations	Conditions
Disorders of cognition	Acute confusion	Alcohol-related cognitive impairment
	Agnosia	Alzheimer's disease and its variants
	Amnesia	Autoimmune encephalopathy
	Anxiety	Cerebrovascular disease
	Apathy	Cognitive syndrome of low intracranial pressure
	Aphasia	Extrapyramidal disorders
	Apraxia	Frontotemporal dementia
	Delirium	Lewy Body disease
	Depression	Normal Pressure Hydrocephalus
	Dyslexia	Prion disease
	Misidentification	Transient Epileptic Amnesia
	Personality and behavioural change	Transient Global Amnesia
Disorders of consciousness	Brainstem death	Cerebrovascular disease
	Coma	Encephalitis
	Delirium	Ischaemic encephalopathy

	Hypersomnia	Neurodegenerative disease
	Hypervigilance	Non-convulsive status epilepticus
	Impaired vigilance	Prion disease
	Insomnia	Raised intracranial pressure
	Locked-in syndrome	Systemic illness
	Minimally conscious state	Toxic encephalopathy
	Prolonged disorders of consciousness (PDOC)	Traumatic brain injury
Headache	Constant headache	Autonomic cephalgias
	Episodic headache	Cluster headache
	Facial pain	Giant cell arteritis
	Sudden onset of severe headache	Headache of musculoskeletal origin
		Low pressure headache
		Medication overuse headache
		Migraine
		Subarachnoid haemorrhage
Pain	Back pain	Atypical facial pain
	Limb pain	Central post stroke pain
	Facial pain	Cervical myeloradiculopathy
		Lumbar disc disease
		Neuropathic pain
		Thoracic outlet syndrome
Epilepsy	Atonic seizures	Autoimmune encephalitides
	Dissociative seizures	Cerebral neoplasms
	Drop attacks	Cerebrovascular disease
	Episodic focal neurological symptoms	Degenerative diseases
	Focal seizures	Developmental and epileptic encephalopathies
	Myoclonus	Focal epilepsies
	Paroxysmal nocturnal events	Generalised epilepsies

	Post-ictal psychosis	Head injury
	Pre-ictal psychosis	Meningoencephalitis
	Syncope	Mitochondrial diseases
	Tonic-clonic seizures	Narcolepsy with or without cataplexy
	Transient amnesia	Non-convulsive status epilepticus
	Transient loss of consciousness	Parasomnias
		Status epilepticus
		SUDEP
		Syncope
Inflammatory Disorders	Abnormal behaviour	Acute Disseminated Encephalomyelopathy
	Abnormal sensation	Antibody mediated encephalitis
	Acute confusion	Autoimmune ataxia
	Bladder, bowel and sexual dysfunction	Balo's concentric sclerosis
	Cerebellar syndrome	Chronic relapsing inflammatory optic neuropathy (CRION)
	Cognitive impairment	Complications of CAR-T therapy
	Diplopia	Hemophagocytic lymphohistiocytosis (HLH)
	Disequilibrium	IgG4 disease
	Dizziness	MOG antibody disease (MOGAD)
	Encephalopathy	Multiple Sclerosis
	Headache	Neuromyelitis optica
	Intractable vomiting	Neurosarcoidosis
	Myelopathy	Optic Neuritis
	Visual loss	Paraneoplastic conditions
	Vertigo	Primary CNS vasculitis
		Systemic Lupus Erythematosus
Infectious diseases	Altered conscious level	Bacterial meningitis
	Behavioural change	CAR-T therapy
	Headache	Cerebral abscess
	Intellectual decline	CNS IRIS
	Memory loss	Epidural abscess
	Photophobia	Fungal infection
	Pyrexia of unknown origin	HIV escape
	Seizures	HIV infection
	Vomiting	HIV seroconversion
	Weakness	Neuroborreliosis

