ISCP INTERCOLLEGIATE SURGICAL CURRICULUM PROGRAMME

ARCP PANEL GUIDE

to the 2021 surgical curriculum

February 2022

This curriculum change is the result of new standards for curricula introduced by the General Medical Council (GMC); Excellence by design and the Shape of Training Review. It followed a lengthy consultation process with input from trainees and trainers and contributions from a wide range of stakeholders including NHS employers, service and education providers, patient and lay groups, statutory education bodies and experts in curriculum and assessment design. The new curricula are approved by the GMC.

Contents

A. Key changes

The ARCP continues to serve a crucial purpose in the assessment system of the new 2021 curriculum. It continues to draw on the portfolio evidence of trainees in order to decide whether they can progress to the next level or phase of training. However, as a result of the changes introduced by the new curriculum, the portfolio evidence of trainees who have transitioned will be different as this guide will explain.

Change 1: A new assessment will assess capabilities

The new curriculum assesses trainees against the fundamental capabilities required of the day-one consultant; the ability to successfully manage the unselected emergency take, clinics and ward care, operating lists and multi-disciplinary working. These clinical capabilities are called Capabilities in Practice or CiPs and must be demonstrated along with the professional capabilities required of all doctors, the Generic Professional Capabilities or GPCs (see appendix 5 for more information about the CiPs and GPCs).

The need to assess these two sets of capabilities has led to the introduction of a new assessment called the Multiple Consultant Report or MCR. The MCR uses the professional judgement of the faculty of consultant Clinical Supervisors who work with trainees on a day-to-day basis to report how far they are progressing towards these capabilities and the degree of supervision they require. The MCR is an optional assessment at the midpoint of each placement and mandatory at the end of the placement.

Change 2: The Learning Agreement has been streamlined

The Learning Agreement has been re-designed so that placement objectives are focused on helping trainees improve on specific areas assessed by the MCR. The Assigned Educational Supervisor's (AES) report is combined with the final review meeting.

Change 3: Training time is indicative

Trainees will be able to progress at their own rate and should be able to progress faster through training if they demonstrate the necessary capability.

Change 4: Training is arranged in 3 phases

Phase 1 is core / early years training. The specialty examination is taken after completion of phase 2, except in Neurosurgery when it can be taken after the ST6 year.

Change 5: Trainees in specialty training must demonstrate learning in critical conditions and index procedures

Appendix 3 and 4 of each specialty curriculum lists the critical conditions and index procedures that are of fundamental importance to safe practice. They are assessed by means of the Case Based Discussion (CBD), Clinical Evaluation Exercise (CEX) and Procedure Based Assessment (PBA).

Change 6: The previous annual target number of assessments has been removed.

Trainees will need to record sufficient CEXs, CBDs and PBAs by the time of certification to demonstrate learning of the critical conditions and index procedures. Appendix 3 and 4 of each specialty curriculum gives indicative numbers. In core surgical training, critical skills are shown in appendix 3.

B. Transition arrangements

Most trainees will need to have transitioned to the new curriculum at the start of the 2021 training year. Trainees must have transitioned on entry to:

- Core surgical training or run-through training at CT1 / ST1
- The second year of training at CT2 / ST2 in Cardiothoracic Surgery or Neurosurgery
- Specialty training at any level up to the penultimate year

There are very few circumstances in which trainees do not need to transition, and for these trainees portfolio evidence will remain unchanged. Trainees who are entering their final year of core / run-through training (in all specialties except Cardiothoracic Surgery and Neurosurgery) do not need to transition. Trainees also do not need to transition when they are entering their final year of specialty training. Additionally, trainees who are remaining at their previous training level (e.g. when less than full time or because of a previous ARCP outcome 3 or 10.2) do not need to transition.

If trainees have not transitioned by the time of their first placement in the training year they should transition at the beginning of the next placement.

Trainees should be made aware at the earliest opportunity if ARCP panels are to recommend a non-standard outcome as a consequence of failure to transition to the new curriculum.

Appendix 1: New curriculum portfolio evidence for the ARCP

The ARCP content and process have not changed. However, the portfolio evidence of trainees who have transitioned to the new curriculum will be different as tabled below.

Mandatory evidence in each placement
• Completed Learning Agreement (final review includes AES report) [1] *see note below* • CEX / DOPS for critical skills (core) • CEXs / CEXCs / CBDs for critical conditions (specialty) • PBAs for index procedures (specialty) • Multisource Feedback (MSF) • Up to date logbook • Final Multiple Consultant Report (MCR) • Final trainee Self-Assessment
Optional evidence in each placement
• Midpoint MCR • Midpoint trainee Self-Assessment • Other WBAs (the annual target number has been removed)
Evidence at the end of core surgical training (section 5.4 of core curriculum)
• MRCS or MRCS(ENT) examination • Final MCRs (from each placement in final year with supervision levels as shown in section 3.4 table 2 and all GPCs appropriate for phase of training) • Final trainee Self-Assessment in each placement in final year • Completed Learning Agreements (in each placement in final year, including one CS report) • Mandatory CEX / DOPS (as shown in appendix 3) • MSF from each whole time equivalent training year • Up to date logbook • In date certification through an approved trauma course

Continued on next page

Evidence at certification (section 5.4 of relevant specialty curriculum)

- MRCS or MRCS(ENT) examination
- Intercollegiate Specialty Board examination
- Final MCRs (in each placement in final year showing level IV or V in all the CiPs and all GPC domains marked as appropriate for stage)
- Final trainee Self-Assessments (in each placement in final year)
- Completed Learning Agreements (in each placement in final year)
- CEX / CEXC / CBDs for full range of critical conditions

(Continued over page)

Evidence at certification continued

- PBAs for full range of index procedures
- MSF from each whole time equivalent training year
- Up to date logbook
- Research – evidence based practice
- Audit / quality improvement projects
- Teaching – training and structured feedback on teaching
- Health service management and leadership - training and related activity
- ATLS (or APLS in Paediatric Surgery) or equivalent, including local trauma courses (except Urology)
- Attendance at national / international meetings
- Management of breadth of clinical experience – defined in the syllabus
- Competence in breadth of operative experience – defined in the syllabus

Certification requirements in each specialty

Note 1: To support the principles set out in the new curriculum, the ISCP has linked the Learning Agreement and MCR. Each stage in the process has to be completed before the next becomes available. While the assessment system in the previous curriculum was trainee-led, the MCR in the new curriculum is led by Clinical Supervisors and, therefore, non-completion of MCRs may be no fault of trainees. In addition, the lack of an MCR may also delay the beginning of the next stage of the Learning Agreement so that uncompleted Learning Agreements may not necessarily be the fault of trainees.

