Academy of Medical Royal Colleges

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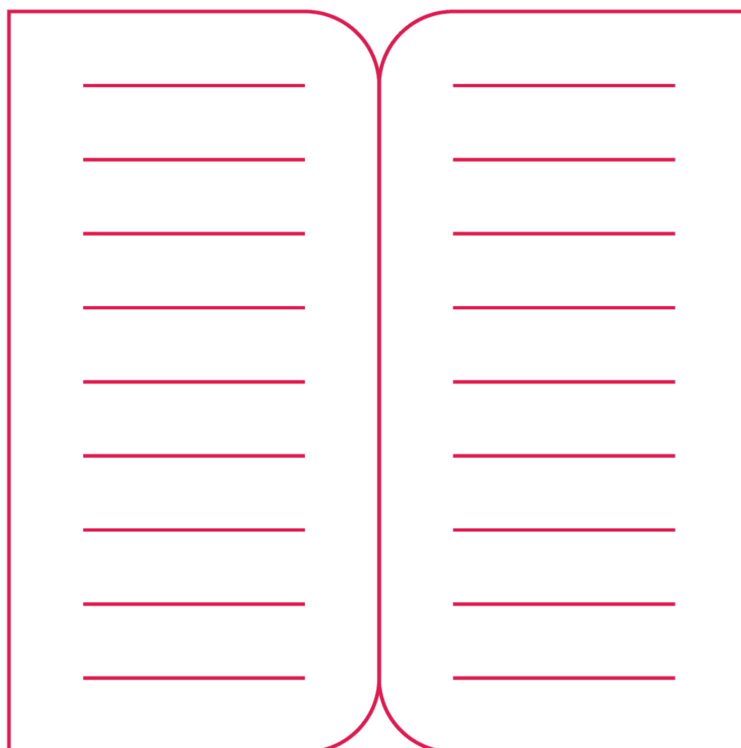
# Curriculum for Broad Based Training Programme

Presented on behalf of the Royal Colleges of General Practitioners, Paediatrics and Child Health, Physicians, and Psychiatrists



# Contents


Section 1: Purpose of the curriculum 4
1.1 Introduction 4
1.2 Purpose and objective of the BBT curriculum 6
1.3 Scope of practice on completion of the curriculum 7
1.4 Curriculum high level learning outcomes 8
1.5 Key interdependencies with other areas of training and practice 9
1.6 BBT supports flexibility and transferability of learning outcomes and performance 9
1.7 Additional information 10

Section 2: Governance and strategic support 12
2.1 Governance 12
2.2 Curriculum development 12
2.3 Input and feedback 13
2.4 Equality and diversity 13

Section 3: Programme of learning 15
3.1 Overview 15
3.2. Ten percent (10%) attachments 15
3.3 BBT high level learning outcomes and mapping to other four specialties 16
3.4 Learning opportunities and styles 17
3.5 BBT curriculum 18

Section 4: Programme of assessments for Broad Based Training 38
4.1 Standards 38
4.1.1 Assessments used in general practice that are relevant to BBT 38
4.1.1.1 Formative assessments in GP 38
4.1.1.2 Summative assessments in GP 39
4.1.2 Assessments used in internal medicine that are relevant to BBT 40
4.1.2.1 Formative assessments In Internal Medicine 40
4.1.2.2 Summative assessments In Internal Medicine 41
4.1.3 Assessments used in paediatrics that are relevant to BBT 41
4.1.3.1 Formative assessments in Paediatrics 41
4.1.3.2 Summative assessments In Paediatrics 43
4.1.4 Assessments used in psychiatry that are relevant to BBT 43
4.1.4.1 Formative assessments In Psychiatry 43
4.1.4.1 Summative assessments In Psychiatry 45
4.2 Summary requirements for BBT / Evidence of progress 45
4.3 Assessment of Learning 47
4.3.1 Overall performance 47
4.3.2 Generic capabilities 47
4.3.3 Clinical capabilities 47
4.4 Additional requirements before entering chosen specialty 50

4.5 Expectations from specialties before entering ST2 / CT2 51

Section 5. Quality assurance and improvement 52
5.1 Organisation of training 52
5.2 Supervision 52
5.2.1 Educational supervisor 53
5.2.2 Clinical supervisor 53
5.2.3 Psychiatric supervisor (for Psychiatry) 53
5.2.4 Trainees 54
5.3 Review of Curriculum and Programme 55

Appendices
1. Key documents and high-level learning outcomes of the four core curricula 56
2. Paediatric Assessment strategy notes 62

Glossary 64

## List of tables

Table 1. BBT high level learning outcomes 8
Table 2. Examples of adjustments possible due to previous training 10
Table 3. BBT learning outcomes 16
Table 4. Generic capabilities for Broad Based Training 18
Table 5. High level learning outcome 8: Clinical and Community Practice (General Practice) 24
Table 6. High level learning outcome 9: Clinical medicine (Internal medicine) 28
Table 7. High level learning outcomes 10: Clinical paediatrics, (Paediatrics) 31
Table 8. High level learning outcome 11: Clinical psychiatry (Psychiatry) 33
Table 9. High level learning outcome 12, Practical procedures 36
Table 10. Decision aid: WBA requirements (indicative numbers) from specialty block requirements by the end of the attached block 46
Table 11. Level descriptors for clinical capabilities 48
Table 12. Competence levels for clinical capabilities 48
Table 13. Additional requirements before entering specialty 51

# Section 1
# Purpose of the curriculum

## 1.1 Introduction

Broad Based Training (BBT) is a two-year structured programme for doctors who have successfully completed the Foundation Programme, providing six-month (indicative time) placements in four specialties to offer a broad experience across healthcare before entering specialty training. The programme provides experiences in the following specialty areas:

- General practice (GP)
- Internal medicine (IM)
- Paediatrics
- Psychiatry.

Successful completion of BBT will ensure that trainees are ready to move into specialist training in any of the four specialty programmes. BBT provides the opportunity for trainees to develop more breadth and general training to allow them to be more versatile and flexible in the future. It gives trainees who are not sure about their career pathway or which medical specialty to follow, more time to explore the options within a UK training programme and make a more confident final decision. This approach meets requirements of the Shape of Training report encouraging joint working and understanding across specialties to the benefit of the public and preparing the future workforce. Therefore, BBT addresses the patient's need for doctors with more generalist training who understand and can deliver healthcare across traditional specialist and service boundaries. Such trainees are more likely to be able to deliver the public's healthcare needs for the future.

The BBT curriculum provides greater contextualised generalist training in a flexible manner. In the long-term this will:

- Enable a greater understanding of the roles, links and interdependence of specialties across acute and community-based medicine enabling a greater understanding of the importance of the 'connectedness' between different parts of the NHS and how these are vital for improving the patient experience
- Promote working with community- and hospital-based non-medical healthcare professionals such as psychologists, pharmacists and advanced nurse practitioners
- Develop a workforce that has a broad base of training allowing greater flexibility for the short term as well as the longer-term
- Contribute breadth of experience to a multiplicity of training pathways if trainees feel they wish to choose another specialty
- Allow trainees to have greater confidence and commitment to their chosen career path

- Enable a workforce that is able to address the challenges of health inequality and the contemporary issues of mental health, child health, lifestyle risk factors such as diet, excess alcohol and smoking
- Provide an opportunity for multi-trained doctors to develop as remote and rural practitioners
- Promote leadership skills and self-directed learning through management and experience of '10%' time spent cross-specialty and being the vanguard of this new curriculum
- Allow services the opportunity to recruit trainees into potentially under-subscribed or expanding specialties.

Only Acute Care Common Stem (ACCS) and BBT provide an opportunity for trainees to explore a selection of related specialties without making a final career selection, within a UK structured GMC-approved training programme.

Each post is for an indicative period of six months (appropriately adjusted for less than full time trainees). It will set the foundations for becoming independent practitioners undertaking life-long learning, as well as giving an understanding of NHS practice and the interdependence of different specialties within healthcare. BBT will enable trainees to develop generic and specialty-specific capabilities across the four identified areas allowing them to experience patient care management across a range of sectors. It will develop practitioners who can:

- Deliver appropriate and timely basic care for acute and chronic conditions in hospital and community settings across the four clinical specialties
- Work in multi-disciplinary teams, being able to coordinate and direct care to health- and social-care professionals most capable of delivering what the patient needs
- Understand the interaction of different medical disciplines, NHS agencies involved in contemporary clinical health care, local authorities, voluntary and faith groups
- Develop a situational awareness in both acute and primary care settings and a comprehensive overall perspective to promote patient orientated personalised decision making
- Be flexible to the healthcare needs of the future.

The principles of BBT align with NHS England's Personalised Care Institute including shared decision making, personalised care, enabling choice and supporting self-management.

During each BBT post, 10% of the training time (ranging from half a day per week to a 2.5 week attachment) will be spent in one of the other three specialties providing opportunity for continuity of training and development of complementary skills that contribute to the BBT learning outcomes. This will provide excellent training, with the trainee following a patient's care across at least two specialty areas simultaneously. This may allow greater training in continuity of patient care; which feedback indicates is highly valued by patients. There is flexibility around what is chosen for the 10% time, but each choice has to be 'signed off' by the educational supervisor, to ensure that it contributes to the learning outcomes. Models for this aspect of training have the potential to vary between trainees and could include, for example, a weekly community-based clinic e.g. Child and Adolescent Mental Health (CAMHS) clinics, a two-week attachment to a neonatal unit or adult high dependency unit, or visits to a joint paediatric / GP integrated care service. This enables the trainee to have flexibility, innovation, and the ability to develop leadership and management skills.

After successful completion of the BBT, trainees will be able to progress directly into the second year in any of the four specialty training programmes without the need for further interview processes.

## 1.2 Purpose and objective of the BBT curriculum

Figure 1. BBT rotation

At the end of the BBT programme the objective is to ensure that the trainee is ready to enter the second year of training in their chosen specialty (one of the four specialties). This is unaffected by changes in the internal medicine and paediatric curricula.

BBT aims to achieve a balance between gaining generic capabilities which can be achieved in any of the four attachments and specialty capabilities. Many of the capabilities required and specified within the respective higher specialty curricula show commonality across GP, internal medicine, level 1 paediatrics and core psychiatry. This includes quality improvement / audit projects, team working, leadership, teaching, research, guidelines and evidence-based approach to medicine, working with patients and families.

There are some specialty-specific capabilities that are required before a trainee starts in the second year of their chosen specialty programme. It is therefore critical that the specialty outcomes are able to explicitly link to the specialty curricula. These have been defined in conjunction with each of the colleges and are incorporated within the BBT curriculum.

### Critical Progress

The BBT programme is managed by a Training Programme Director. During BBT trainees will also be supported by Clinical and Educational supervisors. Over the two years, training achievements will be entered in their BBT e-portfolio. At the end of each year an Annual Review of Competency Progression (ARCP) will be undertaken, leading to a judgement about the trainee's progress. The critical progression point comes at the end of the second year of training. At this point a decision will be made to determine if a trainee has successfully completed BBT. The possible ARCP final outcomes at this stage could be:

- Outcome 3 (needs extra time for training)
- Outcome 4 (not met all required outcomes and released from training)
- Outcome 6 (gained all required competencies with successful completion of training).

