Urology Curriculum
Purpose Statement

Proposal for August 2019

The purpose statement addresses the requirements of the General Medical Council's Excellence by Design: standards for postgraduate curricula[1] (theme 1) and the Shape of Training Review. It sets out patient and service needs, scope of practice and the level of performance expected of doctors in training. GMC approval of the curriculum pertains to UK training programmes while those in the Republic of Ireland are governed by the Royal College of Surgeons of Ireland (RSCI) and the Medical Council of Ireland.

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1. Purpose statement for Urology

1.1 The curriculum scope of practice, service, patient and population needs

The purpose of the curriculum for Urology is to produce, at certification, competent doctors, able to deliver excellent outcomes for patients as consultant surgeons in the UK. The curriculum will provide consultant surgeons with the generic professional and specialty-specific capabilities needed to manage patients presenting with the full range of acute and elective Urology conditions. Trainees will continue to develop their skills in the generality of Urology (both acute and elective) to Level IV at the point of CCT, such that they are competent to deal with 95% of cases presenting during an unselected emergency 'take'. Additionally, trainees will be expected to be competent to manage the full range of acute and elective conditions in the generality of their chosen special interest, including the operation. It is acknowledged that the responsibility for patients in this specialist area will include care for patients up to, including and beyond the point of operation.

Trainees will be entrusted to undertake the role of the Urology Registrar during training and will be qualified at certification to apply for consultant posts in Urology in the United Kingdom

Patient safety and competent practice are both essential and the curriculum has been designed so that the learning experience itself should not affect patient safety. Patient safety is the first priority of training demonstrated through safety-critical content, expected levels of performance, critical progression points, required breadth of experience and levels of trainer supervision needed for safe and professional practice. Upon satisfactory completion of training programmes, we expect trainees to be able to work safely and competently in the defined area of practice and to be able to manage or mitigate relevant risks effectively. A feature of the curriculum is that it promotes and encourages excellence through the setting of high-level outcomes, supervision levels for excellence, and tailored assessment and feedback, allowing trainees to progress at their own rate.

1.2 Shape of training review

The Shape of Training (SoT) review[2] provides an opportunity to reform postgraduate training to produce a workforce fit for the needs of patients, producing a doctor who is more patient focused, more general and has more flexibility in career structure. The Urology curriculum meets the main recommendations of SoT as shown below.

1. *Takes account of and describes how the proposal will better support the needs of patients and service providers:*

The curriculum has been developed with extensive input and representation from stakeholders including trainees, trainers, patient and lay representatives, education providers and NHS employers. A driver for curriculum change was the GMC's introduction of updated standards for curricula and assessment processes laid out in *Excellence by Design*[2], requiring all medical curricula to be based on high-level outcomes. These high-level outcomes are called Capabilities in Practice (CiPs) and describe the professional tasks or work within the scope of specialty practice. At the centre of each of these groups of tasks are Generic Professional Capabilities[3] (GPCs), interdependent essential capabilities that underpin professional medical practice and are common to all who practice medicine and are in keeping with Good Medical Practice (GMP). Equipping all trainees with these transferable capabilities will result in a more flexible, adaptable workforce.

Previous attempts at revising the Urology curriculum were centred on defining a series of core diagnostic and therapeutic capabilities in a three-year training program. Its uptake amongst trainees was limited principally because it failed to equip trainees with those skills needed to deliver an unselected take in adult and paediatric emergency urology and to support colleagues from other specialities in the secondary care setting. The current proposals aim to do so.