Note 2: A JCST Specialty Advisory Committee (SAC) Liaison Member should continue to provide externality at 75% of all ARCPs to advise on trainee suitability for progression and as part of quality assured training in surgery.

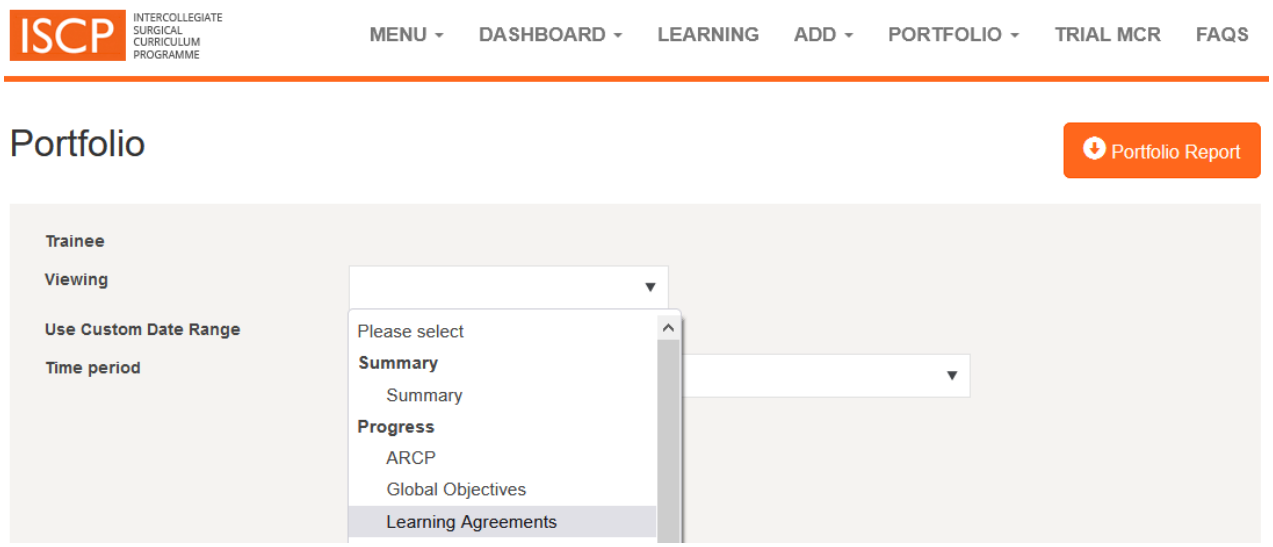
Appendix 2: New Learning Agreement portfolio summary report

AESs will continue to be responsible for each trainee's educational development through the Learning Agreement and for summarising progress through the end of placement AES report.

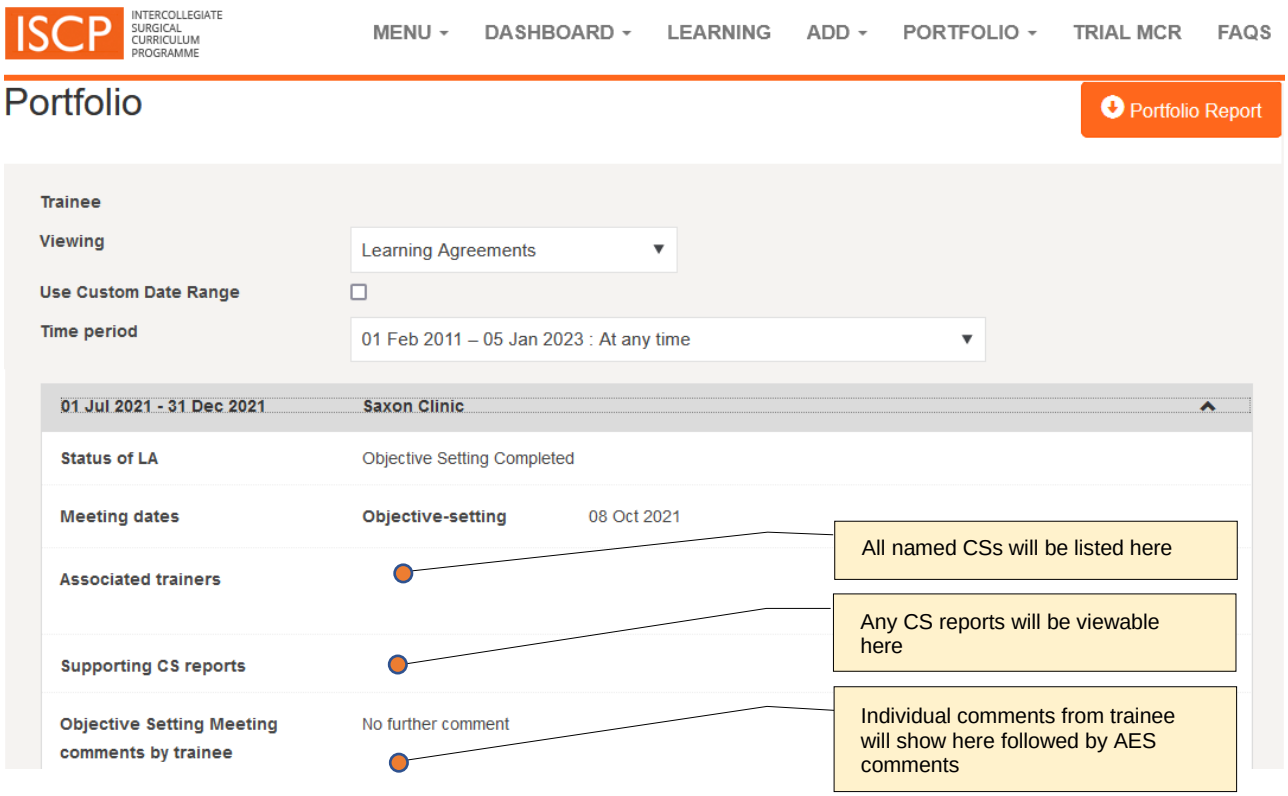
The Learning Agreement consists of 3 meetings. In the new curriculum the AES report is part of the final review.