		Neurocysticercosis
		Neurosyphilis
		Pneumocystosis
		Progressive Multifocal Leucoencephalopathy
		Shingles
		Subacute Sclerosing Panencephalitis
		Syphilis
		Tuberculous meningitis
		Viral encephalitis and meningitis
		Whipple's disease
		Zoster ophthalmicus
Movement disorders	Cerebellar Ataxia	
	Chorea	Corticobasal syndrome
	Dystonia	Drug-induced movement disorders
	Myoclonus	Essential Tremor
	Parkinsonism	Functional movement disorders
	Tics	Huntington's disease
	Tremor	Multiple System Atrophy
		Parkinson's disease
		Progressive supranuclear palsy
		Tourette's syndrome
Neuromuscular disorders	Altered sensation	
	Camptocormia	Acquired myopathies
	Contractures	Acquired neuropathies
	Dysarthria	Autonomic neuropathy
	Dysphagia	Congenital myaesthetic syndromes
	Falls in the home	Congenital myopathies
	Fasciculation	Diffuse axonal injury
	Foot drop	Guillain-Barré syndrome
	Head drop	Inherited muscular dystrophies
	Kyphoscoliosis	Inherited neuropathies

	Malignant Hyperthermia	Lambert-Eaton Myaesthetic syndrome
	Myotonia	Metabolic myopathies
	Ophthalmoplegia	Mitochondrial myopathy
	Pain	Mitochondrial neuropathy
	Ptosis	Motor Neurone Disease
	Rhabdomyolysis	Myasthenia Gravis
	Type 2 Respiratory failure	Neuromuscular weakness
	Weakness (focal / generalised, symmetrical/asymmetrical)	Spinal cord injury
		Spinal Muscular Atrophy
Traumatic Brain Injury	Mild, moderate and severe head injury	Traumatic subarachnoid haemorrhage
	Raised intracranial pressure	Subdural haemorrhage
	Post-traumatic cognitive impairment	Traumatic cranial nerve palsies
	Post-traumatic hearing loss and vertigo	Diffuse axonal injury
	Post-traumatic headache	Chronic Traumatic Encephalopathy (CTE)
	Post-traumatic sleep disorder	
	Post-concussion syndrome	
Neurorehabilitation	Cognitive impairment	Acquired brain injury
	Conduct disorder	Cerebral palsy
	Gait disorders	Spinal cord injury
	Spasticity	Neuromuscular weakness
		Rehabilitation following neurosurgery
Neuropsychiatry	Aggression	Acute confusional state
	Agitated behaviour	Autoimmune encephalitides

		Delirium
	Apparent sabotaging of care	Dementia
	Challenging consultations	Depression
		Dissociative memory loss
	Delusions	Functional cognitive disorder
	Depression	Functional movement disorder
	Difficulty establishing trust	Functional weakness
	Hallucinations	Infectious encephalitis
	High use of healthcare	Non-epileptic attack disorder
	Panic attacks	Panic disorders
	Splitting clinical teams	Parkinson's disease
	Suicidal ideation	Psychosis e.g. in Parkinson's disease and epilepsy
	Thought disorder	Toxidromes
		Traumatic brain injury
		Unstable personality disorder
		Non-epileptic attack disorder
	Chronic pain	Functional weakness
	Cognitive impairment	Functional cognitive disorder
	Dizziness	Functional movement disorder
Functional Neurological Disorders	Dysarthria	Persistent posture-perceptual dizziness (PPPD)
	Dysphagia	Functional sensory loss
	Dysphasia	
	Episodes of collapse and blackout	
	Fatigue	
	Focal cognitive impairment	
	Gait disturbance	
	Health anxiety	
	Incontinence	
	Insomnia and hypersomnia	
	Limb weakness	
	Movement disorders	
	Sensory symptoms	
	Speech disorders	
	Visual loss	

	Weakness	
	Word-finding difficulty	
	Content to be same as in stroke curriculum	Conditions
Three stroke CiPs	Presentations	
Acute stroke		
Stroke prevention		
Stroke rehabilitation		

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).

Procedure	ST3	ST4	ST5	ST6	ST7
Minimum level required					
Lumbar Puncture (Diagnostic and therapeutic)	3	4	4	4	4
Botulinum toxin injection (hemifacial spasm, cervical dystonia, spasticity, migraine)	2	2	3	3	3
Greater Occipital nerve injections	2	2	3	4	4

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 (CS) and a named Educational Supervisor (ES). 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.

Each training programme will include placements to cover the Neurology CiPs. All trainees will also complete the three stroke CiPs, therefore this curriculum should be read in conjunction with the most up-to-date stroke subspecialty curriculum

Mandatory training

Attendance at ABN at least twice during training, and attendance at two courses annually – local or national - to address outstanding training requirements.