The decision to award a successful completion of BBT will be made depending on completing the curriculum, assessed by:

- Achievement of work-based assessments (WBAs)
- Multi-source feedback (MSF) (one for each year)
- Educational supervisor reports (one for each attachment)
- Generic and specialty-specific capabilities
- Practical procedures and teaching attendance.

An ARCP decision aid will be used to ensure that all assessment criteria have been met.

In order to progress to their chosen specialty, in addition to a successful outcome in BBT the following are required (unaltered from previous curriculum):

- For internal medicine, it is highly desirable for trainees to have passed Part 1 MRCP (UK)
- For core psychiatry, trainees must have achieved a second Case Based Discussion Group Assessment (CbDGA). One CbDGA is already required in BBT training. They must also provide evidence of ECT competence e.g. via DOPS
- There are no additional requirements for paediatrics or general practice.
  These requirements are aligned to the GMC-approved curricula for these specialties.

## 1.3 Scope of practice on completion of the curriculum

BBT provides a core level of training, preparing trainees for subsequent specialist training. It allows flexibility and gives trainees time to gain experience of which specialty training programme they may wish to follow, therefore giving them more confidence and commitment to their decision. In addition, the breadth of training allows the trainee to be more holistic, inclusive, and more connected with other specialties and healthcare professions.
Specifically, by the end of BBT training they will be ready to start training in either:

- Specialty Training 2 (ST2) general practice
- Internal Medicine 2 (IM2)
- Core Training 2 (CT2) psychiatry
- Specialty Training year 2 (ST2) paediatrics

Trainees will bring a wide range of generic capabilities which are likely to facilitate accelerated progress through core training. In addition, trainees would be able to apply to other specialty programmes. The BBT capabilities are applicable for and may be transferable to, other programmes if none of the four parent specialties are chosen (see below).

In practice they will need to make their final choice of specialty during their third (out of four) attachments, but they will have had some experience all four specialties either through a main attachment, through 10% time attachments or through both.

## 1.4 Curriculum high level learning outcomes

At the end of the BBT programme of learning, a qualifying trainee will be able to achieve the high-level outcomes as outlined in Table 1 below.

Table 1. BBT high level learning outcomes

| | BBT learning outcomes.<br>At the end of BBT training, you will be able to undertake the following: | GPCs |
|---|---|---|
| 1 | Trainees will demonstrate knowledge of the principles required to practise as a doctor | 1,2,3 |
| 2 | Ethical and legal frameworks: Trainees will demonstrate knowledge and application of ethical and legal frameworks that are relevant to medical practice and how they impact on patient care (e.g. caring for vulnerable patients) | 1,3,6,7 |
| 3 | Health promotion: Trainees will support and deliver health promotion in all age groups | 1,3,4 |
| 4 | Working in a team: Trainees will work and communicate with colleagues to provide an effective team | 1,2,5 |
| 5 | Patient safety: Trainees will know the importance of patient safety in all age groups and be able to demonstrate this in clinical practice | 1,6,7 |
| 6 | Teaching and training: Trainees will demonstrate ability to teach students and train post-graduate medical staff in addition to other healthcare professionals | 8 |
| 7 | Research methods: Trainees will be capable to undertake, evaluate and apply research and evidence-based medicine in practice | 9 |
| 8 | Clinical and community practice: Trainees will be capable to work across the continuum of care between community and hospital, and work with all agencies involved in supporting this | 1,2,3 |
| 9 | Clinical medicine: Trainees will be able to deliver safe basic medical care | 1,2,3 |
| 10 | Clinical paediatrics: Trainees will be able to deliver safe basic paediatric care | 1,2,3 |
| 11 | Clinical psychiatry: Trainees will be able to deliver safe basic mental health care | 1,2,3 |
| 12 | Integrated practical procedures: Trainees will be proficient to perform key practical procedures competently and safely. | 2 |

## 1.5 Key interdependencies with other areas of training and practice

Working across professional boundaries, as well as with other key individuals involved with patient care is integral to the BBT programme. This flexibility gives trainees a greater understanding of the primary / secondary care interface while promoting transferable skills. The 10% time provides an excellent opportunity for trainees to explore cross-specialty and cross-sector working. This includes attachments at specialty clinics in community such as outreach diabetes clinics or sexual health clinics, opportunities to work in falls centres, to work with allied healthcare professionals (e.g. physiotherapy, speech therapy, occupational therapy), community staff (e.g. district nurses, community pharmacy), third sector workers (e.g. Marie Curie nurses) and other services such as time with funeral directors and high street pharmacists. Trainees may also choose time in neonatal intensive care units, high dependency units or other acute settings.

## 1.6 BBT supports flexibility and transferability of learning outcomes and performance

BBT trainees will undertake training in each of general practice, internal medicine, paediatrics and psychiatry. Throughout their training they will have the opportunity to choose to continue in any of these four specialties upon successful completion of the programme but without the need for entering a further interview process. Trainees choose their final specialty most commonly nine months before finishing BBT. This is just before specialty posts are advertised, allowing specialties to advertise for one fewer specialty post, so that the BBT trainee can be accommodated.

Trainees who successfully complete BBT will have a range of broad capabilities aligned to the GMC's Generic Professional Capabilities (GPCs) which will readily be transferable if they wish to enter another specialty separate to one of the four within the programme. The key clinical and communications skills learned in the three specialties that they had chosen not to pursue will still be beneficial to them throughout their career, as they are generic and can be contextualised within the chosen specialty and also support a more holistic approach to patient management. The successful BBT trainee will have greater awareness of the issues affecting these other specialties and a general awareness of the difficulties faced across healthcare delivery. Some trainees choose BBT having already decided which career to pursue because they specifically want to gain training in another specialty area that they would not otherwise have had access to e.g. a career physician wanting experience in psychiatry, general practice or in paediatrics where experience of transition of adolescents to adult medicine in patients with chronic medical conditions is essential.

In addition, trainees who move across training programmes and have previously gained relevant capabilities can have these assessed following the Academy of Medical Royal Colleges *Guidance for Flexibility in Postgraduate Training and Changing Specialties* (2020). This may allow a shortened training time and would be assessed at the first ARCP meeting. Trainees who have already spent post-Foundation time in one of the parent specialties would have some of this time recognised for BBT training, up to a maximum of six months for each specialty previously undertaken but with an overall maximum of 12 months being recognised.

For trainees transferring to BBT from other programmes, Table 2 provides examples of what may be considered. These are indicative examples, and an individual approach will be taken for each trainee using the principles in the Academy document *Guidance for Flexibility in Postgraduate Training and Changing Specialties* (2020). Trainees entering BBT who have experience in specialties other than GP, internal medicine, paediatrics and psychiatry will also be considered for gaining recognition of prior capabilities.

Table 2. Examples of adjustments possible due to previous training

| Previous CCT programme | Duration in previous programme | Possible recognition of previous training* | Minimum residual time required to complete the BBT programme |
|---|---|---|---|
| Psychiatry | 6 months | 0-6 months psychiatry | 18 months |
| Internal medicine<br>Paediatrics | 6 months<br>12 months | 0-6 months<br>0-6 months | 12 months |
| GP<br>Internal medicine<br>Psychiatry | 6 months<br>6 months<br>6 months | 0-6 months<br>0-6 months<br>0-6 months | 12 months |

*depending on ARCP panel assessment of previous competencies accomplished

Trainees are entitled to opt for Less than Full Time Training (LTFT). Time on out of hours rotas would be on a pro-rata basis of what is expected of their full-time colleagues. The length of time of training would also be on a pro-rata duration of the normal training time, which will allow LTFT trainees to achieve the required capabilities and assessments. The duration of training would be addressed at the ARCP.

## 1.7 Additional information

The BBT programme has undergone robust analysis by the University of Cardiff as published in the 2017 *Evaluation of Broad Based Training* report on behalf of the Academy of Medical Royal Colleges, Health Education England and Cardiff University. It reported that trainees saw BBT as a positive choice and not just a way to delay decision making. BBT training gave them greater confidence, contentment, and conviction in their decision-making. They were particularly skilled at managing complexity and offering patient-focussed care. The Q-sort analysis showed that BBT attracted a wide range of individuals and not just those with a generalist disposition but also those open-minded to specialist learning. In addition to the obvious skills obtained, the 10% time part of the curriculum strengthened aspects of self-directed learning, confidence and leadership skills.

In addition, in a survey of trainees applying to the Scottish BBT programme, 22% indicated that they would have gone abroad if they had not been offered a BBT post.

A summary of the study was also published in the open British Medical Journal (Bullock et al BMJ Open 2018;8: e021388). It showed that BBT trainees were more confident than comparator trainees that their training would result in:

- Understanding how specialties complement one another
- A wider perspective of healthcare provision
- The ability to apply learning across related specialties
- Being adept at managing patients with complex medical presentations
- A grounding in providing patient-focussed care.

BBT trainees and their supervisors also considered that they were better able to tailor patient referrals and consider psychological as well as physical needs.

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

# Section 2
# Governance and strategic support

## 2.1 Governance

Broad Based Training (BBT) is supported by a unified four-nation Governance Group which meets 2-3 times per year. The Group comprises the following members:

- Representatives from the Royal College of General Practitioners
- Representatives from the Royal College of Physicians / JRCPTB
- Representatives from the Royal College of Paediatrics and Child Health
- Representatives from the Royal College of Psychiatry
- Training Programme Directors from the nations involved in delivering BBT
- Associate postgraduate deans from the nations involved in delivering BBT
- UK Lead Dean for Broad Based Training
- Trainee representatives from the nations involved in delivering BBT
- Lay Representative
- Representative from the Academy of Medical Royal Colleges.

The Governance Group's terms of reference outline the following responsibilities:

- To provide good governance for the BBT programme in all member countries of the UK as appropriate
- To ensure that the Governance Group is informed by representatives of the four colleges (JRCPTB, RCGP, RCPsych and RCPCH) of all changes to curricula that will impact the BBT programme
- To ensure that the BBT curriculum is updated by representatives of the relevant college, and that Deans in the relevant countries are informed promptly of any changes
- To provide a voice for BBT trainees, training programme directors, and Deans
- To approve new BBT training posts
- To consider curriculum changes.

The programme delivery is reviewed and adapted according to feedback from trainees, trainers, and quality feedback processes.

## 2.2 Curriculum development

The curriculum combines the four parent specialty core curricula by taking the key descriptors from each and integrating them into the BBT generic capabilities. Specialty-specific capabilities from each curricula also populate the specialty-specific outcomes within the curriculum.

Therefore the learning outcomes directly reflect those in the four specialty-specific core curricula.

Assessments will reflect the assessments used in the core specialties, but the number and frequency of assessments will reflect the duration of the BBT attachments.

## 2.3 Input and feedback

The BBT Governance Group developed the new curriculum after each parent specialty had published their own curriculum so that the BBT curriculum could reflect the changes made by the parent specialties.

Feedback on BBT has been sought from the following sources:

- GMC National Training Survey
- Scottish National Training Surveys
- University of Cardiff report on Broad Based Training
- Preliminary report from Scottish Medial Education Research Collaboration (SMERC)
- Regular reports from the BBT Governance Group
- Feedback from BBT training days
- Academy of Medical Royal Colleges web-based survey.