The Learning Agreement needs only to focus on the areas of the CiPs and GPCs that trainees need to develop over the next 3-6 months of training in that placement. Areas that are progressing well do not need to be mentioned.

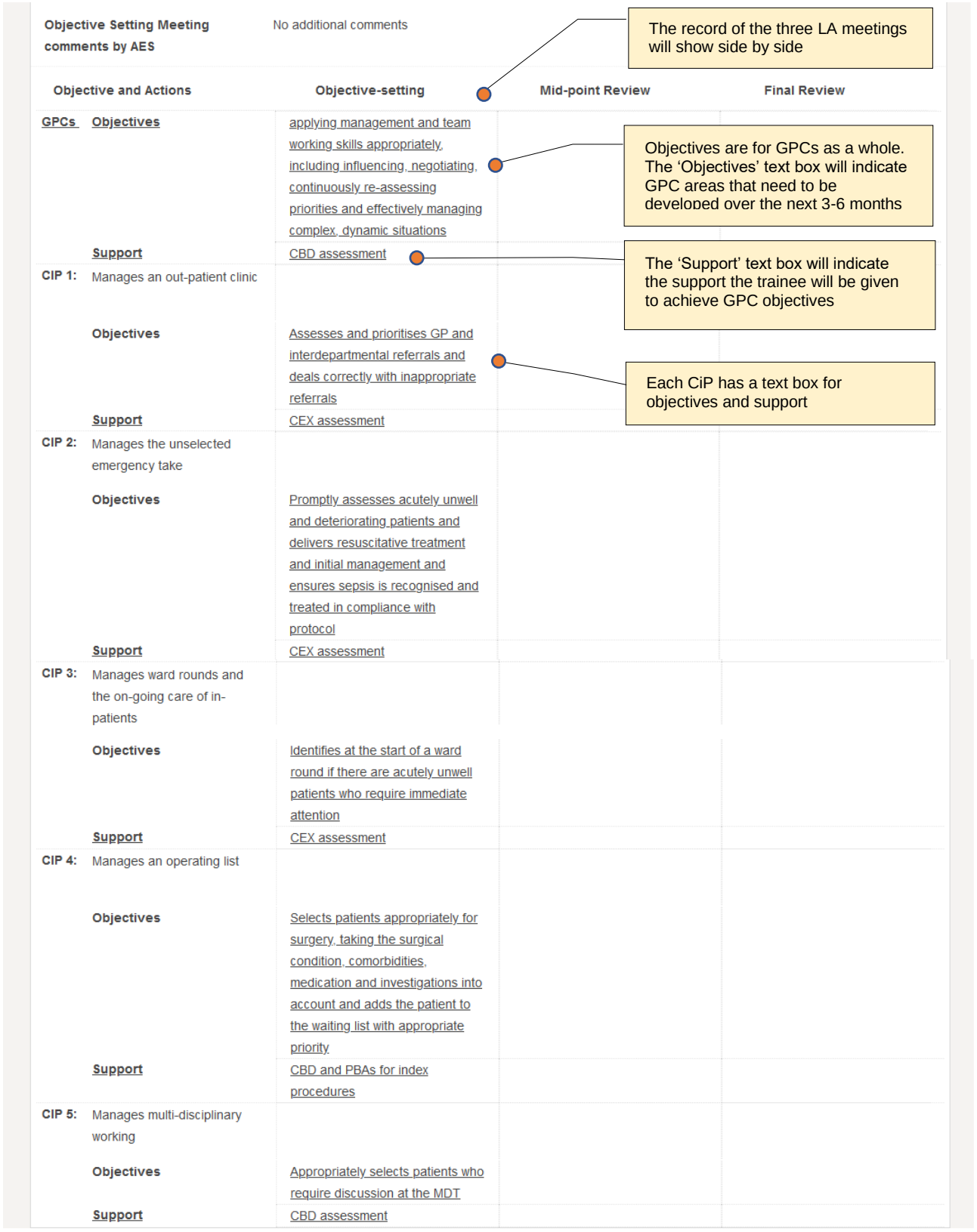
To navigate to the report, go to *Portfolio*, then *Portfolio Summary* and use the drop down menu to select *Learning Agreements*



The report will look like this:



Learning Agreement report continued



Objective Setting Meeting comments by AES	No additional comments		
Objective and Actions	**Objective-setting**	**Mid-point Review**	**Final Review**
GPCs **Objectives**	applying management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations		
Support	CBD assessment		
CIP 1: Manages an out-patient clinic			
Objectives	Assesses and prioritises GP and interdepartmental referrals and deals correctly with inappropriate referrals		
Support	CEX assessment		
CIP 2: Manages the unselected emergency take			
Objectives	Promptly assesses acutely unwell and deteriorating patients and delivers resuscitative treatment and initial management and ensures sepsis is recognised and treated in compliance with protocol		
Support	CEX assessment		
CIP 3: Manages ward rounds and the on-going care of in-patients			
Objectives	Identifies at the start of a ward round if there are acutely unwell patients who require immediate attention		
Support	CEX assessment		
CIP 4: Manages an operating list			
Objectives	Selects patients appropriately for surgery, taking the surgical condition, comorbidities, medication and investigations into account and adds the patient to the waiting list with appropriate priority		
Support	CBD and PBAs for index procedures		
CIP 5: Manages multi-disciplinary working			
Objectives	Appropriately selects patients who require discussion at the MDT		
Support	CBD assessment		