Additionally, the curriculum provides for areas of special interest in which trainees can develop areas of expertise which in turn have been proven to deliver better outcomes for patients. The curriculum framework articulates the standard required to work at the consultant level, and at key progression points during training, as well as encouraging the pursuit of excellence in all aspects

of clinical and wider practice. Service providers and patients benefit from Consultant Urologists who are trained in the generality of the specialty but who also have special interest skills to provide more specialist care. The curriculum ensures that trainees will, at certification, have both a special interest skill and full range of general emergency and elective skills

The Shape of Training Report from October 2013, as well as further discussions held informally and through the SAC have identified the need for a review of the curriculum without altering the depth of knowledge and practical skills that the current curriculum demands. Once consensus will be arrived at, in conjunction with the GMC, stakeholders will be approached with the proposed change in training. These include:

- NHS Employers
- Other SACs
- Specialty Association (BAUS)
- Education providers – Lead Dean, Training Programme Directors
- Trainees
- Core Surgery
- Intercollegiate Exam Board representatives
- Patient/Lay representatives

This list is not exhaustive. Once responses are received, these will be collated and presented by the SAC Curriculum representatives and the SAC Chair to the Committee. Where there is disagreement these points will be addressed in rewriting the syllabus.

2. *Ensures that the proposed curriculum to CCT equips doctors with the generic skills to participate in the acute unselected take and to provide continuity of care thereafter:*

The curriculum will deliver emergency competent urological surgeons with a range of skills such that they are able to deliver the unselected admission and management of emergency adult and paediatric urological patients and to support (where necessary) their colleagues within the hospital setting and in the wider community at large.

3. *Where appropriate describes how the proposal would better support the delivery of care in the community:*

Trainees will continue to develop the required skills principally within the established hospital setting where increasingly a ‘one-stop’ approach to diagnosis and management relies on the availability of endoscopy and radiological imaging, which has significantly impacted on the need for repeat attendance in the out-patient setting and/or in-patient investigation. Where opportunities arise within the community setting (subject to appropriate contractual and governance issues) trainees will be encouraged to work alongside Urological Clinical Nurse Specialists (CNS) to support and investigate patients in the community (including but not limited to urodynamics, intermittent self-catheterisation etc.). The curriculum will emphasise aspects of community based

care whilst not losing sight of the need for excellence in all hospital based care. Multi-disciplinary team practice is part of modern urology and good communication with community based care will be emphasised in the new curriculum. An appreciation of what is suitable for community based care, what is right for District General Hospital care and what requires tertiary referral will be part of what the trainees will learn in this curriculum.

4. *Describes how the proposal will support a more flexible approach to training:*

The curriculum allows ease of transfer into other surgical specialties following core training (CT1-2) or run through ST1-2 training. Currently Urology training comprises of specialist training (with entry to Higher Surgical Training) at ST3 level (following the completion of Core Surgical Training) and from August 2019 Urology will join the Improving Surgical Training Pilot and will admit approximately 20% of those wishing to undertake specialist urological training as run through trainees in the pilot. Trainees entering on the IST programme will follow a urology themed core surgical curriculum in the first 2 years of training (phase 1 of the run through urology curriculum), and pass, without further selection, into Phase 2 of specialist urology training on the successful completion of the outcomes shared with the core curriculum, gaining a pass in the MRCS examination and an ARCP 1 at the end of the ST2 year with bench-marking with an appointable score at Urology ST3 National Selection. There is generic Urology training until the end of Phase 2, allowing flexibility in special interest choice until relatively late in training pathway.

The curriculum describes clinical Capabilities in Practice (CiPs) shared with other specialties in surgery supporting flexibility for trainees to move between the specialties in line with the recommendations set out in the GMC's report to the four UK governments[3]. The CiPs include the Generic Professional Capabilities (GPCs) common to all medical specialties, facilitating transferability of learning outcomes across other related specialties and disciplines. It will, therefore, be possible for trainees to transfer generic knowledge, clinical and surgical skills to another surgical specialty without restarting at CT1/ST1 level. As an example, prior learning of history-taking, physical examination, health promotion, medical record keeping and technical skills in one specialty may allow accelerated learning in the clinical areas of another specialty with identical requirements for communication skills, team-working and empathy, compassion and respect for patients. Consequently, trainees will acquire generic skills in the CiPs which can be transferred to other surgical specialties, or to other non-surgical specialties. Trainees who choose a different career route may be able to have a shorter than usual training pathway in their new training programme, in recognition of learning already gained.