## 2.4 Equality and diversity

BBT training will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010. Equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the medical profession.

LETBs / deaneries' quality assurance processes will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by the 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
- LETBs / deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every three years
- LETBs / 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 that trainees have an appropriate, confidential, and supportive route to report examples of inappropriate behaviour of a discriminatory nature. LETBs / deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route by which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. LETBs / 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)
- 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
- Ensuring all efforts are made to ensure the participation of people with a disability in training through reasonable adjustments
- Raising awareness and training in unconscious bias.

# SECTION 3
# Programme of learning

## 3.1 Overview

There are 12 High Level Learning Outcomes (HLOs) in the BBT curriculum (Table 3). These are broad capabilities that need to be achieved during BBT. Each has been developed in more detail with specific descriptors or requirements. They reflect the capabilities outlined in each of the four parent specialties (general practice, internal medicine, paediatrics and psychiatry). The common generic capabilities required across the four core specialty curricula (such as, principles of practice, teaching, research, quality improvement etc) have been integrated into the generic BBT capabilities. These also include some more specific capabilities. For example, safeguarding that may traditionally be considered as specialty specific. Although obviously relevant to paediatrics this capability, also relates to other specialties such as psychiatry and therefore has been included as a generic capability. All generic capabilities are incorporated into BBT outcomes 1 to 7 (Table 4).

BBT outcomes 8-11 describe specialty-specific capabilities that are not already covered within the generic capabilities. Outcome 8 is for general practice (Table 5), outcome 9 for internal medicine (Table 6), outcome 10 for paediatrics (Table 7) and outcome 11 for psychiatry (Table 8). Outcome 12 describes practical procedures in which trainees are required to become proficient across all four specialties (Table 9). Feedback from trainees using the previous BBT curriculum has indicated that to focus these capabilities in this way would be helpful.

Each of the required capabilities identified in general practice, internal medicine (phase 1), Level 1 paediatrics and core psychiatry have been numbered (Appendix 1) and mapped across to the BBT objectives as shown in Table 3. This will aid in identifying where specialty-specific objectives are 'housed' within the BBT curriculum, which should help in particular when trainees move on to their chosen specialty after BBT has been completed. Table 3 also maps each objective to the Generic Professional Capabilities as outlined by the GMC.

Trainees are encouraged to collect evidence of capability acquisition and discuss their progress with their educational and clinical supervisors throughout their training programme.

## 3.2. Ten percent (10%) attachments

During each specialty placement (6 months indicative time) trainees will spend 10% of their time in one of the other three specialties. This can be done as anything between half a day per week, to a 2-2.5-week block and allows flexibility for deaneries to design programmes or some other intermediary arrangement. This means that for each specialty there will be a main placement of 90%, and an additional attachment of 10% within a different specialty (a total of 100% in each of the four specialties over the two years).

The 10% time needs to be agreed by the Educational Supervisor or TPD but it is designed to allow trainees to shape their own training to give them educational opportunities that may promote special interest areas. It provides an opportunity for trainees to be innovative, but it also requires management and organisational skills to implement.

## 3.3 BBT high level learning outcomes and mapping to the other four specialties

Table 3 summarises the BBT High Level Learning Outcomes. They are mapped to the GPC Domains and to the specialty High Level Learning Outcomes (HLO) from the four parent curricula. When mapping against the four parent curricula, the numbering used follows the HLOs in the order of each curriculum. The detail is shown in Appendix 1.

Table 3. BBT learning outcomes

| | BBT High Level Learning Outcomes. At the end of BBT training, you will be able to undertake the following: | GPCs | GP HLO n=13 | MED HLO n=14 | PAED HLO n=11 | PSY HLO n=9 |
|---|---|---|---|---|---|---|
| 1 | Trainees will demonstrate knowledge of the principles required to practise as a doctor | 1,2,3 | 1,2 | 1,3 | 1,2 | 1,2,3 |
| 2 | Ethical and legal frameworks: Trainees will demonstrate knowledge and application of ethical and legal frameworks that are relevant to medical practice and how they impact on patient care (e.g., caring for vulnerable patients) | 1,3,6,7 | 2 | 2 | 1 | 3 |
| 3 | Health promotion: Trainees will support and deliver health promotion in all age groups | 1,3,4 | 8,12,13 | 3,5 | 5 | 1,3,4 |
| 4 | Working in a team: Trainees will work and communicate with colleagues to provide an effective team | 1,2,5 | 3,7,9,11 | 3,9,11 | 2,6 | 1,2,5 |
| 5 | Patient safety: Trainees will know the importance of patient safety in all age groups and be able to demonstrate this in clinical practice | 1,6,7 | 8,10,12 | 4 | 7,9 | 1,6,7 |
| 6 | Teaching and training: Trainees will demonstrate ability to teach students and train post-graduate medical staff in addition to other healthcare professionals | 8 | 10 | 6 | 10 | 8 |

|  | BBT High Level Learning Outcomes. At the end of BBT training, you will be able to undertake the following: | GPCs | GP HLO n=13 | MED HLO n=14 | PAED HLO n=11 | PSY HLO n=9 |
|---|---|---|---|---|---|---|
| 7 | Research methods: Trainees will be capable to undertake, evaluate and apply research and evidence-based medicine in practice | 9 | 6,10 | 4,5 | 8,11 | 9 |
| 8 | Clinical and community practice: Trainees will be capable to work across the continuum of care between community and hospital, and work with all agencies involved in supporting this | 1,2,3 | 3,4,5,6, 7,11,12, 13 | 11 |  | 1,2,3 |
| 9 | Clinical medicine: Trainees will be able to deliver safe basic medical care | 1,2,3 | 7,8 | 7-14 |  |  |
| 10 | Clinical paediatrics: Trainees will be able to deliver safe basic paediatric care | 1,2,3 |  | 11 | 1,3,4 |  |
| 11 | Clinical psychiatry: Trainees will be able to deliver safe basic mental health care | 1,2,3,7 | 5 | 11 | 3 | 1,2,3,7 |
| 12 | Integrated practical procedures: Trainees will be proficient to perform key practical procedures competently and safely | 2 | 5 | 7,8 | 3 | 2 |

Assessment of the capabilities will be underpinned by descriptors for each outcome. Assessments from each of the four specialty areas are identified which may be helpful in demonstrating the capability, but these are designed to be advisory and are not meant to be restrictive.

## 3.4 Learning opportunities and styles

There are a variety of learning opportunities, all of which should be encouraged and used depending on the learning environment. These include:

- Formative assessments using supervised learning events (SLEs)
- Simulation. There are opportunities in each specialty for simulated learning within skills laboratories. The potential for this is expected to increase with time
- Work-based experiential learning
- Opportunities for concentrated practice in skills and procedures. The ‘10% time’ is a particularly good opportunity for dedicated and protected learning of this type. Skills Laboratories with simulation are available in many hospitals to enhance this experience

- Learning with peers. BBT trainees will be involved in local training opportunities delivered to core staff in the specialty they train in, allowing them to learn with their peers. In addition, there will be 2-3 dedicated days per year for study days exclusively for BBT trainees, where part of the day is protected for peer-to-peer learning. This also promotes best practice across geographical areas
- Learning in formal situations inside and outside the department. This includes formal study days, lectures, conferences etc
- Personal study. This will be encouraged including opportunities for personal reflection.

## 3.5 BBT curriculum

The curriculum provides descriptors of the capabilities (Table 4). These provide means of evidencing how the outcomes may be achieved. It also links these to the GMC's GPCs, and maps them across to the Learning outcomes in the four parent specialties. Finally, there is a summary of suitable assessment methods which would provide evidence for each capability. These will be signed off in e-portfolios as either 'achieved' or 'not achieved'. Further detail of each assessment tool is provided in Section 4.

Table 4. Generic capabilities for Broad Based Training

| 1. Able to function in the health service organisation and management systems | |
|---|---|
| Descriptors | — Demonstrate attitudes and behaviours expected of a good doctor (Good Medical Practice guidance) and adhere to the GMC professional requirements<br>— Show compassion, empathy, and respect for patients and families<br>— Demonstrate effective consultation skills<br>— Demonstrate effective examination skills<br>— Use all clinical information to develop a management plan<br>— Evaluate and reflect on your own practice and seek feedback on performance<br>— Communicate effectively in writing and verbally with patients, relatives and colleagues, including where there may be barriers e.g. hearing, cognition, capacity, inequalities<br>— Demonstrate the ability to consult by telephone and / or video consultation in addition to face-to-face consultation and also reflecting patient need and choice<br>— Share decision making with relevant other individuals e.g. patients, relatives, colleagues<br>— Manage factors influencing their behaviour and wellbeing. Seek timely support and guidance including acknowledging if you have a protected characteristic that might impact on your training<br>— Demonstrate promotion of an honest open and transparent culture<br>— Take action when aware of poor or unsafe practice and raises concerns if necessary |

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| | — Demonstrate self-awareness and reflection of own limitations and recognise when to escalate problems<br>— Keep practice up to date through learning and teaching<br>— Use resources wisely<br>— Manage the impact of a complaint<br>— Demonstrate ability to be flexible, lead, use initiative, be able to prioritise and effectively manage your time and resources<br>— Recognise and address systemic and structural inequalities, intersectionality, and their impact on clinical outcomes and on working relationships with colleagues |
| GPCs: | **1.** Professional values and behaviour<br>**2.** Professional skills<br>**3.** Professional knowledge |
| Mapping to four specialty curricula | General Practice HLOs: 1, 2,3, 4<br>Internal Medicine HLOs: 1,3,9<br>Paediatric HLOs: 1,2<br>Psychiatry HLOs:1,2,3,5 |
| Assessments:<br><br>[1]Paediatric version<br>[2]Includes safeguarding CbD | General Practice: CBD, COT, MSF, Audio COTs<br>Internal Medicine: MCR, MSF, PS, MRCP, ACAT, mini-CEX,<br>Paediatric: CbD[1, 2], mini-CEX[1], DOC, LEADER, ACAT, HAT, MSF[1], CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP)<br>Psychiatry: ACE, mini-ACE, CbD, mini-PAT, MRCPsych (Paper A), DONCS, Journal club presentation, reflective practice |
| 2. Can work within an ethical and legal framework | |
| Descriptors: | — Follow the principles of the law with regard to confidentiality, consent, right to refuse treatment, death of a child, safeguarding and vulnerable groups<br>— Apply knowledge of key mental health legislation<br>— Behave in accordance with ethical and legal requirements<br>— Demonstrate ability to offer apology or explanation when appropriate<br>— Treat others fairly without discrimination<br>— Discuss ethical dilemmas and differing opinions with patients, carers and colleagues<br>— Manage advanced directives and DNR and consider capacity issues<br>— Demonstrate ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently<br>— Anticipate and manage situations in which your personal and professional interests might be brought into conflict<br>— Take appropriate action when you become aware of people acting in an abusive, bullying or intolerant manner |