The record of the three LA meetings will show side by side

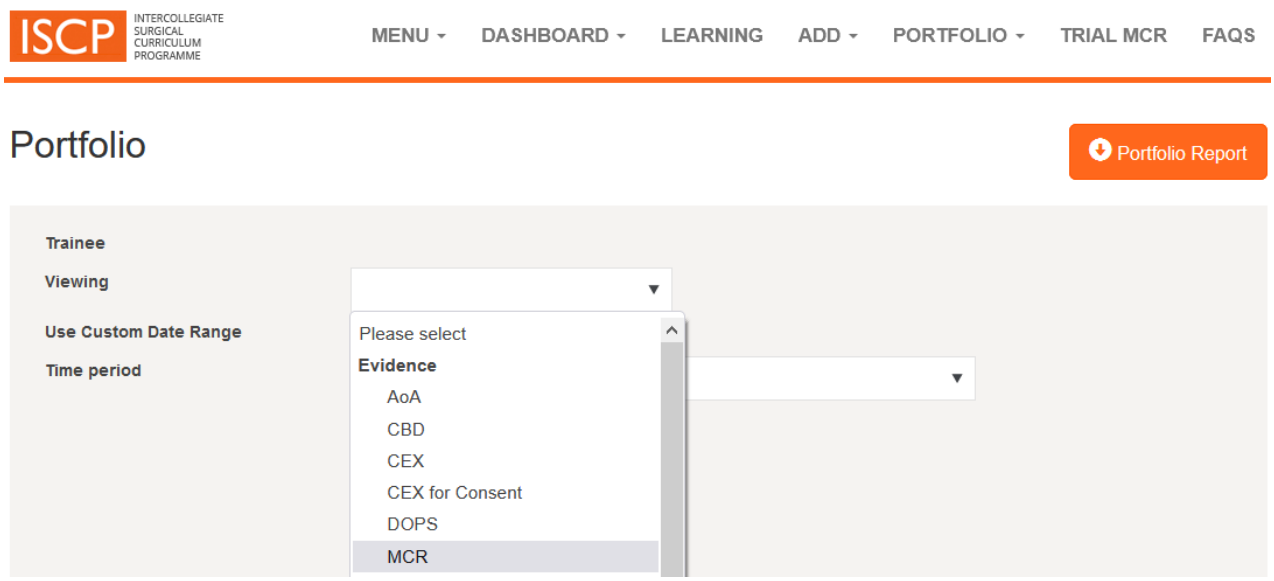
Objectives are for GPCs as a whole. The 'Objectives' text box will indicate GPC areas that need to be developed over the next 3-6 months

The 'Support' text box will indicate the support the trainee will be given to achieve GPC objectives

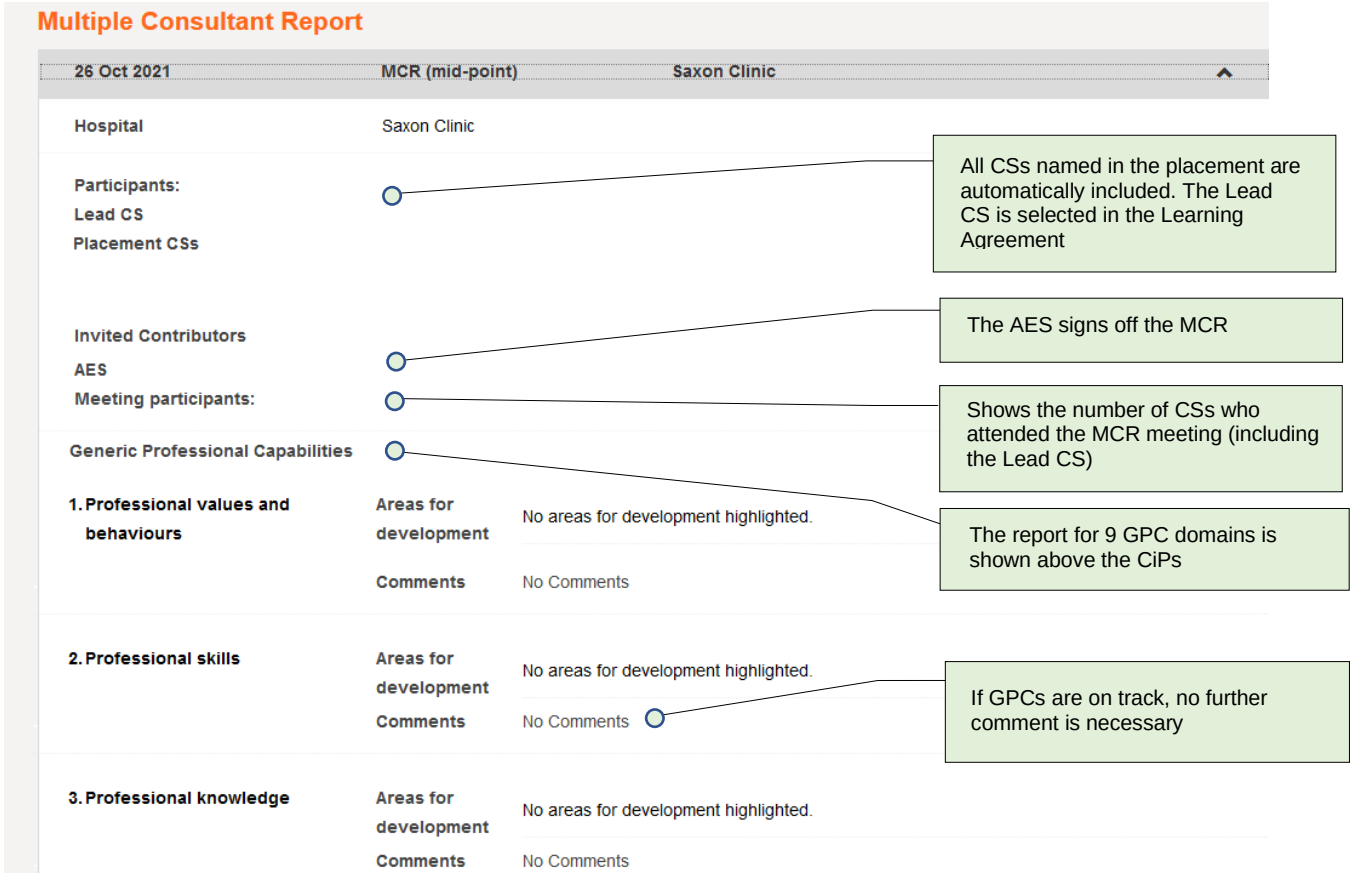
Each CiP has a text box for objectives and support