Much of the more detailed and specialty specific syllabus is not transferable as the knowledge and detailed skills are specific to the practice of urological surgery. There are however some opportunities where even quite specialty specific skills are transferable (such as to the fields or uro-gynaecology as with female incontinence and endocrine adrenal surgery to general surgery etc.). Also, generic operative skills are transferable to any craft specialty.

This flexible approach with acquisition of transferable capabilities will allow training in Urology to adapt to current and future patient and workforce needs as well as to changes in surgery with the advent of new treatments and technologies.

5. *Describes the role that credentialing will play in delivering the specialist and sub-specialist components of the curriculum:*

Post-certification credentialing will be considered for super-specialist areas of work to meet service and patient needs'; these areas are detailed in 1.4.3. (*Please see Reference Section for GMC definition of 'Credentialing')*

1.3 The high-level outcomes in Urology Training

The curriculum is outcomes-based, specifying the high-level generic, shared and specialty-specific capabilities that must be demonstrated to complete training. There is a greater focus on the generic professional capabilities common to all doctors.

1.3.1 Capabilities in Practice

The high-level outcomes of the curriculum are expressed as Capabilities in Practice (CiPs) and describe the professional tasks or work within the scope of Urology. These are:

1) Manages an out-patient clinic

2) Manages the unselected emergency take

3) Manages ward rounds and the ongoing care of inpatients

4) Manages an operating list

5) Manages a multi-disciplinary meeting

Trainees will also have acquired competencies described in the 9 domains of the Generic Professional Capability Framework and by the completion of training, the trainee must demonstrate that they are capable of practice at the level of a day one consultant in all CiPs and have met the GPC competencies.

1.3.2 Generic Professional Capabilities

Embedded within each CiP are the full range Generic Professional Capabilities (GPCs) which describe the professional responsibilities of all doctors in keeping with Good Medical Practice.

These attributes are common, minimum and generic standards expected of all medical practitioners achieving certification or its equivalent. The GPCs have equal weight in the training and assessment of clinical capabilities and responsibilities in the training programme. The nine domains of the GPC framework are:

1. Professional knowledge
2. Professional skills
3. Professional values and behaviours
4. Health promotion and illness prevention
5. Leadership and team-working
6. Patient safety and quality improvement

7. Safeguarding vulnerable groups
8. Education and training
9. Research and scholarship

1.3.3 Supervision levels

The assessment of CiPs draws on the holistic judgement of Clinical Supervisors by ascribing the supervision level required by the trainee to undertake each CiP to the standard of certification. The level of supervision will change in line with the trainee's progression, consistent with safe and effective care for the patient. Typically, there should be a gradual reduction in the level of supervision required and an increase in the complexity of cases managed until the level of competence for independent practice is acquired. The supervision levels are:

Level I	Able to observe only
Level II	Able and trusted to act with direct supervision: a) supervisor present throughout b) supervisor present for part
Level III	Able and trusted to act with indirect supervision
Level IV	Able and trusted to act at the level of a day one consultant
Level V	Able and trusted to act at a level beyond that expected of a day one consultant

Phase 1 of training will be completed when the appropriate level of competency (as defined in 1.4 below) has been achieved in each CiP, and a trainee will be eligible for certification when level IV has been achieved. Level V indicates excellence.

1.3.4 Descriptors

Each CiP contains key descriptors associated with the clinical activity or task and all the GPC descriptors. The descriptors are intended to help trainees and trainers recognise the level of knowledge, skills and professional behaviours which must be demonstrated for independent practice. All descriptors will be taken in to account when carrying out assessment and they will be used by Clinical Supervisors to highlight where trainees achieve excellence at a faster rate and when targeted training is necessary in the manner of an exception report. They, therefore, provide the basis for specific, constructive feedback to the trainee. The CiPs will also provide trainees with

a self-assessment, providing an opportunity to show insight and actively engage in the feedback discussion.