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| | — Demonstrate partnership and shared decision making that is clear concise, non-discriminatory and non-judgemental, by valuing patients' ideas, values, concerns and expectations |
| GPCs: | **1** Professional values and behaviour<br>**6** Capabilities in patient safety and quality improvement<br>**7** Capabilities in safeguarding vulnerable groups |
| Mapping to four specialty curricula | General Practice HLOs: 1,2, 3,5<br>Internal Medicine HLO: 2<br>Paediatric HLO: 1<br>Psychiatry HLOs: 1,3,6,7 |
| Assessments:<br>[1]Paediatric version<br>[2]Includes safeguarding CbD | General Practice: CBD, COT, MSF,<br>Internal Medicine: MCR, MSF, CbD, DOPS, mini-CEX, MRCP(UK), ALS<br>Paediatric CbD[1, 2], mini-CEX[1], DOC, LEADER, ACAT, HAT, MSF[1], CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP)<br>Psychiatry: ACE, mini-ACE, DONCS, CbD, mini-PAT, reflective practice |
| **3. Able to engage in health promotion** | |
| Descriptors: | — Demonstrate knowledge of public health issues including population health, epidemiology, social determinants of health and global health perspectives<br>— Demonstrate the holistic mind-set of a generalist medical practitioner<br>— Build relationships with the communities with which you work<br>— Enable people living with long-term conditions to improve their health<br>— Adopt safe and effective approaches for patients with complex health needs<br>— Understand the impact of social environment, mental health, discrimination and inequalities on health and disability<br>— Able to discuss child health inequalities and the impact on children's health |
| GPCs: | **1** Professional values and behaviour<br>**3** Professional knowledge<br>**4** Capabilities in health promotion and prevention |
| Mapping to four specialty curricula | General Practice HLOs: 8,12,13<br>Internal Medicine HLOs: 3,5<br>Paediatric HLO: 5<br>Psychiatry HLOs: 1,3,4 |
| Assessments:<br>[1]Paediatric version | General Practice: CBD, COT, MSF, Audio COT<br>Internal Medicine: MCR, MSF, PS, MRCP(UK) |

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| | Paediatric: CbD[1], mini-CEX[1], DOC, LEADER, HAT, MSF[1], CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP)<br>Psychiatry: ACE, miniACE, CbD, DONCS, mini-PAT, MRCPsych (Paper A) |
| 4. Can work effectively in teams | |
| Descriptors: | — Establish and maintain a relationship with patients and carers<br>— Ensure that patients' values, concerns and expectations are at the heart of clinical decision making<br>— Demonstrate an understanding that patients may define a good outcome differently from a healthcare professional<br>— Establish and maintain a relationship with colleagues of all professional groups<br>— Actively participate across a range of teams<br>— Demonstrate effective clinical leadership<br>— Involve and coordinate timely care with other professionals and services (including social care)<br>— Apply management and team working skills appropriately, including influencing, negotiating, reassessing priorities and effectively managing complex, dynamic situations to improve organisational performance<br>— Develop the financial and business skills required for your role<br>— Make effective use of information management and communication systems<br>— Involved in local Clinical Governance initiatives<br>— Understand the limits of your clinical capabilities, seeking timely support and supervision when appropriate |
| GPCs: | **1** Professional values and behaviour<br>**2** Professional skills<br>**5** Capabilities in leadership and team working |
| Mapping to four specialty curricula | General Practice HLOs: 1,3,7,9,11<br>Internal Medicine HLOs: 3,9,11<br>Paediatric HLOs: 2,6<br>Psychiatry HLOs: 1, 2, 3, 5,6 |
| Assessments:<br>[1]Paediatric version<br>[2] Includes safeguarding CbD | General Practice: CBD, COT, MSF<br>Internal Medicine: MCR, MSF, ACAT, CbD, PS, MRCP(UK)<br>Paediatric: CbD[1,2], mini-CEX[1], DOC, LEADER, ACAT, HAT, MSF[1], CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP)<br>Psychiatry: CbD, MRCPsych (paper A), ACE, mini-ACE, DONCS, mini-PAT |

| 5. Able to deliver patient safety | |
|---|---|
| Descriptors: | — Safely prescribe for both adults and children<br>— Follow local procedure for serious incidents and medication errors<br>— Continuously evaluate and improve the care provided and from patient safety investigations and complaints<br>— Avoid organising unnecessary investigations or prescribing poorly evidenced treatments<br>— Support people through individual experiences of health, illness and recovery<br>— Understand basic Human Factors principles and practice at individual, team, organisational and system levels<br>— Recognise situations where safeguarding may be an issue<br>— Apply knowledge of local interagency procedures for children in need of safeguarding support<br>— Apply knowledge of how to act in cases of suspected abuse or disclosure, and how to escalate a safe response<br>— Recognises the long-term impact of adverse childhood experiences, including maltreatment and the system of adoption and fostering.<br>— Demonstrate specialist knowledge of the individual and systemic factors contributing to the vulnerabilities and safeguarding concerns in people of all ages with mental disorders<br>— Work within legislative frameworks and local processes to raise and report safeguarding concerns in a timely manner and contributes to safeguarding processes |
| GPCs: | **1** Professional values and behaviour<br>**6** Capabilities in patient safety and quality improvement:<br>**7** Capabilities in safeguarding vulnerable groups |
| Mapping to four specialty curricula | General Practice HLOs: 8,10,12<br>Internal Medicine HLO: 4<br>Paediatric HLOs: 7,9<br>Psychiatry HLOs: 2,6,7 |
| Assessments:<br>[1]Paediatric version<br>[2] includes safeguarding CbD | General Practice: CBD, COT, MSF,<br>Internal Medicine: MCR, MSF, QIPAT<br>Paediatric: CbD[1,2], mini-CEX[1], DOC, LEADER, ACAT, HAT, MSF[1], CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP)<br>Psychiatry: CbD, MRCPsych (paper A) |

| 6. Able to deliver teaching and training | |
|---|---|
| Descriptors: | — Deliver effective teaching and training to medical students, junior doctors and other health care professionals<br>— Deliver effective feedback with action plan<br>— Supervise less experienced trainees in their clinical assessment and management of patients<br>— Supervise doctors in earlier stages of training |
| GPCs: | **8** Capabilities in education and training |
| Mapping to four specialty curricula | General Practice HLO: 10<br>Internal Medicine HLO: 6<br>Paediatric HLO: 10<br>Psychiatry HLO: 8 |
| Assessments:<br>[1]Paediatric version | General Practice: CBD, MSF,<br>Internal Medicine: MCR, MSF, TO, Relevant training course<br>Paediatric: mini-CEX[1], LEADER, ACAT, HAT, MSF[1], CCF, DOPS,<br>Psychiatry: AoT, CP, JCP, mini-PAT |
| 7. Can undertake research and understand research methods | |
| Descriptors: | — Adopt scientific and evidence-based approach to clinical practice<br>— Critically appraise research and explains findings to patients, carers, and colleagues<br>— Contribute to and delivers quality improvement initiatives<br>— Understand principles of research and academic writing<br>— Demonstrate appropriate knowledge of research principles and concepts and the translation of research into practice |
| GPCs: | **9** Capabilities in research and scholarship |
| Mapping to four specialty curricula | General Practice HLOs: 6,10<br>Internal Medicine HLOs: 4,5<br>Paediatric HLOs: 8,11<br>Psychiatry HLOs: 6,9 |
| Assessments:<br>[1]Paediatric version | General Practice CBD, QIP, MSF,<br>Internal Medicine: QIPAT, MCR, MSF, MRCP(UK), GCP, literature search, critical appraisal of research, use of clinical guidelines, research activity<br>Paediatric: mini-CEX[1], LEADER, ACAT, HAT, MSF[1], DOPS, MRCPCH (FOP / TAS / AKP)<br>Psychiatry: AoT, CP, JCP, CbD, MRCPsy (Part B) |

## General Practice

Table 5. High level learning outcome 8: Clinical and Community Practice (General Practice)

*These areas also map to HLO 11 in internal medicine (Managing medical problems in patients in other specialties. See Appendix 1)*

| 8.1 Communication and consultation: (maps to GP HLO 3) | |
|---|---|
| Descriptors | — Use the general practice consultation to bring about an effective and collaborative doctor–patient relationship, with respect for their patient's autonomy<br>— Manage the additional challenge of consultations with patients who have different languages, cultures, beliefs and educational backgrounds from their own |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills |
| Assessments | CBD, MSF, COT, Audio COT |
| 8.2 Applying a structured approach to data gathering and investigation: (maps to GP HLO 4) | |
| Descriptors | — Demonstrate proficiency in interpreting the patterns of symptoms, signs and other findings that, in a non-selected population, may signify potentially significant risk and respond accordingly<br>— Apply techniques that enable you to assess, monitor and review patients with undifferentiated presentations safely, and allow diagnostic information to be synthesised over time<br>— Tailor your clinical approaches to the contexts in which you work, considering additional sources of information and the appropriate use of investigations<br>— Demonstrate understanding of how the predictive value of symptoms, signs and investigations may vary and apply this to your decision-making<br>— Demonstrate proficiency in identifying and managing the self-limiting health conditions that commonly present in the community<br>— Demonstrate understanding of the mechanisms through which apparently simple health problems may become chronic, complex and severe (known as 'yellow flags') |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**3** Professional knowledge<br>**4** Capabilities in health promotion and prevention |
| Assessments | CBD, MSF, COT, Audio COT |

| 8.3 Clinical and examination skills (maps to GP HLO 5) | |
|---|---|
| Descriptors | — Identify individual cultural and ethical issues relating to examinations and discuss these sensitively with the patient to ensure their understanding and informed consent<br>— Perform and accurately interpret focused clinical examinations in challenging or suboptimal circumstances<br>— Understand the appropriate use of chaperones |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**7** Capabilities in safeguarding vulnerable groups |
| Assessments | CBD, MSF, COT, CEPs |
| 8.4 Making decisions (maps to GP HLO6) | |
| Descriptors | — Apply guidelines and use decision aids (such as algorithms and risk calculators) where appropriate for clinical decisions<br>— Address problems that may present early and in the course of an illness recognising when to act and when to defer a decision if safe and appropriate to do so<br>— Recognise the inevitable uncertaintyin general practice problem-solving, sharing uncertainty and risk with the patient where appropriate<br>— Demonstrate skills in the decision-making required for managing urgent, unfamiliar, unpredictable and other high-risk clinical situations |
| GPCs | **2** Professional skills<br>**5** Capabilities in leadership and team working |
| Assessments | CBD, MSF, COT, Audio COT |
| 8.5 Clinical management (map to GP HLO 7) | |
| Descriptors | — Demonstrate the knowledge and skills required to provide general medical care in the community setting to patients of all backgrounds and consider the needs of carers and family<br>— Formulate and implement appropriate management plans for the full range of health conditions that you are likely to encounter in the community<br>— Provide 'safety-netting advice' appropriate for primary care setting checking the patient's and carer's understanding<br>— Respond rapidly, skilfully and safely toemergencies<br>— Ensure appropriate follow up for patients who have experienced a medical emergency or serious illness appropriately, also considering the needs of their carers and family |