Appendix 3: New MCR portfolio summary report

To navigate to the report, go to *Portfolio*, then *Portfolio Summary* and use the drop down menu to select *MCR*



The report will look like this:



4. Capabilities in health promotion and illness prevention	**Areas for development**	No areas for development highlighted.
	Comments	No Comments
5. Capabilities in leadership and team working	**Areas for development**	demonstrating appropriate leadership behaviour and an ability to adapt their leadership behaviour to improve engagement and outcomes
	Comments	No Comments
6. Capabilities in patient safety and quality improvement	**Areas for development**	No areas for development highlighted.
	Comments	No Comments
7. Capabilities in safeguarding vulnerable groups	**Areas for development**	No areas for development highlighted.
	Comments	No Comments
8. Capabilities in education and training	**Areas for development**	No areas for development highlighted.
	Comments	No Comments
9. Capabilities in research and scholarship	**Areas for development**	No areas for development highlighted.
	Comments	No Comments
Capabilities in practice		
1. Manages an out-patient clinic	**Supervision Level**	III - Able and trusted to act with indirect supervision: The supervisor may be required to be physically present on occasion. The supervisor does not need to guide all aspects of the activity. For those aspects which do need guidance, this may be given from another setting.
	Areas for development	Assesses and prioritises GP and inter-departmental referrals and deals correctly with inappropriate referrals
	Areas of excellence	No areas of excellence highlighted.
	Comments	No Comments
2. Manages the unselected emergency take	**Supervision Level**	III - Able and trusted to act with indirect supervision: The supervisor may be required to be physically present on occasion. The supervisor does not need to guide all aspects of the activity. For those aspects which do need guidance, this may be given from another setting.
	Areas for development	Promptly assesses acutely unwell and deteriorating patients, delivers resuscitative treatment and initial management, and ensures sepsis is recognised and treated in compliance with protocol
	Areas of excellence	No areas of excellence highlighted.
	Comments	No Comments

GPC area for development – descriptors can be picked and added to the report

The second part of the MCR is about the CiPs

The supervision level (showing its definition) must be indicated. Levels lower than IV must be justified in the 'Areas for development' text box

Areas of excellence can be indicated

3. Manages ward rounds and the on-going care of in-patients	**Supervision Level**	III - Able and trusted to act with indirect supervision: The supervisor may be required to be physically present on occasion. The supervisor does not need to guide all aspects of the activity. For those aspects which do need guidance, this may be given from another setting.
	Areas for development	Ensures that all documentation (including results of investigations) will be available when required and interprets them appropriately
	Areas of excellence	No areas of excellence highlighted.
	Comments	No Comments
4. Manages an operating list	**Supervision Level**	III - Able and trusted to act with indirect supervision: The supervisor may be required to be physically present on occasion. The supervisor does not need to guide all aspects of the activity. For those aspects which do need guidance, this may be given from another setting.
	Areas for development	Selects patients appropriately for surgery, taking the surgical condition, co-morbidities, medication and investigations into account, and adds the patient to the waiting list with appropriate priority
	Areas of excellence	No areas of excellence highlighted.
	Comments	No Comments
5. Manages multi-disciplinary working	**Supervision Level**	III - Able and trusted to act with indirect supervision: The supervisor may be required to be physically present on occasion. The supervisor does not need to guide all aspects of the activity. For those aspects which do need guidance, this may be given from another setting.
	Areas for development	Effectively manages potentially challenging situations such as conflicting opinions
	Areas of excellence	No areas of excellence highlighted.
	Comments	No Comments

Post-meeting Feedback Summary

Total responses: **1 (1 agreed, 0 disagreed)**
No Responses: **2**

After the MCR is submitted, comments / agreement can be added by the whole group, giving absent members an opportunity to be involved

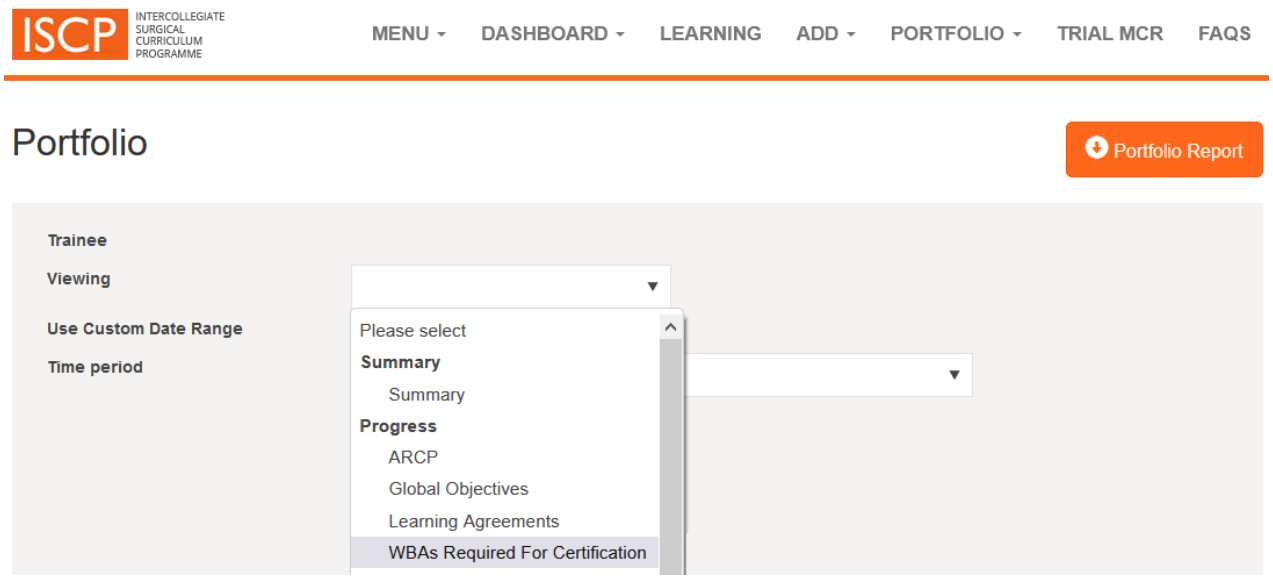
Feedback received - agreed	**Feedback received - disagreed**
AESComments	I agree
MCR Details	Clinical Supervisor 1, Bussey (Mrs) [GMC: 444444444] (Lead CS) created on 08 Oct 2021 Clinical Supervisor 1, Bussey (Mrs) [GMC: 444444444] (Lead CS) submitted on 08 Oct 2021 Bussey, AES (Mrs) [GDC: 333333333] (AES) completed on 26 Oct 2021