1.4. Progression through training

Trainees will enter Urology training via a national selection process at either ST3, or through the ST1 run-through programme (the pilot of which will commence in August 2019). Trainees will learn in a variety of settings using a range of methods, including workplace-based experiential learning in a variety of environments, formal postgraduate teaching, simulation based education and through self-directed learning.

Urology training is outcome-based rather than time-based. However, there is an expectation that this will normally be completed in an indicative time of 7 years (2 years in phase 1, 3 years in phase 2 and 2 years in phase 3) for those entering the pilot run through training at ST1 and 5 years for uncoupled trainees entering at ST3 (3 years in phase 2 and 2 years in phase 3).

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 of 7 years. There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (the Gold Guide[4]).

Trainees who choose less than full time training (LTFT) will have the indicative training time extended pro-rata in accordance with the Gold Guide. LTFT trainees will perform both elective and out-of-hours duties pro rata throughout the time of LTFT.

Phases of training

Phase 1 (indicative 2 years): Trainees entering urology run through training at ST1 will follow a urology themed core surgical curriculum in the first 2 years of training, and pass, without further selection, into Phase 2 of specialist urology training on the successful completion of the outcomes shared with the core curriculum, gaining a pass in the MRCS examination and an ARCP 1 at the end of phase 1. Those Improving Surgical Training pilot run through trainees will be required to bench-mark with an appointable score at Urology ST3 National Selection to progress to phase 2.

Phase 2 (indicative 3 years): Trainees will gain many of the GPCs and the knowledge, clinical and technical skills in urological surgery, as defined in the CiPs and syllabus. Uncoupled trainees should have acquired generic skills, both technical and non-technical, during core training. Phase 2 will be completed when Supervision Level III has been achieved in each CiP, and a trainee will be eligible for certification when Supervision Level IV has been achieved. At the end of phase 2 there is a critical progression point where trainees will demonstrate competencies in knowledge, and professional behaviours commensurate with a day one consultant in Urology and become eligible to sit the Intercollegiate Specialty Board Examination in Urology. A waypoint at the end of phase 2 will guide ARCP panels as to both level of competencies achieved and indicative numbers..

Phase 3 (indicative 2 years): Trainees will further develop the technical skills in the elective and emergency aspects of the specialty and will undertake more focussed training in a particular area of interest. A special interest area module will be followed after discussion with the Training Programme Director (TPD) and will be based on the preference of the trainee, the needs of the service and the ability of the programme to support the trainee in that special interest. Whilst we anticipate programmes will offer most or all of the special interest areas, either within the programme or by arrangement with a neighbouring programme, there is no requirement for any one programme to offer all the areas of special interest. There may additionally be instances where there are more trainees in a cohort who wish to pursue an area of a specific special interest than a programme can accommodate, and the TPD may need to suggest a different special interest to some of these trainees. On completion of phase 3 trainees will have reached supervision level IV in each of the shared CiPs and acquired all GPCs and recorded a pass in the Intercollegiate Specialty Board Exam in Urology. This will allow the award of ARCP 6 and recommendation for certification and entry onto the specialist register. Trainees who do not meet the requirements of Phase 3 within the indicative 2 years may require an extension of training time in accordance with the Gold Guide.

A number of special interest modules are currently considered suitable for delivery in Phase 3 (pre-CCT) and include Endo-urology, Andrology and Infertility, Functional Urology and Incontinence, Advanced General Urology (including the specialist management of BPH which may include HoLEP and laser ablative surgery etc.) and Urological Oncology Surgery (which will consist of those components relating to Renal Cancer Surgery and the management of benign upper tract pathology such as renal cysts and PUJ obstruction, Prostate Cancer and Bladder Cancer) one or more components of which may be completed within this period depending on progression).