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|---|---|
| | — Understand your role in coordinating care for patients of all ages and backgrounds |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**3** Professional knowledge<br>**6** Capabilities in patient safety and quality improvement |
| Assessments | CBD, MSF, COT, Audio COT |
| 8.6 Managing medical complexity (maps to GP HLO 8) | |
| Descriptors | — Recognise how health conditions commonly coexist and interact<br>— Undertake a problem-based approach to identify, clarify and prioritise the needs of patients with multiple problems<br>— Recognise the risk of over diagnosis, diagnostic overshadowing and clinical stereotyping when dealing with patients who have been labelled with complex diagnoses<br>— Minimise the overall treatment burden and to use resources cost-effectively, considering human resources and environmental impacts<br>— Effectively signpost and 'navigate' patients with multiple problems along and between care pathways, enabling them to access clinical teams and services appropriately<br>— Recognise the limitations and challenges of applying single disease clinical evidence and protocols to the care of patients with multi-morbidity and complex needs<br>— Manage the inevitable uncertainty in complex problem-solving through an enhanced use of risk assessment, surveillance, and by seeking timely advice from colleagues |
| GPCs | **2** Professional skills<br>**6** Capabilities in patient safety and quality improvement |
| Assessments | CBD, MSF, COT, Audio COT |
| 8.7 Organisational management and leadership (maps to GP HLO 11) | |
| Descriptors | — Routinely record and appropriately code each clinical contact in a timely manner and follow the record-keeping and data governance requirements of your organisation<br>— Make effective use of information and communication systems |
| GPCs | **1** Professional values and behaviour<br>**3** Professional knowledge |
| Assessments | CBD, MSF, Audio COT |

| 8.8 Practising holistically, promoting health and safeguarding (maps to GP HLO 12) | |
|---|---|
| Descriptors | — Take account of the physical, psychological, and social impact of ill health on the patient and how it affects their daily functioning<br>— Provide high-quality, holistic and comprehensive care flexibly to groups of patients with differing healthcare needs<br>— Recognise the impact of the problem on the patient's family and carers, providing support, and involving them in decisions where appropriate<br>— Demonstrate interpersonal skills to challenge unhelpful health beliefs or behaviours while maintaining a continuing and constructive relationship |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**4** Capabilities in health promotion and prevention<br>**7** Capabilities in safeguarding vulnerable groups |
| Assessments | CBD, MSF, COT, Audio COT |
| 8.9 Community Orientation (maps to GP HLO 13) | |
| Descriptors | — Demonstrate awareness and value of both the shared and diverse health characteristics of the local populations, and identify any relevant 'at-risk' groups<br>— Demonstrate approaches that balance the needs of individual patients with the health needs of the local community, within available resources<br>— Understand your role in a health care system that serves a continuum of individuals, families, and communities |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills |
| Assessments | CBD, MSF |

## Internal Medicine

Table 6. High level learning outcome 9: Clinical medicine (Internal medicine)

| 9.1 Managing an acute unselected and specialty take | |
|---|---|
| Descriptors | — Performs accurate clinical examinations<br>— Shows appropriate clinical reasoning by analysing physical and psychological findings<br>— Formulates an appropriate differential diagnosis<br>— Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required<br>— Uses an evidence-based approach<br>— Explains clinical reasoning behind diagnostic and clinical management decisions to patients / carers / guardians and other colleagues<br>— Appropriately selects, manages and interprets investigations<br>— Recognises need to liaise with specialty services and refers where appropriate |
| GPCs | **1** Professional values and behaviours<br>**2** Professional skills<br>**3** Professional knowledge<br>**4** Capabilities in health promotion and illness prevention<br>**5** Capabilities in leadership and team working<br>**6** Capabilities in patient safety and quality improvement |
| Assessments | MCR, MSF, CbD, ACAT, MRCP(UK), Logbook of cases, Simulation training with assessment |
| **9.2 Provide continuing care to medical in-patients** | |
| Descriptors | — Delivers patient centred care including shared decision making<br>— Demonstrates effective consultation skills<br>— Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required<br>— Explains clinical reasoning behind diagnostic and clinical management decisions to patients / carers / guardians and other colleagues<br>— Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take<br>— Recognises need to liaise with specialty services and refers where appropriate |

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|---|---|
| | — Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions)<br>— Demonstrates awareness of the quality of patient experience |
| GPCs | 1 Professional values and behaviours<br>2 Professional skills<br>3 Professional knowledge<br>4 Capabilities in health promotion and illness prevention<br>5 Capabilities in leadership and team working<br>6 Capabilities in patient safety and quality improvement |
| Assessments | MCR, MSF, mini-CEX, ACAT, DOPS, MRCP(UK) |
| **9.3 Managing patients in an outpatient clinic, ambulatory or community setting** | |
| Descriptors | — Delivers patient-centred care including shared decision making<br>— Demonstrates effective consultation skills<br>— Formulates an appropriate diagnostic and management plan, taking into account patient preferences<br>— Explains clinical reasoning behind diagnostic and clinical management decisions to patients / carers / guardians and other colleagues<br>— Appropriately manages comorbidities in outpatient clinic, ambulatory or community setting<br>— Demonstrates awareness of the quality of patient experience<br>— Demonstrates ability to discharge patients safely with clear ongoing instruction (e.g. in letters) |
| GPCs | 1 Professional values and behaviours<br>2 Professional skills<br>3 Professional knowledge<br>5 Capabilities in leadership and team working |
| Assessments (and suggested evidence) | MCR, ACAT, mini-CEX, PS, MRCP(UK), Letters generated at outpatient clinics |
| **9.4 Managing a multi-disciplinary team** | |
| Descriptors | — Applies management and team working skills appropriately, including influencing, negotiating, continuously reassessing priorities and effectively managing complex, dynamic situations<br>— Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover<br>— Effectively estimates length of stay |

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| | — Delivers patient centred care including shared decision making<br>— Develops appropriate discharge plan with patient / carer starting from admission<br>— Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge |
| GPCs | **1** Professional values and behaviours<br>**2** Professional skills<br>**5** Capabilities in leadership and team working |
| Assessments | MCR, MSF, ACAT, MRCP[UK], discharge summaries |
| **9.5 Delivering effective resuscitation and managing the acutely deteriorating patient** | |
| Descriptors | — Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious<br>— Demonstrates the professional requirements and legal processes associated with consent for resuscitation<br>— Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families<br>— Demonstrates competence in carrying out resuscitation |
| GPCs | **1** Professional values and behaviours<br>**2** Professional skills<br>**3** Professional knowledge<br>**5** Capabilities in leadership and team working<br>**6** Capabilities in patient safety and quality improvement<br>**7** Capabilities in safeguarding and vulnerable groups |
| Assessments | MCR, DOPS, ACAT, MSF, MRCP[UK], ALS, Logbook of cases, Reflection, Simulation training with assessment |
| **9.6 Managing end of life and applying palliative care skills** | |
| Descriptors | — Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs with patient / carer<br>— Identifies the dying patient and develops an individualised care plan, with the patient / carer, being aware of different cultural and faith requirements including anticipatory prescribing at end of life<br>— Demonstrates safe and effective use of syringe pumps in the palliative care population<br>— Able to manage non-complex symptom control including pain<br>— Facilitates referrals to specialist palliative care across all settings |

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| | — Demonstrates effective consultation skills in challenging circumstances<br>— Demonstrates compassionate professional behaviour and clinical judgement |
| GPCs | **1** Professional values and behaviours<br>**2** Professional skills<br>**3** Professional knowledge |
| Assessments | MCR, CbD, Mini-CEX, MSF, MRCP(UK), Regional teaching, Reflection |

## Paediatrics

Table 7. High level learning outcomes 10: Clinical paediatrics, (Paediatrics)

*These areas also map to HLO 11 in internal medicine (Managing medical problems in patients in other specialties. See Appendix 1)*

| 10.1 Ethical and legal issues in children (maps to paediatric HLO 1) | |
|---|---|
| Descriptors | — Applies knowledge of how the law applies to paediatric practice<br>— Understands importance of confidentiality and consent in the paediatric context<br>— Understands and works with principles of parental responsibilities<br>— Uses local and national guidelines when considering withdrawing and withholding life-sustaining treatments, including in neonates<br>— Acts as an advocate for the child |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**6** Capabilities in patient safety and quality improvement<br>**7** Capabilities in safeguarding vulnerable groups |
| Assessments | CbD, mini-CEX, DOC, LEADER, ACAT, HAT, MSF, CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP) |
| 10.2 Professional skills and knowledge: Clinical communication and examination (maps to Paediatric HLO 2, 3) | |
| Descriptors | — Demonstrates both excellent spoken and written communications (including electronic notes) with patients, families and colleagues that are presented in clear, straightforward English, avoiding jargon where appropriate |

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| | — Performs appropriate clinical examinations of a baby, child and young person<br>— Adapts clinical examinations to meet the needs of the child and family or carers<br>— Performs basic life support for children<br>— Skilled in venepuncture<br>— Skilled in capillary blood sampling |
| GPCs | **2** Professional skills<br>**6** Capabilities in patient safety and quality improvement |
| Assessments | CbD, mini-CEX, DOC, LEADER, ACAT, HAT, MSF, CCF, EPA, DOPS |
| 10.3 Professional Skills and Knowledge: Clinical Management (maps to Paediatric HLO 4) | |
| Descriptors | — Conducts an assessment, makes a differential diagnosis, plans appropriate investigations and initiates a treatment plan for a child or young person.<br>— Recognises sick children and young people and understands how assessment and management may differ from that in an adult<br>— Recognises the life-threatening nature of some acute situations in children and young people (CYP) and knows when to call for assistance or seek personal support<br>— Carries out an assessment, makes a differential diagnosis, plans appropriate investigations and initiates a treatment plan in accordance with national and local policies (covering a range of paediatric conditions e.g. respiratory, gastro, neuro-disability, palliative, endocrine, congenital, metabolic) and in a range of settings |
| GPCs | **2** Professional skills<br>**3** Professional knowledge<br>**5** Capabilities in leadership and teamworking |
| Assessments | CbD, mini-CEX, DOC, LEADER, ACAT, HAT, MSF, CCF, EPA, DOPS, MRCPCH (FOP / TAS / AKP) |

## Psychiatry

Table 8. High level learning outcome 11: Clinical psychiatry (Psychiatry)

*These areas also map to HLO 11 in internal medicine (Managing medical problems in patients in other specialties. See Appendix 1)*

| 11.1 Demonstrate an awareness of effective adaptable communication relevant to the patient's context and clinical skills in psychiatry (maps to psychiatry HLO 2) | |
|---|---|
| Descriptors | — Demonstrate effective communication with patients and relevant others, making reasonable adjustments where appropriate, including the use of new technologies<br>— Demonstrate development of active listening skills and empathic language which respects the individual, removes barriers and inequalities, ensures partnership and shared decision making, and is clear, concise, non-discriminatory and non-judgemental<br>— Demonstrate an awareness of the ways in which you, as well as patients and others communicate both verbally and non-verbally<br>— Demonstrate effective communication and shared decision making with patients, taking into consideration their ideas, values, concerns and expectations<br>— Explain the outcome of assessment, treatment and management to patients, families, carers of all ages as well as relevant others<br>— Demonstrate an adaptable approach which considers communication, sensory and cognitive needs, as well as the ethnic, social and cultural context of a patient |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**3** Professional knowledge |
| Assessments | ACE, Mini-ACE, CbD, Mini-PAT, DOPS, DONCS, CbDGA, SAPE, PACE, Reflective practice, MRCPsych Exam |
| 11.2 Clinical Knowledge and Skills: Recognise, assess and diagnose mental disorders.<br>Construct a formulation and deliver a range of holistic treatments and interventions for mental disorder tailoring them to meet the individual patients needs in a wide range of clinical contexts under supervision. (maps to psychiatry HLO 2) | |
| Descriptors | — Demonstrate experience receiving a full psychiatric history from, and performing a Mental State Examination (MSE) on patients with a range of mental and neurodevelopmental disorders across the lifespan, in routine, urgent and emergency situations<br>— Receive a collateral history from a range of informants involved in patient care<br>— Assess the risk of self-harm, suicide, risk to others as well as other risks, and ensure a safety plan is in place |