Appendix 4: New WBAs Required For Certification report

Trainees will need to record sufficient CEXs, CBDs and PBAs to demonstrate learning of the critical conditions and index procedures. Appendix 3 and 4 of each specialty curriculum provide the lists of critical conditions and index procedures. In core surgical training, critical skills are shown in appendix 3. The indicative numbers shown replace the previous annual target number of assessments.

This new portfolio report has been designed to tally the appropriate WBAs, along with their global rating, against the required critical conditions and index procedures in the trainee's parent specialty.

To navigate to the report, go to *Portfolio*, then *Portfolio Summary* and use the drop down menu to select *WBAs Required for Certification*



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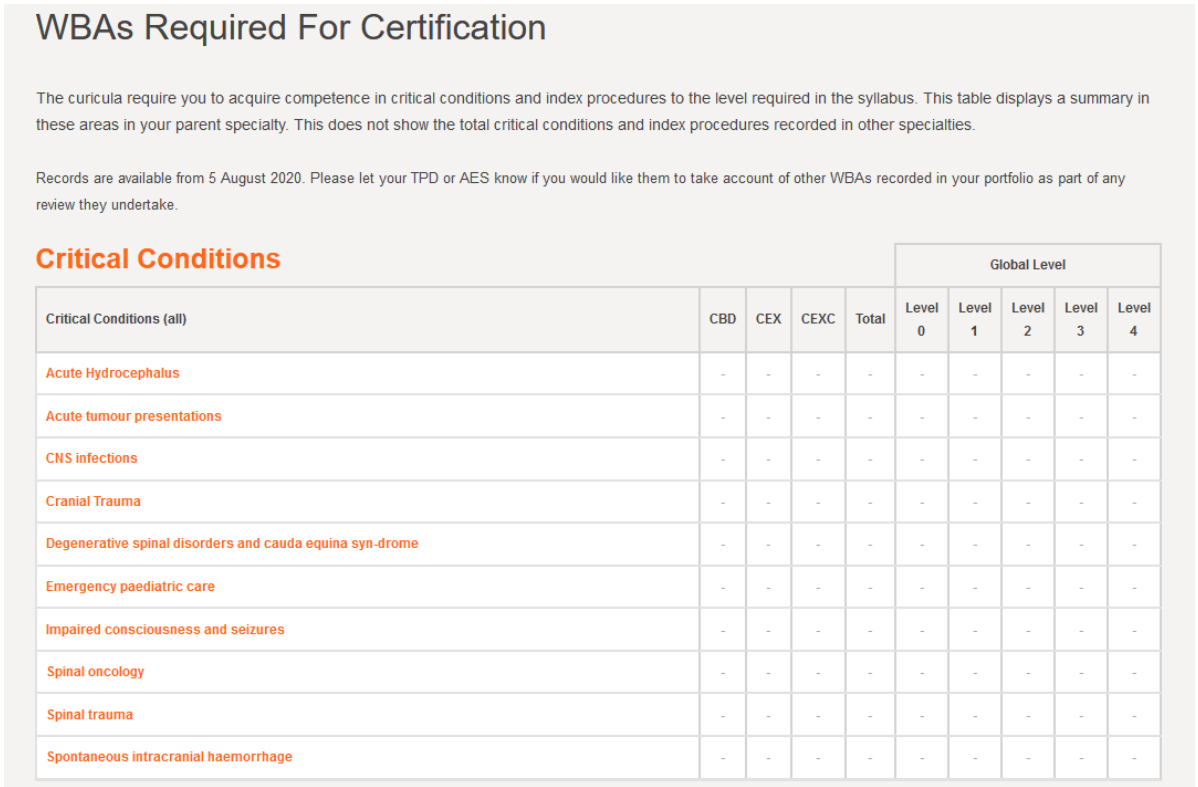

WBAs Required For Certification

The curicula require you to acquire competence in critical conditions and index procedures to the level required in the syllabus. This table displays a summary in these areas in your parent specialty. This does not show the total critical conditions and index procedures recorded in other specialties.

Records are available from 5 August 2020. Please let your TPD or AES know if you would like them to take account of other WBAs recorded in your portfolio as part of any review they undertake.

Critical Conditions

					Global Level				
Critical Conditions (all)	CBD	CEX	CEXC	Total	Level 0	Level 1	Level 2	Level 3	Level 4
Acute Hydrocephalus	-	-	-	-	-	-	-	-	-
Acute tumour presentations	-	-	-	-	-	-	-	-	-
CNS infections	-	-	-	-	-	-	-	-	-
Cranial Trauma	-	-	-	-	-	-	-	-	-
Degenerative spinal disorders and cauda equina syn-drome	-	-	-	-	-	-	-	-	-
Emergency paediatric care	-	-	-	-	-	-	-	-	-
Impaired consciousness and seizures	-	-	-	-	-	-	-	-	-
Spinal oncology	-	-	-	-	-	-	-	-	-
Spinal trauma	-	-	-	-	-	-	-	-	-
Spontaneous intracranial haemorrhage	-	-	-	-	-	-	-	-	-