Recommended training

Trainees will be encouraged to engage with a range of healthcare professionals who diagnose and treat patients with neurological conditions including amongst many others Neurosurgeons, Urologists, Clinical Psychologists, Physiotherapists and Speech Therapists.

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.

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

Medical clinics including specialty 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 informative 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 and reflection on clinical problems.

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.

Telephone clinics and video consultations.

The changes in the delivery of healthcare associated with the Covid epidemic has led to the increased use of remote consultations, particularly for follow-up consultations and for the triage of new referrals. Training in the appropriate use of these techniques will be required.

Palliative and end of life care

The palliative care needs of patients with diseases of the nervous system are importantly different to those of patients with advanced malignancy. The ability to communicate may

be compromised at an early stage, and pain may be only a minor symptom compared to breathlessness, confusion, agitation, seizures and oral feeding failure.

Trainees undertaking a palliative medicine attachment (this will not be obligatory for Neurology trainees, but could with planning be included in a placement on an appropriate training programme) 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 (e.g. 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. Examples include management and leadership courses and communication courses, which are particularly relevant to patient safety and experience.

4.3 Academic training

The four nations have different arrangements for academic training and doctors in training should consult the local deanery for further guidance.

Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent. Academic trainees can be recruited at any point in the training programme.

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

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 speciality
- 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.

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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		ST4	ST5	ST6	ST7	
1. Managing an acute unselected take	CRITICAL PROGRESSION POINT				4	CRITICAL PROGRESSION POINT
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 Neurology 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

Neurology CiPs	CRITICAL PROGRESSION POINT	ST4	ST5	ST6	ST7	ST8	CRITICAL PROGRESSION POINT		
1. Managing disorders of cognition and consciousness								4	
2. Managing headache and pain								4	
3. Managing seizures and epilepsy								4	
4. Managing inflammatory and infectious disorders								4	
5. Managing movement disorders								4	
6. Managing neuromuscular disorders								4	
7. Managing traumatic brain injury and patients requiring neurorehabilitation								4	
8. Managing neuropsychiatric disorders, including functional disorders								4	

The Stroke sub-specialty CiPs are included here for information and clarity

Stroke sub-specialty CiPs		ST4	ST5	ST6	ST7	ST8	
1. Managing the care of acute stroke patients, including hyperacute care and cerebral reperfusion strategies	CRITICAL PROGRESSION POINT	2	2	2	2	4	CRITICAL PROGRESSION POINT
2. Managing the primary and secondary prevention of stroke and Transient Ischaemic Attack		2	2	2	2	4	
3. Managing early and late stroke rehabilitation in hospital and community settings		2	2	2	2	4	

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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)
- Specialty Certificate Examination (SCE)

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)
- Clinical Supervisor Report (CSR)

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		

Blueprint for WPBAs mapped to CiPs

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini-CEX	MSF	PS	QIPAT	TO
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
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			√						
Neurology CiPs									
Managing disorders of cognition and consciousness	√	√		√	√	√			
Managing headache and pain		√	√	√	√	√	√		
Managing seizures and epilepsy		√		√	√	√	√		
Managing inflammatory and infectious disorders	√	√	√	√	√	√			
Managing movement disorders	√	√	√	√	√				
Managing neuromuscular disorders	√	√		√	√	√			
Managing traumatic brain injury and patients requiring neurorehabilitation	√	√		√	√	√	√		
Managing neuropsychiatric disorders, including functional disorders		√		√	√	√	√		

Learning outcomes

	ACAT	ChD	DOPS	MCR	Mini-CEX	MSF	PS	QIPAT	TO	Mini-IPX
Stroke Specialty CiPs										
Managing the care of acute stroke patients, including hyperacute care and cerebral reperfusion strategies	√	√	√	√	√	√				√
Managing the primary and secondary prevention of stroke and Transient Ischaemic Attack	√	√	√	√	√	√	√			√
Managing early and late stroke rehabilitation in hospital and community settings	√	√	√	√	√	√				

Knowledge based assessment (SCE)

The 100 questions of the Specialty Specific Exam will cover the 8 Neurology CiPs and the 3 Stroke CiPs.

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 (9).

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 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 (10)

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.

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 a 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 (11). 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.

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 (12).

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.

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