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| | — Demonstrate an understanding of established psychiatric terminology and phenomenology, and incorporate such terminology into the mental state examination<br>— Demonstrate an understanding of the most up-to-date relevant classification system to establish a psychiatric diagnosis as well as a differential diagnosis<br>— Thoroughly assess the general health of your patients, taking into account the impact of their physical health on their psychiatric needs and vice versa. This assessment should include consideration of nutritional, metabolic and endocrine factors, and the physical impact of substance use and addiction<br>— Conduct a thorough physical examination, undertaking relevant physical investigations and take responsibility for acting on your findings in a timely fashion<br>— Demonstrate experience in presenting the history, mental state examination, diagnosis and differential diagnosis, and findings of the physical examination to other professionals<br>— Formulate the presentation of the patient using an appropriate framework<br>— Use the formulation to devise safe, effective, collaborative management plans<br>— Apply knowledge of the pharmacodynamics, pharmacokinetics, efficacy, tolerability, interactions, and short and long-term side effects of medication<br>— Demonstrate the ability to use reflective practice during psychiatric supervision and consistently attend a case-based discussion group (Balint Group) |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills<br>**3** Professional knowledge |
| Assessments | ACE, Mini-ACE, CbD, Mini-PAT, DOPS, DONCS, CbDGA, Reflective practice, MRCPsych (Paper A) |
| 11.3 Complexity and Uncertainty<br>Describe the various factors that are inherent to the complexity and uncertainty within psychiatric practice and the impact that they have on self, patients, carers of all ages, and colleagues (maps to Psychiatry HLO 2) | |
| Descriptors | — Demonstrate an understanding of unconscious processes, including transference, counter transference, projection and splitting and the impact of these on yourself and others<br>— Consider how these unconscious processes are managed effectively and safely to help with ongoing clinical care via supervision and reflective practice |

| | |
|---|---|
| | — Review treatment and management plans of patients when the outcome is not as expected or hoped for<br>— Under supervision, observe, absorb, contain and reflect on complex clinical / non-clinical situations to develop a balanced response<br>— Manage increasing levels of uncertainty safely under supervision |
| GPCs | **1** Professional values and behaviour<br>**2** Professional skills |
| Assessments | ACE, Mini-ACE, CbD, Mini-PAT, DOPS, DONCS, CbDGA, Reflective practice, MRCPsych (Paper A) |
| 11.4 Legislative and organisational frameworks in psychiatry (maps to psychiatry HLO 3) | |
| Descriptors | — Understand and be able to apply the current legislation (relevant to your stage of training) governing the care and treatment of people with mental disorders in your UK jurisdiction<br>— Balance the duty of care to the patient and the protection of others with the restriction of human rights when considering the use of legal powers<br>— Demonstrate knowledge of the structure and development of national health and care services and regulatory authorities both routinely and in unforeseen circumstances<br>— Demonstrate working knowledge of local health and social care services through your interactions with them both routinely and in unforeseen circumstances |
| GPCs | **2** Professional skills<br>**3** Professional knowledge<br>**7** Capabilities in safeguarding vulnerable groups |
| Assessments | ACE, Mini-ACE, CbD, Mini-PAT, DOPS, DONCS, CbDGA, Reflective Practice, MRCPsych (Paper A) |
| 11.5 Factors contributing to vulnerability and safeguarding (maps to psychiatry HLO 7) | |
| Descriptors | — Demonstrate knowledge of the individual and systemic factors contributing to vulnerabilities and safeguarding concerns in people of all ages<br>— Work within legislative frameworks and local procedures to raise and report safeguarding concerns in a timely manner and contribute to safeguarding processes |
| GPCs | **2** Professional skills<br>**3** Professional knowledge<br>**7** Capabilities in safeguarding vulnerable groups |
| Assessments | ACE, Mini-ACE, Mini PAT, DOPS, DONCS, CbDGA, Reflective Practice, MRCpsych |

## Integrated Practical Procedures

Table 9. High level Learning Outcome 12, Practical procedures

| General Practice | |
|---|---|
| Descriptors: | — Breast examination<br>— Male genital examination<br>— Female genital examination, which includes speculum and bimanual examination<br>— Rectal examination<br>— Prostate examination (separate from rectal examination) |
| GPCs: | **2** Professional skills |
| Assessments | CEPS<br>Two or more of the above are expected for completion of BBT, with additional evidence of progress in CEPS in reflections |
| **Internal medicine** | |
| Descriptors: | — Direct current (DC) cardioversion<br>— Pleural aspiration for fluid (diagnostic)<br>— Ascitic tap<br>— Lumbar puncture<br>— Nasogastric tube. Evidence of completion in Foundation is satisfactory |
| GPCs: | **2** Professional skills |
| Assessments | Skills Lab or satisfactory supervised practice e.g. DOPS |
| **Paediatrics** | |
| Descriptors: | — Basic and advanced life support<br>— Bag / mask ventilation<br>— Peripheral venous cannulation<br>— Venepuncture and capillary sampling<br>— Lumbar puncture - desirable but not mandatory |
| GPCs: | **2** Professional skills |
| Assessments | DOPS in 3 or more of the above is expected for completion of BBT |

| Psychiatry | |
| --- | --- |
| Descriptors: | — ECT experience. Demonstrate an awareness of how Electro-Convulsive Therapy (ECT) and other physical treatments can be used for the treatment of mental disorders<br>— CbDGA. Demonstrate the ability to use reflective practice during psychiatric supervision in your 6-month Core Psychiatry training post through attendance at a case-based discussion group |
| GPCs: | **2** Professional skills |
| Assessments | Evidence of CbDGA<br>ECT evidenced by DOPS or other<br>All the above are expected for completion of BBT |

# Section 4
# Programme of assessments for Broad Based Training

## 4.1 Standards

The programme will use the standards used and developed by the four parent specialties.

### 4.1.1 Assessments used in General Practice that are relevant to BBT

#### 4.1.1.1 Formative assessments in GP

*Clinical Skills Assessment (CSA)*

The CSA is a summative assessment of a doctor's ability to integrate and apply clinical, professional, communication and practical skills appropriate for general practice. Simulating a typical GP's work, the CSA assesses a range of scenarios from general practice that are relevant to most parts of the curriculum, which can also target aspects of clinical care and expertise.

*Case-based Discussion (CbD)*

The Case-based discussion (CbD) is a structured oral interview designed to assess your professional judgement in a clinical case. It assesses your performance against the capabilities and looks at how you made holistic, balanced and justifiable decisions in relation to patient care. It assesses your understanding and application of medical knowledge and ethical frameworks, your ability to prioritise and how you recognised and approached the complexity and uncertainty of the consultation.

*Care Assessment Tool (CAT)*

This tool includes CbDs and it has been introduced for trainees in ST3. It allows you to demonstrate your performance in other activities, which can be assessed in your GP rotation. The CAT, like CbDs, assesses your abilities against the capabilities and feedback is given immediately. Examples of CATs include a case review, a review of referrals or a review of prescribing to follow up the prescribing assessment.

*Clinical Evaluation Exercise (mini-CEX)*

The Clinical Evaluation Exercise (mini-CEX) assesses your clinical skills, attitudes and behaviours while consulting with patients. The assessments need to cover a range of different clinical problems. Your supervisor will observe your interaction with a patient and provide immediate feedback on your performance. This assessment is completed during your hospital placements and is replaced by the Consultation Observation Tool (COT) during your GP rotations.

*Consultation Observation Tool (COT)*

The COT assesses your face-to-face consultations within the primary care setting. As with the mini-CEX, it gives you an opportunity to demonstrate your skills in consulting. It assesses the clinical skills and professionalism necessary for good clinical care. In addition, it includes your performance of the more holistic judgements needed to consult in general practice. Immediate feedback is provided on your performance.

*The Audio-COT*

The Audio-COT assesses your ability to consult on the telephone. As with the COT, it assesses your performance and competence in consulting but recognises that different skills are needed to carry out a consultation safely and appropriately on the telephone. Immediate feedback is provided on your performance.

*Multi-source Feedback tool (MSF)*

The Multi-source Feedback (MSF) tool is used to obtain your colleagues' opinions of your clinical performance and professional behaviour. The responses are amalgamated and allow you to reflect, evaluate and develop a learning plan if any issues arise.

*Patient Satisfaction Questionnaire (PSQ)*

The Patient Satisfaction Questionnaire (PSQ) asks your patients to assess your performance within the consultation. It provides feedback on your empathy and relationship-building skills. As with the MSF tool, you are required to reflect on the assessment and develop an action plan if any issues arise. Within BBT the PSQ would require a response from 15 patients (this is different to the main PSQ requirements in ST3 of GP).

*Clinical examination and procedural skills (CEPS)*

The assessment of clinical examination and procedural skills (CEPS) is an assessment of your ability to perform examinations and procedures with patients and should cover the full range of examinations required in general practice. In addition, there are five specific GMC-mandated intimate examinations: breast, rectal, prostate and male and female genital examinations.

*Quality improvement project (QIP)*

This activity is designed to assess your competence in your understanding and completion of a quality improvement project (QIP). You are assessed on your choice of project, how you effectively measured the data, your use of quality improvement methods, your suggestions for change, how you involved the team and your evaluation of any proposed changes and their impact.

#### 4.1.1.2 Summative assessments in GP

- CEPS. Successful completion of CEPS as outlined in HLO 12
- QI Project. One in 12 months – within Psychiatry or another BBT specialty

## 4.1.2 Assessments used in Internal Medicine that are relevant to BBT

### 4.1.2.1 Formative assessments in Internal Medicine

*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. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT. This tool can also be used to assess other situations where a trainee is interacting with a number of different patients (e.g. in a day hospital or a business ward round).

*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, 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 included in the educational supervisor's report.

#### 4.1.2.2 Summative assessments in Internal Medicine

- DOPS. Successful completion of DOPS as outlined in outcome 12
- QI Project. One in 12 months – within Psychiatry or another BBT specialty

### 4.1.3 Assessments used in Paediatrics that are relevant to BBT

#### 4.1.3.1 Formative assessments in Paediatrics

*Mini Clinical Evaluation exercise [ePaedMini-CEX]*

The purpose of the ePaedMini-CEX is to provide feedback on skills essential to the provision of good clinical care in a paediatric setting. It enables trainees to be assessed in real patient encounters. Further specific assessments have been developed for use in the clinical arena, such as ACAT and HAT.

*Case-based Discussion [ePaedCbD]*

The purpose of the ePaedCbD is to assess clinical reasoning and decision making, and the application or use of medical knowledge in relation to patient care. This is a formative assessment, and so cases should be chosen that have created challenge, doubt or difficulty in

order to maximise the learning opportunity. A family of ePaedCbDs now exist, specifically targeting safeguarding (Safeguarding CbD) and leadership (LEADER).