Index Procedures

Index Procedures (all)	PBA	DOPS	Total	Global Level								
				Level 0	Level 1A	Level 1B	Level 2A	Level 2B	Level 3A	Level 3B	Level 4A	Level 4B
Advanced adult infratentorial	-	-	-	-	-	-	-	-	-	-	-	-
Advanced Adult Supratentorial	-	-	-	-	-	-	-	-	-	-	-	-
Advanced paediatric infratentorial	-	-	-	-	-	-	-	-	-	-	-	-
Advanced paediatric supratentorial	-	-	-	-	-	-	-	-	-	-	-	-
Burr hole evacuation of chronic subdural haematoma	-	-	-	-	-	-	-	-	-	-	-	-
Complex Spinal Fusion	-	-	-	-	-	-	-	-	-	-	-	-
Convexity and falcine meningiomas	-	-	-	-	-	-	-	-	-	-	-	-
Craniotomy	-	-	-	-	-	-	-	-	-	-	-	-
Endoscopic and Transphenoidal	-	-	-	-	-	-	-	-	-	-	-	-
Insertion of external ventricular drain (EVD)	-	-	-	-	-	-	-	-	-	-	-	-
Insertion of ICP monitor	-	-	-	-	-	-	-	-	-	-	-	-
Intradural Spine	-	-	-	-	-	-	-	-	-	-	-	-
Lumbar decompression (approach)	-	-	-	-	-	-	-	-	-	-	-	-
Lumbar puncture and lumbar drain insertion	-	-	-	-	-	-	-	-	-	-	-	-

Because of the technical differences between the old and new system, the tally could only be started in August 2020 and, therefore, previous assessments are not included in this report. If trainees have created their own spreadsheet to account for earlier assessments, they may have uploaded it to the *Miscellaneous* folder in the *Other Evidence* section of the portfolio.

Appendix 5: The CiPs and GPCs

The MCR will assess trainees on their ability to practice as day-one consultants. The requirements have been divided into clinical outcomes called Capabilities in Practice (CiPs) and professional outcomes called Generic Professional Capabilities (GPCs). Together, these will indicate whether trainees have reached the end-point of training and are ready for certification.

See the full Capabilities in Practice
See the full Generic Professional Capabilities

CiPs common to all specialties
1. Manages an out-patient clinic. 2. Manages the unselected emergency take. 3. Manages ward rounds and the on-going care of in-patients. 4. Manages an operating list. 5. Manages multi-disciplinary working.
Specialty-specific CiPs
Cardiothoracic surgery 6. Manages patients within the critical care area 7. Assesses surgical outcomes both at a personal and unit level *Paediatric Surgery* 6. Assesses and manages an infant or child in a NICU/PICU environment *Plastic surgery* 6. Safely assimilates new technologies and advancing techniques in the field of Plastic Surgery into practice
GPCs
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

Appendix 6: Phases and levels of training

The table below shows how the phases of training relate to CT/ST grades. The number of years is indicative as trainees will be able to progress at their own rate.

R/T: Run-through training / U: Uncoupled training

Specialty	Route	Phase 1	Phase 2	Phase 3
Cardiothoracic Surgery	R/T	1. ST1 2. ST2 3. ST3 Cardiac & Thoracic	4. ST4 5. ST5 Cardiac or Thoracic + on call Cardiothoracic	6. ST6 7. ST7 Cardiac or Thoracic + on call Cardiothoracic Cardiac sub-specialty option Formerly 8 years
	U	1. CT1 2. CT2 [National selection] 3. ST3 / 4. ST4 (Progression may be quicker) Cardiac & Thoracic	5. ST5 6. ST6 Cardiac or Thoracic + on call Cardiothoracic	7. ST7 8. ST8 Cardiac or Thoracic + on call Cardiothoracic Cardiac sub-specialty option
General Surgery Otolaryngology Paediatric Surgery Plastic Surgery Trauma & Orthopaedic Surgery Vascular Surgery	R/T	1. ST1 2. ST2	3. ST3 4. ST4 5. ST5 6. ST6	7. ST7 8. ST8
	U	1. CT1 2. CT2	3. ST3 4. ST4 5. ST5 6. ST6	7. ST7 8. ST8
Neurosurgery	R/T	1. ST1 2. ST2	3. ST3 4. ST4 5. ST5 6. ST6 7. ST7	8. ST8
Oral & Maxillofacial Surgery	R/T	1. ST1 [ST2 skipped]	2. ST3 3. ST4 4. ST5	5. ST6 6. ST7
	U	1. CT1	2. ST3 3. ST4 4. ST5	5. ST6 6. ST7
Urology	R/T	1. ST1 2. ST2	3. ST3 4. ST4 5. ST5	6. ST6 7. ST7
	U	1. CT1 2. CT2	3. ST3 4. ST4 5. ST5	6. ST6 7. ST7

The training pathway diagrams can be accessed here

Appendix 7: FAQs

Who is responsible for the MCR?

The Lead CS is responsible for organising the MCR meeting, filling in the online MCR form on behalf of the group and providing MCR feedback to trainees. Different CSs may be the Lead CS for different trainees. All CSs should contribute to the MCR and at least two CSs are necessary for the meeting. All, including others who were unable to attend can add comments separately for a 2-week period after the MCR is submitted by the Lead CS after which it is ready for sign off by the AES.

As well as final sign off of the MCR, the AES is responsible for addressing any gaps in the assessment of GPCs 6-9 which cannot be observed in the workplace.

Trainees must list their CSs when setting up a placement. They must also select the Lead CS at the start of the Learning Agreement under the guidance of the AES. Trainees are not responsible for organising or progress-chasing their MCR on behalf of their trainers.

What role does the MCR play in the ARCP?

The MCR is a mandatory assessment, providing an additional source of evidence in trainee portfolios and contributing to the AES report at the end of each placement.

ARCP makes the final decision about whether a trainee can progress to the next level or phase of training, basing its decision on the evidence that has been gathered in the trainee's learning portfolio during the period between ARCP reviews, particularly the AES report in each training placement.

How many MCRs should there be by the time of the ARCP?