1.4.1 Critical Progression points

Indicative levels of supervision are indicated for the end of phase 2. At the end of phase 3 trainees are required to reach level IV Capabilities in Practice.

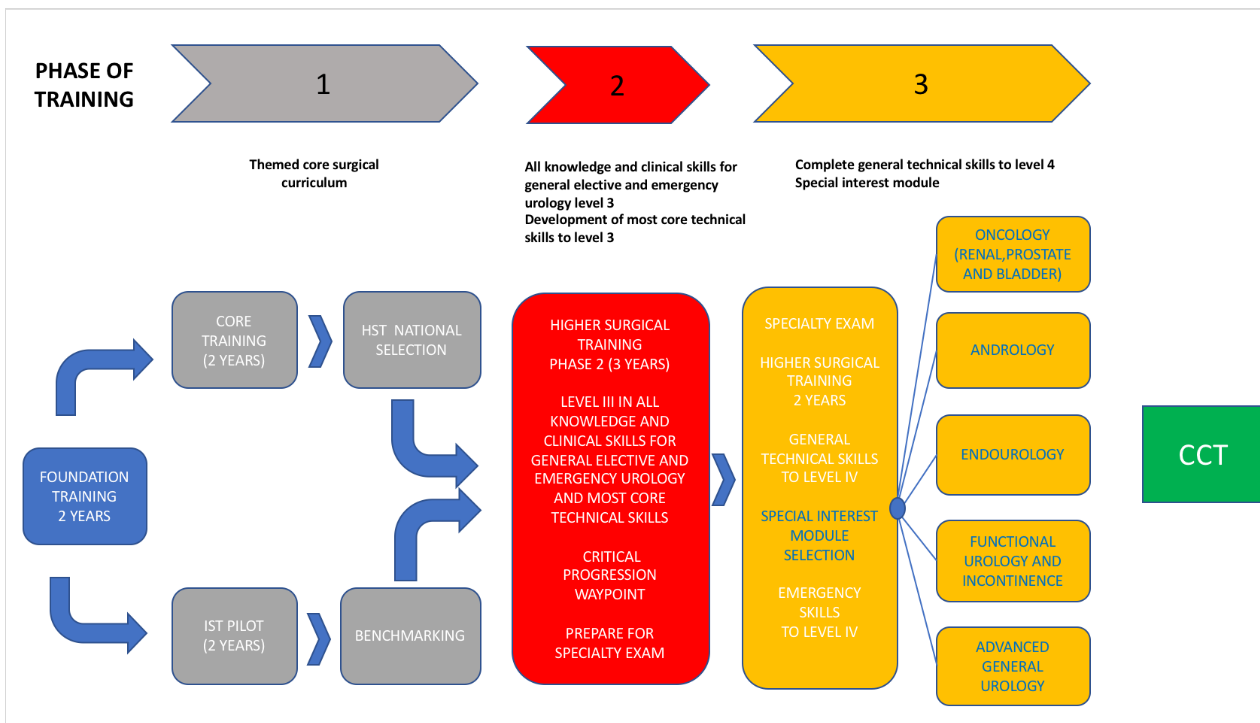
Excellence will be recognised by:

a) achievement of Level V in any of the Capabilities in Practice
b) exceeding the supervision level expected for the end of Phase 1
c) achievement of a supervision level at an earlier stage than would normally be expected
d) recognition of particularly good performance in any of the descriptors within a Capability in Practice

Capability in practice (shared)	Supervision level (end of phase 2)	Supervision level (end of phase 3)
1. Manages an out-patient clinic	Level III	Level IV
2. Manages the unselected emergency take	Level III	Level IV

3. Manages ward rounds and the ongoing care of inpatients	Level III	Level IV
4. Manages an operating list	Level III	Level IV
5. Manages a multi-disciplinary meeting	Level III	Level IV

1.4.2 Training Pathway



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