*Handover Assessment Tool (HAT)*

This is a sub-set of the ePaedMini-CEX assessment. The purpose of the HAT is to evaluate the effectiveness of a trainee's contribution to handover and is designed to be sufficiently flexible to be used in a range of handover settings.

*Acute Care Assessment Tool (ACAT)*

This is a sub-set of the ePaedMini-CEX and ePaedCbD assessments. The purpose of the ACAT is to provide the trainee with formative feedback on their ability to integrate multiple skills in a complex and challenging environment with competing priorities, and over a sustained period, such a paediatric 'take', and the intensive care shift of post-take ward round.

*Clinical Leadership skills assessment (LEADER)*

This is a sub-set of the ePaedCbD assessment. The purpose of LEADER is to provide the trainee with formative feedback on their leadership skills in relation to a specific case or problem. While only compulsory at Level 2 and Level 3, it is also strongly recommended for use at Level 1 to highlight the broad scope of leadership required from doctors at all levels of their clinical practice.

*Directly Observed Practical Skills (DOPS)*

The purpose of the DOPS is to assess the trainee's capability to perform specific procedures without supervision. DOPS are both formative, as trainees should be given feedback after each assessment, and summative, as all procedures must be demonstrated to a satisfactory level (i.e. capable to perform without supervision).

The full list of procedures for which a DOPS must be completed satisfactorily are contained within the core syllabus document for each level and are available as a separate list on DOPS page of the RCPCH website.

*Discussion of Correspondence (DOC)*

The purpose of the DOC is to provide a structured assessment and opportunity for learning development across a variety of types of written communication (e.g. correspondence and clinical notes).

*Multi Source Feedback (ePaedMSF)*

The purpose of ePaedMSF is for the trainee to receive and reflect on feedback from a wide range of individuals from their professional sphere. ePaedMSF has been adapted to each level of training. This assessment is invaluable for assessing a trainee's performance over time, in everyday practice.

*Neonatal EPA*

This comprises two arenas of professional activity:

Part (a): Term / Late Preterm
Management of the term infant (37+ weeks) and late preterm infant (35–36 weeks), including resuscitation at birth; identification of infants requiring specific investigations or monitoring risk of sepsis, hypoglycaemia and drug withdrawal); postnatal newborn examination and review; and the identification, investigation and initial management of infants who require neonatal unit admission.

Part (b): Intensive Care
Management of the neonatal intensive care unit, including the stabilisation of the infant following preterm delivery; investigation and initial management of infants who are acutely unwell (e.g. septicaemia, acute respiratory deterioration and neurological dysfunction); and planning and directing care for infants with high dependency or special care dependency requirements.

*General Paediatrics EPA*

This activity involves planning care and being able to lead the ward round on a general paediatric inpatient unit and assesses bed / cot-side clinical assessment and formulation of management plans; communication with team and family / carer; organisation of clinical team with appropriate prioritisation of clinical tasks arising from ward round decisions; and documentation of admission in the hospital electronic discharge system generating a letter for the family and/or general practitioner.

#### 4.1.3.2 Summative assessments in Paediatrics

- DOPS. Successful completion of DOPS as outlined in outcome 12
- QI Project. One in 12 months – within Paediatrics or another BBT specialty

### 4.1.4 Assessments used in Psychiatry that are relevant to BBT

#### 4.1.4.1 Formative assessments In Psychiatry

*Assessment of Clinical Expertise (ACE)*

Modified from the Clinical Evaluation Exercise (CEX), in which an entire clinical encounter is observed and rated thus providing an assessment of a doctor's ability to assess a complete case.

*Assessment of Teaching (AoT)*

Developed at the Royal College of Psychiatrists to enable an assessment to be made of planned teaching carried out by a trainee.

*Case Based Discussion (CBD)*

Also used in the Foundation Programme and is an assessment made on the basis of a structured discussion of a patient whom a trainee has recently been involved with and has written in their notes.

*Case Based Discussion Group Assessment (CBDGA)*

Developed by the Royal College of Psychiatrists to provide structured feedback on a trainee's attendance and contribution to case discussion groups (also known as Balint-type groups) in Core Psychiatry Training.

*Case Presentation (CP)*

An assessment of a major case presentation by a trainee, such as a Grand Round.

*Direct Observation of non-Clinical Skills (DONCS)*

The DONCS is designed to provide feedback on a trainee's performance of non-clinical skills by observing them chairing a meeting, teaching, supervising others or engaging in another non-clinical procedure.

*Direct Observation of Procedural Skills (DOPS)*

Direct Observation of Procedural Skills (DOPS) is also used in the Foundation Programme and is similar to mini-ACE except that the focus is on technical and procedural skills.

*Journal Club Presentation (JCP)*

Similar to a Case Presentation but enables an assessment to be made of a Journal Club presented by a trainee.

*Mini-Assessed Clinical Encounter (Mini-ACE)*

Modified from the mini-Clinical Evaluation Exercise (mini-CEX) used in the Foundation Programme, part of a clinical encounter, such as history-taking, is observed and rated.

*Multi-Source Feedback (MSF)*

Obtained using the Mini Peer Assessment Tool (mini-PAT), which is an assessment made by a cohort of co-workers across the domains of Good Medical Practice. In psychiatry training, trainees should nominate 10-12 suitable assessors who they currently work with for the mini-PAT assessment. Ideally, this should include no more than 2 assessors in any one position (i.e. 2 consultants, 2 nurses, 2 peers, 2 juniors, 2 admin, 2 healthcare professionals etc). Trainees should nominate their named clinical supervisor, that is, the consultant who is responsible for the majority of clinical supervision in their current placement unless stated otherwise by their deanery. This may or may not be the same person as the trainee's educational supervisor. The trainee must discuss / agree with their clinical supervisor those who are to be nominated. A valid mini-PAT requires at least 6 responses.

*Patient survey*

To provide feedback from patients using structured questionnaire.

*Reflective practice*

To provide evidence of reflective practice using relevant form.

#### 4.1.4.2 Summative assessments in Psychiatry

- DOPS. Successful completion of DOPS (as outlined in outcome 12)
- QI Project. One in 12 months – within Psychiatry or another BBT specialty

## 4.2 Summary requirements for BBT / Evidence of progress

At the end of year 1 Broad Based Training the following should have been achieved:

- One MSF
- One PS / PSQ
- ALS or equivalent
- Two educational supervisor reports (one each relating to each specialty undertaken in year 1)
- Achieved at least 50% of the descriptors for outcomes 1-7
- Achieved completion of the capabilities in two out of the four outcomes 8-11 including the specialty related capabilities in outcome 12.

At the end of year 2, in addition to the above, the following should also have been achieved:

- A second MSF
- A second PS / PSQ
- ALS
- Two further educational supervisor reports (one each relating to each specialty undertaken in year 2)
- Achieved at least all of the general competencies for outcomes 1-7
- Achieved completion of the capabilities in all four outcomes 8-11 including the specialty related capabilities in outcome 12.

In addition, the requirements set out in Table 10 should have been achieved during each specialty attachment.

Table 10. Decision aid: WBA requirements (indicative numbers) from specialty attachment requirements by the end of the attached block

| | General practice | Internal medicine | Paediatrics | Psychiatry |
|---|---|---|---|---|
| miniCEX / COT / ACE and miniACE | 2 | 0-2[1] | Some[2] | 2 |
| CbD / CAT | 2 | 0-2[1] | safeguarding CBD[1]<br>Some others[2] | 2 CbD & CbDGA |
| ACAT | | 2 | Suggested[2] | |
| HAT | | | 1 | |
| Case Presentation | | | | 1 |
| Journal Club | | | | 1 |
| TO/AOT | | | | Desirable |
| DOPS/CEPS | 2 | 4 | 3 | 2 |
| MSF | 0-1* | 0-1* | 0-1* | 0-1* |
| Patient Survey | 0-1* | 0-1* | 0-1* | 0-1* |
| QI Project | 0-1* | 0-1* | 0-1* | 0-1* |
| Learning Logs | 18[3] | - | - | - |
| Reflective Practice | Some | Some | Some | Some |
| Outpatient clinics | | 12 | | |
| Clinical Activity | | Actively involved in the care of an indicative number of 50 patients presenting with acute medical problems | | |
| MCR | - | 2 | - | - |
| Educational Supervisor report | 1 | 1 | 1 | 1 |

[1] Overall 2 mini-CEX or CbDs are required as a minimum as an indicative number
[2] Overall it is normally expected that 12 SLEs would be completed during the Paediatric attachment. ('useful SLEs will challenge, act as a stimulus and mechanism for reflection, uncover learning needs and provide an opportunity for developmental feedback'). See Appendix 2
[3] Pro-rata number for six month attachment
* One of these is required each year. It can be done in either of the two six-month blocks within that year.

## 4.3 Assessment of Learning

### 4.3.1 Overall performance

An overall assessment is required for trainees in the educational supervisor (ES) reports so that a judgement about performance can be made. This requires 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. This will be based on formative feedback to the trainee throughout their attachment.

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. This global rating scale will use specific anchor statements as shown (see information box below), decided upon by the educational supervisor with a commentary.

**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

### 4.3.2 Generic capabilities

The ES will indicate whether the trainee is meeting expectations or not, using the global anchor statements in the box 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.

### 4.3.3 Clinical capabilities

The ES will make an entrustment decision for each capability and record the indicative level of supervision required with detailed comments to justify their entrustment decision (see Table 11). Entrustability scales are behaviourally anchored ordinal scales based on progression to competence and reflect a judgement that has clinical meaning for assessors.

Table 11. Level descriptors for clinical capabilities

| Level | Descriptor |
| --- | --- |
| Level 1 | Entrusted to observe only:<br>No provision of clinical care |
| Level 2 | Entrusted to act with direct supervision:<br>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:<br>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 |

Table 12 outlines the level of competence for each clinical capability that is expected in the BBT curriculum.

