CURRICULUM CHANGE

1. What are the key changes to the curriculum?

The curriculum will be 'outcomes-based', allowing trainees to be assessed against the standard of a day-1 consultant in their specialty i.e. you will reach the end of training when you reach the standard expected of a day-1 consultant. A new assessment tool called the Multiple Consultant Report (MCR) will measure the progression of trainees towards that standard. Trainees will be assessed by the Clinical Supervisors with whom they work on a daily basis, rated on the level of supervision they require to perform the five Capabilities in Practice (CiPs). They will also be rated on the Generic Professional Capabilities (GPCs) required of all doctors.

2. What are the Capabilities in Practice (CiPs)?

The Capabilities in Practice (CiPs) describe the generic clinical activities and skills needed to practice independently at the level of a day-1 consultant. When trainees are assessed through the Multiple Consultant Report (MCR) as able to perform these essential activities independently (level IV or V), together with the Generic Professional Capabilities (GPCs), then they are considered safe and ready for certification and appointment to a consultant post. The five CiPs cover:

- Managing an outpatient clinic
- Managing the unselected emergency take
- Managing ward rounds and inpatients
- Managing the operating list
- Managing multi-disciplinary team working

The specialties below have described CiPs in addition to the five shared between all surgical specialties, and these describe areas of practice that are essential to that specialty, but also specific to that specialty:

Cardiothoracic
- Manage patients within the critical care area
- Assess surgical outcomes both at a personal and unit level

Paediatrics
- Able to manage premature infants, children and adolescents up to adult-hood within neonatal intensive care unit, paediatric intensive care unit and high dependency settings for congenital and acquired conditions and trauma presenting in infancy and childhood.

Plastics
- Able to safely assimilate new technologies and advancing techniques in the field of Plastic Surgery into practice

Trainees will have to reach level IV in all CiPs described by a specialty to practice as a day-1 consultant in that specialty.

Capabilities in Practice (CiPs) video

3. What are the Generic Professional Capabilities (GPCs) and why were they introduced?

The GPCs describe the essential professional behaviours required of all doctors in the UK, replacing the professional and leadership skills syllabus. They are equivalent in importance to the Capabilities in Practice (CiPs) and satisfactory achievement by trainees will demonstrate that they have the professional behaviours needed to provide safe, effective and high quality medical care in the UK and the Republic of Ireland.

The GPCs were developed by the General Medical Council and Academy of Medical Royal Colleges in response to fitness to practise data and reports from several high profile patient safety inquiries which identified major deficits in basic areas of professional practice. They recommended the need for specific training to address these shortfalls which corresponded with the outcome of the Shape of Training review which recognised the need to develop a consistent approach that embedded common generic outcomes and content across all postgraduate medical curricula. The nine GPC domains are:

- 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
- 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

Generic Professional Capabilities (GPCs) video

4. What are the benefits of this curriculum change?

The benefit for trainees is that by being assessed against the standard of a day-1 consultant, they and their trainers will be able to better monitor whether they are on track to meet that standard at the end of training. Trainees will be able to move through training at their own speed and finish early if they acquire the necessary skills faster than the indicative time. The Multiple Consultant Report (MCR) will also result in improved feedback to drive learning, and workplace-based assessment will be tailored to trainee need rather than requiring a trainee to record a certain number per year.

The benefit for Clinical Supervisors will be that the MCR will centre on their professional judgement of trainee performance based on their knowledge of working with trainees rather than on the use of checklists. Training Programme Directors and Assigned Educational Supervisors should also benefit from the information from the MCR to help them monitor trainee needs and progression and tailor the next period of training to specific areas for development identified by the MCR and self-assessment.

5. Does this change mean that if a trainee meets all the requirements to the level of a day-1 consultant earlier than the norm that they can apply for Certification earlier?

That is correct. In an outcomes based curriculum a trainee can be awarded an ARCP outcome 6 when they reach the level of a day-1 consultant (supervision level IV in all the CiPs and ‘appropriate for stage’ in all the GPCs) and have met any other certification requirement. Certification will follow the rules of the Gold Guide and minimum training times described by legislation.

6. Can a trainee stay on the old curriculum or do they need to switch to the new curriculum?

Trainees entering surgical training and starting a new curriculum from August 2020 will follow the new curriculum.

A trainee entering the final year of training in their specialty or the final year of decoupled core training can remain on the old curriculum or choose to move to the 2020 curriculum after consultation with their training programme director.

Trainees who have not reached the final year of training will move to the new curriculum as they enter their next training year – for most this will be August or October 2020.