The first MCR from August 2021 will be at the midpoint of the placement, although at the midpoint it is optional. It will need to be completed at least 2-3 weeks in advance of the midpoint Learning Agreement meeting.

At the beginning of the Learning Agreement, trainee and AES will select a Lead Clinical Supervisor for the MCR before they begin the objective setting meeting. The Lead Clinical Supervisor will be able to start the MCR as soon as the objective-setting meeting has been signed off. The MCR should be completed at least 2 weeks before the next Learning Agreement meeting. Approximate timings for the MCR and Learning Agreement are shown below.

Approximate timings				
	Midpoint MCR	Midpoint LA	Final MCR	Final LA
4-month placements	End of month 2 (2-3 weeks before midpoint LA)	Beginning of month 3	End of month 3 (2-3 weeks before final LA)	Middle of month 4
6-month placements	End of month 3 (2-3 weeks before midpoint LA)	Beginning of month 4	End of month 5 (2-3 weeks before final LA)	Middle of month 6
12-month placements	Optimal if divided into two 6-month placements and timed as above			

How can supervisors complete the MCR if they 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 AES.

What is the impact if a trainee does not have a midpoint MCR?

At the midpoint, the MCR is optional but highly important while at the endpoint it is mandatory. If the MCR is not done at the midpoint the risks are that deficiencies will not get highlighted and the MCR outcome at the endpoint may not be what the trainee is expecting. There will also be a lack of information for the trainee's midpoint Learning Agreement meeting with knock on effects for the rest of the placement and insufficient evidence for the ARCP.

Do trainees have to do the Self-Assessment?

Yes, trainees are expected to complete the Self-Assessment. It gives them the opportunity of presenting their opinion of their strengths and development needs which can then be discussed at the feedback meeting. At the midpoint it is not mandatory.

Can a trainee have an MCR if they only have one supervisor?

The MCR is a group opinion rather than the view of one person and is very powerful. It should involve a minimum of two surgical consultants who work with you on a day to day basis. Non-surgical consultants can also be invited to attend by the Lead CS if they work with trainees in particular areas.

How many WBAs do trainees require?

Please refer to appendix 3 of the core surgical curriculum and appendices 3 and 4 of each specialty curriculum. The numbers shown are for certification and are indicative only.

Is the Multisource Feedback (MSF) still required?

Yes. While the MCR is a consultant report, the MSF provides an opportunity for constructive feedback from a wider range of multi-professional team members on the attitudes and behaviours that relate to good team working.

Appendix 8: Useful links

Training Programme Directors, Assigned Educational Supervisors, Clinical Supervisors and Trainees have new defined roles in the new 2021 curriculum. The links below take you directly to the information you need to know.
Supervisor and trainee roles and responsibilities

Transition

Transition (pop up) video
Trainees must have transferred if they have:

- Entered ST1 / CT1
- Entered ST2 / CT2 in Cardiothoracic Surgery / Neurosurgery
- Moved into ST3, ST4, ST5, ST6
- Moved into ST7 in all specialties except OMFS and Urology

The Multiple Consultant Report (MCR)

The MCR is led by the Lead Clinical Supervisor. The person in the role is selected by the trainee and assigned educational supervisor at the beginning of the learning agreement. They are selected from among all the clinical supervisors named in the trainee's placement page.
How to start an MCR for Lead Clinical Supervisors
MCR guidance for Clinical Supervisors and Assigned Educational Supervisors
MCR (pop up) video for Clinical Supervisors
Demo of an MCR meeting for Clinical Supervisors
Capabilities in practice (CiPs)
Generic Professional Capabilities framework
Supervision levels (core) see section 5.3.3
Supervision levels (specialty)
Capabilities in Practice (CiPs) explained
Generic Professional Capabilities (GPCs) explained
The Multiple Consultant Report (MCR) explained

Trainee Self-Assessment

Trainees can assess themselves against the GPCs and CiPs at the midpoint and endpoint of each training placement. The midpoint is optional but should be used when placements are 6 months or longer. The endpoint self-assessment is a curriculum requirement.
Trainee Self-Assessment (pop up) video
Trainee Self-Assessment guidance
Completion of core surgical training
Certification requirements each specialty

The Learning Agreement

The new Learning Agreement helps to focus objectives on the achievement of GPCs and CiPs, directing progress towards readiness for day-1 consultant practice.
Learning Agreement (pop up) video
Learning Agreement (longer video)

General

Curriculum change webinar
FAQs
2021 Surgical Curricula (PDFs)
2021 Surgical Curricula (Web pages)
Training pathway diagrams
More information at JCST/ISCP YouTube channel
For technical help and advice you can contact the ISCP Helpdesk

Appendix 9: Glossary of terms

Abbreviation	Term	Description
Key roles		
AES	Assigned Educational Supervisor	Responsible for the learning agreement and final sign off of the MCR
Lead CS	Lead Clinical Supervisor	Responsible for convening the MCR meeting, submitting the MCR and giving verbal feedback to trainees
TPD	Training Programme Director	Responsible for the training of trainers and induction of trainees on the new curriculum
Existing workplace-based assessments		
CBD	Case Based Discussion	Assesses professionalism and clinical judgement in the management of a patient case
CEX	Clinical Evaluation Exercise	Assesses professionalism, communication and clinical skills in any encounter with a patient
DOPS	Direct Observation of Procedural Skills	Assesses professionalism and technical skills in a range of basic diagnostic and interventional procedures
MSF	Multisource Feedback	Assesses professionalism within a team-working environment
PBA	Procedure Based Assessment	Assesses professionalism, leadership and technical skills in a range of advanced specialty procedures
Assessment of capabilities		
CiP	Capability in Practice	The clinical capabilities required by the new curriculum
GPC	Generic Professional Capability	The professional capabilities required by the new curriculum
MCR	Multiple Consultant Report	The new formative, mandatory workplace-based assessment

Abbreviation	Term	Description
	Other	
ATLS / APLS	Advanced Trauma Life Support (or Advanced Paediatric Life Support in Paediatric Surgery)	This courses and its equivalents are mandated in the curriculum except in Urology