All trainees will have moved to the 2020 curriculum by October 2022 at the latest.

THE ASSESSMENT SYSTEM

7. Will trainees still need to do Workplace-based assessments (WBAs)?

Yes, WBAs will still be important as a formative tool for trainee learning. They can still be used by trainees to generate and record feedback on specific tasks, or by trainers as part of a package to ensure that specific training development needs have been addressed. WBAs will be particularly important for ensuring attainment of breadth and depth of knowledge and skill in the Index Procedures (DOPS and PBA) and Critical Conditions (CEX/C and CBD). However, they will no longer be driven by minimum numbers for all but by trainee learning needs.

8. Will the Clinical Supervisor (CS) Report still be mandatory?

Clinical Supervisors will still be available to make short feedback ‘field notes’ in trainee portfolios throughout training, but they will no longer be a mandatory element of the Learning Agreement.

THE MULTIPLE CONSULTANT REPORT (MCR)

9. Who participates in the Multiple Consultant Report (MCR)?

All the Clinical Supervisors (CSs) who work with a trainee should assess the trainee through the MCR, with one CS also providing feedback to the trainee.

10. What is the minimum number of Clinical Supervisors (CSs) needed for the MCR?

The MCR should include all the CSs who work with the trainee on a day-to-day basis. The minimum is more than one and there is no maximum number.

11. How many Multiple Consultant Reports (MCR) will I need within a training year?

For every placement there will be two MCRs (one near the mid-point and one near the end) – in total there will be six MCRs when there are three 4-month placements; four MCRs when there are two 6-month placements and *at least* two MCRs for a 1-year placement.

12. Do Clinical Supervisors (CSs) need to meet to complete the Multiple Consultant Report (MCR) or can each CS provide an individual report?

The MCR should result from a collective discussion between all the CSs who are involved in training the trainee and represent a consensus view of the trainee's trajectory and any required development. These meetings often happen informally and need to be captured more formally in future e.g. they might typically be fitted in at the end of other scheduled meetings. If any CS cannot attend the MCR meeting or disagrees with the consensus report, they will be able to add comments to the consensus MCR afterwards.

The recommended and preferred method of completing the MCR is through a local faculty meeting as described above. However, if a unit is unable to arrange such a meeting then individual CSs can complete their own MCR form. It would then be up to the AES to collate these opinions in their own MCR form.

13. Who drives the Multiple Consultant Report (MCR) process?

The process is managed by the Clinical Supervisors responsible for a trainee. From this group a lead Clinical Supervisor (CS) will be chosen to organise and chair the MCR meeting, arrange or delegate the transcription of the consensus report during the meeting and provide an MCR discussion with the trainee after the meeting.

14. Why isn't the trainee present at the Multiple Consultant Report (MCR) meeting?

The MCR is a high-level faculty discussion that may encompass more than judgement about trainee performance. It may identify common ground and a plurality of ideas and approaches through small group discussion. It may also review and evaluate areas of the quality management and control of training, as well make decisions about action plans and resources. Trainees have a corresponding self-assessment and will be able to discuss the MCR assessment in a subsequent face-to-face session.

15. How does the Multiple Consultant Report (MCR) guard against biased judgements about trainees?

The nature of the MCR is subjective because it engages a wide range of professional judgements from a group of consultant Clinical Supervisors (CSs) who have worked with the trainee on a day-to-day basis. A critical role will be played by the lead CS who will ensure that the group understands their role, helping to ensure balanced views are recorded as well as ensuring all have an opportunity to participate. The MCR approach encourages the sharing and discussion of the reasons for the judgements made.

Trainees will have a corresponding self-assessment and be able to discuss this and the MCR in a face to face session. The trainee's Assigned Educational Supervisor (AES) will be responsible for taking an overall view of the MCR and it will be important that trainees raise any concerns they may have with their AESs, especially in advance of the mid-point review. Training Programme Directors will be responsible for quality managing the overall process.

16. Can supervisors who are not consultants or surgeons take part in the Multiple Consultant Report (MCR)?

No, The MCR has been designed to be assessed by consultant surgeons who act as Clinical Supervisors.

17. Isn't this going to be a lot more work for me?

Not really, although, as with any new system it might take a little longer to use at first until you become familiar with it. The MCR will put professional judgement of trainers at the

centre of assessment, and will also improve feedback for trainees and for these reasons it has been very warmly received in our pilots.

Clinical Supervisors (CSs)
You will need to participate in the Multiple Consultant Report (MCR) meeting on two occasions in each placement and may be nominated as the person who provides the trainee with a face to face discussion. However, this additional assessment will be balanced against the removal of target numbers of workplace-based assessments (WBAs) and the removal of a mandatory requirement for CS Reports.

Assigned Educational Supervisors (AESs)
You will need to review the MCR as part of your assessment of trainee portfolios to be discussed with trainees during Learning Agreement meetings. However, the Learning Agreement will streamline the process by feeding in information from the MCR in a meaningful way. The AES Report will also be combined with the Learning Agreement final review.

Training Programme Directors (TPDs)
The introduction of the new curriculum will result in the need for local training and induction for trainers and trainees respectively and consequent quality management. As the TPD you should make provision at the earliest opportunity to allow for this as well as the transition of trainees to the new curriculum. It is particularly important that arrangements are put in place well in advance for trainees who are out of programme or less than full time. Please refer to the transition statement below:

> *All trainees must transition to the new curriculum at the latest by 3 August 2022. Trainees should transition to the new curriculum after the ARCP at the end of their current level of training, except: Trainees moving into CT2 in decoupled Core Surgery or into ST8 (or ST7 in Urology or OMFS) who may choose to remain on the old curriculum.*

Trainees
You will have an additional self-assessment and feedback session on two occasions in each placement. The MCR might result in feedback for consideration or further development which might impact on your training. The requirement for a target number of WBAs has been removed in order that they can be selected to your needs. However, WBAs will still be important and will be required to demonstrate achievement of the index procedures (DOPS and PBA) and critical conditions (CEX/C and CBD).

18. How can the Multiple Consultant Report (MCR) show progression in the early years when trainees cannot reach level IV?

In the early stages of training, a few small tasks relevant to the day-1 consultant may reflect very significant responsibilities for junior trainees, and as trainees develop, these become part of larger, more encompassing responsibilities. The MCR can be used to indicate whether trainees are on an appropriate trajectory and highlight areas that they need to consider or develop further over the next 3-6 months. In core surgical training there is a finer gradation of supervision levels to capture early progress more meaningfully and allow demonstration of progress towards consultant level.

19. What role does the Multiple Consultant Report (MCR) play in the Annual Review of Competence Progression (ARCP)?

The MCR (incorporating the professional judgement of trainers) will provide a key source of evidence for the Assigned Educational Supervisor's (AES) Report in each placement and these will be central to the ARCP panel's decision about the trainee's progression to

the next level, phase or completion of training. The ARCP panel will provide the final decision on training progression. Any appeals following that must follow the appeal process described in the Gold Guide.

20. How will the Multiple Consultant Report (MCR) work if a trainee is returning from long term leave / less than full time training / out of programme?

The MCR and the trainee self-assessment should allow a smoother transition back into clinical training than is currently the case by helping to identify any specific learning needs soon after return. The MCR will still take place at the mid and end-point of each placement, and before the mid-point it will be important to check on the achievement of the Generic Professional Capabilities (GPCs) and Capabilities in Practice (CiPs) and identify any additional support needed such as additional supervision, time and targeted assessments.

DESCRIPTORS

21. Do Clinical Supervisors need to rate trainees on each descriptor within the Generic Professional Capabilities (GPCs) and Capabilities in Practice (CiPs)?

No. The descriptors provide prompts to aid the holistic professional judgement made by Clinical Supervisors rather than a competence checklist. They help to provide the language to feedback to trainees about their performance where it is considered necessary. In order to complete training, trainees need to be judged to be at supervision level IV or V in all the CiPs and 'appropriate for stage' in all the GPCs within the context of the specialty syllabus.

22. Could a trainee fail if a single Generic Professional Capability (GPC) or Capability in Practice (CiP) descriptor is marked as 'development required'?

Not necessarily. During training, trainees may be progressing satisfactorily with some areas marked as 'for development'. However, in order to complete training, trainees need to be judged to be at supervision level IV or above in all the CiPs and 'appropriate for stage' in all the GPCs within the context of the specialty syllabus.

23. Why can't I flag more than 5 descriptors against each Capability in Practice (CiP)?

In order to avoid overwhelming the trainee, any feedback for consideration or further development should be focused on what can be achieved over the next 3-6 months.

24. How can I comment on a domain in either the Generic Professional Capabilities (GPCs) or Capabilities in Practice (CiPs) if I haven't worked with the trainee in that area?

Collectively, the Clinical Supervisors (CSs) who are involved in training trainees on a day-to-day basis should be able to make judgements about all the CiPs. Some may not be able to make a judgement about all the domains of the GPCs and coverage of these areas will also be provided by the trainee's Assigned Educational Supervisor.