Table 12. Competence levels for clinical capabilities

| Curriculum Clinical capability | Expected Level of Entrustability by the end of the attachments |
| --- | --- |
| BBT HLO 8: Clinical and Community Practice (General Practice) | |
| 8.1 Communication and consultation | **Level 3** |
| 8.2 Applying a structured approach to data gathering and investigation | **Level 2** |
| 8.3 Clinical and examination skills | **Level 2** |
| 8.4 Making decisions | **Level 2** |
| 8.5 Clinical management | **Level 2** |
| 8.6 Managing medical complexity | **Level 2** |
| 8.7 Organisational management and leadership | **Level 2** |
| 8.8 Practising holistically, promoting health and safeguarding | **Level 2** |
| 8.9 Community Orientation | **Level 1** |

| BBT HLO 9: Clinical medicine |
| --- |

| | |
|---|---|
| 9.1 Managing an acute unselected and specialty take | Level 2 |
| 9.2 Provide continuing care to medical in-patients | Level 2 |
| 9.3 Managing patients in an outpatient clinic, ambulatory or community setting | Level 2 |
| 9.4 Managing a multi-disciplinary team | Level 2 |
| 9.5 Delivering effective resuscitation and managing the acutely deteriorating patient | Level 2 |
| Managing end of life and applying palliative care skills | Level 2 |
| BBT HLO 10: Clinical paediatrics | |
| 10.1 Ethical and legal issues in children (maps to paediatric HLO 1) | Level 1 |
| 10.2 Professional skills and knowledge: Clinical communication and examination | Level 2 |
| 10.3 Professional Skills and Knowledge: Clinical Management | Level 2 |
| BBT HLO 11: Clinical psychiatry | |
| 11.1 Demonstrate an awareness of effective adaptable communication relevant to the patient's context and clinical skills in psychiatry | Level 2 |
| 11.2 Clinical Knowledge and Skills | Level 2 |
| 11.3 Complexity and Uncertainty | Level 1 |
| 11.4 Legislative and organisational frameworks in psychiatry | Level 1 |
| 11.5 Factors contributing to vulnerability and safeguarding | Level 1 |
| HLO 12 - Practical Procedures | |
| 12.1 General Practice | Level 2 |
| 12.2 Internal Medicine | Level 2 |
| 12.3 Paediatrics | Level 2 |
| 12.4 Psychiatry | Level 2 |

*Clinical Supervisor's Report (CSR)*

The Clinical Supervisor's Report (CSR) is a structured report of your clinical ability and gives you observational information on your performance. The capabilities are assessed and commented on by your supervisor. This report is completed by clinical supervisors in both hospital and non-primary care posts, as well as GP trainers in general practice. If the Clinical supervisor is the same person as the educational supervisor, then only an Educational supervisor report is required, although that will be informed by other clinicians who are supervising.

*Educational Supervisor's Review (ESR)*

The Educational Supervisor's Review (ESR) is a structured review of and judgement on your progression. You should complete a self-assessment of your progression against each of the capabilities. The supervisor rates these capabilities and along with all the available information within your ePortfolio (which includes assessments, observations in practice, naturally occurring evidence and reports) makes a global judgement on your progression. An ESR is required for each six-month attachment. This feeds into the ARCP assessment, which all trainees are required to undergo on an annual basis.

*ARCP Decisions and Progression*

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 at the appropriate level of supervision for each capability. 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 at the end of BBT year 1 and BBT year 2.
Progression will be based on:

a) Achieving the WBAs and SLEs in the decision aid
b) Showing adequate progression in capabilities. This includes achieving specialist capabilities within each rotation, and pro-rata completion of generic capabilities
c) Successful achievement of summative assessments.

Trainees should undergo induction at the start of each post and develop a training plan with their supervisor. This will be reviewed at the mid-point and at the end of the 6-month post at a minimum.

Trainees who are failing to achieve the competencies required will be supported by the educational supervisor and TPD. If necessary, they will be directed to additional support and may have their training extended.

## 4.4 Additional requirements before entering chosen specialty

On completion of BBT there may be some essential or desirable additional requirements a trainee needs to achieve before entering their chosen specialty. It is recommended that the desirable requirements are completed within the specialty that the trainee wishes to enter (see Table 13). Although it is not mandatory it will help with the transition.

Table 13. Additional requirements before entering specialty

| Specialty | Essential | Desirable |
|---|---|---|
| General Practice | None | |
| Internal medicine | None | Part 1 MRCP (UK)<br>IM simulation (Boot Camp) |
| Paediatrics | None | 1-2 theory exams (MRCPCH: FOP, TAS & AKP)<br>APLS<br>DOPS in LP |
| Psychiatry | None | A second CbDGA (one is required in the BBT curriculum)<br>Part A MRCPsych<br>Qi project |

## 4.5 Expectations from specialties before entering ST2 / CT2

The four parent Colleges have set out below what is expected from trainees moving from year 1 into year 2. This also applies to BBT trainees moving into year 2 of their chosen specialty. BBT trainees will broadly be expected to be at a similar (but not identical) stage of capabilities to a specialty trainee. In reality the BBT trainee may have a different balance of capabilities, but overall is expected to more than meet the minimum standards with the training they have received. The BBT curriculum has been reviewed and mapped across to the capabilities in the specialist curricula to ensure this (see section 3.3 BBT curriculum).

*Requirements from BBT curriculum*

When trainees complete BBT they will enter ST2 / CT2 of their chosen specialty. To be able to progress they will need to have successfully completed BBT training. In addition, there are some desirable achievements aligned to specific specialties. BBT trainees are highly recommended to achieve some of the suggestions in their chosen specialty (Table 13) before starting their CT2 / ST2 year.

*Expectations of Specialist Training by the end of year 1*

Each of the four specialties has expectations for its own trainees at the end of ST1 / CT1 before entering the second year of training. ***These are all covered in the BBT curriculum***. However, the expectations for moving from year 1 to year 2 are laid out in each of the core specialty and GP curricula. Trainees are advised to check these for the specialty to give them confidence that they are achieving the relevant capabilities.

# Section 5
# Quality assurance and improvement

## 5.1 Organisation of training

The organisation of training programmes for BBT is the responsibility of HEE LETBs / local teams and the devolved nations' deaneries, depending on where the programme is delivered.

The LETBs / deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the GP / BBT / Public Health / Occupational medicine Specialty Training Board in Scotland will undertake the following roles:

- Oversee recruitment and induction of trainees from Foundation to BBT
- Allocate trainees into BBT rotations
- Oversee the quality of training posts provided locally
- Interface between the specialty groupings within BBT e.g. GP, internal medicine, paediatrics and psychiatry but also with other specialty training faculties where necessary
- Ensure adequate provision of appropriate educational events
- Ensure curricula implementation across training programmes
- Oversee the workplace-based assessment (WPBA) 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.

## 5.2 Supervision

High quality supportive and constructive feedback, with trainee reflection is an important part of trainee development. 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. The opportunity must be available to discuss outpatient and referred on cases. Each trainee must have an educational supervisor and a clinical supervisor. These can be the same person, but the clinical supervisor must change for each rotation. The roles of educational and clinical supervisor are described in the GMC's Promoting excellence: standards of medical education and training.

Educational programmes to train educational supervisors and assessors in workplace based assessment, face to face and other forms of feedback may be delivered by LETBs / deaneries, the Colleges or both. Further detail is outlined in the Academy guide for trainees and trainers Improving feedback and reflection to improve learning.

All training delivery, including workplace based assessments must comply with the Gold Guide and with the GMC requirements in Promoting excellence: standards for medical education and training.

### 5.2.1 Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a **summative judgement** about trainee performance to allow decisions on progression at the end of the placement or series of placements.

The educational supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of untoward clinical incidents involving the trainee. If the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the educational supervisor. 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.

### 5.2.2 Clinical supervisor

The clinical supervisor oversees the doctor's clinical work throughout a placement. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.

It is essential that training in assessment is provided for trainers and trainees r 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 workplace-based assessments, regular meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

It is recommended that the Clinical supervisor will require 0.25 PA per week per trainee in their job plan.

### 5.2.3 Psychiatric supervisor (for Psychiatry)

Psychiatric supervision is required for all trainees throughout their core placement and must be for one hour per week. It plays a critical role in the development of psychiatrists in training in developing strategies for resilience, well-being, maintaining appropriate professional boundaries and understanding the dynamic issues of therapeutic relationships. It is also an opportunity to reflect on and develop leadership capabilities and is informed by psychodynamic, cognitive coaching models. It is imperative that consultants delivering psychiatric supervision have

protected time within their job plans to deliver this. This aspect of supervision requires 0.25 PA per week per trainee.

The psychiatric supervisor is responsible for producing the Psychiatric Supervisor Report (one required for the core placement) informing the ARCP process and will ensure contributions are received from key individuals involved in the local training programme including clinical supervisors.

### 5.2.4 Trainees

Trainees should make the safety of patients their priority. Trainees should not practise in clinical scenarios which are beyond their experiences and competences 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 need to plan their WPBAs so that they collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers 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 use feedback to regularly self-reflect and self-evaluate. and formulate action plans with further learning goals in discussion with their trainers.

Regular review of training goals and progress is an important element of feedback and provides continuity between posts. Induction and end of post meetings should be recorded on e-portfolio. A formal mid-point review is also encouraged but not mandatory. At each meeting a review of progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post and to plan the 10% attachments. The 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. 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 any review.

The end of post meeting should review the PDP and curriculum progress with the educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of post 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. This should be recorded. If there are significant concerns following the end of post appraisal, then the training programme director should be informed.

## 5.3 Review of Curriculum and Programme

Development, implementation, monitoring and review of the curriculum are the responsibility of the Broad Based Training Governance group in conjunction with the help and advice of the representatives from the four Colleges. The Governance Group comprises formally constituted representatives from each nation delivering the BBT programme along with trainee and lay representation. It will be the responsibility of the Academy of Medical Royal Colleges to ensure

that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

A robust quality assurance infrastructure will be in place to support BBT, including annual monitoring, data review, trainee and trainer feedback. Feedback from the ARCP process will also be included. Information will be reviewed annually by the Governance Group.

Each of the four parent Colleges provide a role in quality management by monitoring and driving improvement in the delivery of training in their own specialist area. In addition, the BBT Governance group will monitor the quality of training for BBT as a whole, especially how the BBT rotations work in relation to each other, and how trainees exit the BBT programme into their chosen specialty. The Governance group will monitor quality assurance arrangements such as externality when reviewing ARCP panels and make decisions about changing the curriculum. Lay representation on the Governance group will guide any changes to the curriculum and feedback from a wider spectrum of patients' groups will be sought as needed. This could involve linking in with lay representative groups from each of the four parent specialty Colleges.

Where possible the BBT governance group will support a standardised approach across all four nations, this will include standardised assessment tools and documentation. Training will be reviewed in each nation, using standardised quality review processes, using GMC and other data.

Datasets that will be used to assess the quality of training will include the GMC National Training Survey (NTS), Scottish Training Survey (STS), ARCP outcomes, successful progress into specialties on completion of BBT, External Advisor reports, Heads of school annual specialty reports and the monitoring visit reports.

# Appendix 1
# Key documents and high-level learning outcomes of the four core curricula

Each High Level Learning Outcome has been numbered to identify it clearly so that it can be mapped to the BBT High Level Learning Outcomes.

## Paediatrics

### Curriculum documents

Level 1 generic syllabus: Paediatric specialist syllabus (August 2018).
Curriculum: Paediatric specialty. Postgraduate Training (August 2018).

Table A1. Paediatrics High-level learning outcomes (n=11)

| Domain | |
|---|---|
| 1 | Professional values and behaviours |
| 2 | Professional skills and knowledge: communication |
| 3 | Professional skills and knowledge: clinical procedures |
| 4 | Professional skills and knowledge: patient management |
| 5 | Health promotion and illness prevention |
| 6 | Leadership and team working |
| 7 | Patient safety, including safe prescribing |
| 8 | Quality Improvement |
| 9 | Safeguarding |
| 10 | Education and training |
| 11 | Research and scholarship |

## General Practice

### Curriculum documents

The RCGP curriculum: Being a General Practitioner (July 2020).

Table A2. General Practice high-level learning outcomes (n=13)

| Area of capability | Specific capabilities for general practice<br>To be a GP, you must be capable of: |
| --- | --- |
| A. Knowing yourself and relating to others | **1. Fitness to practise**<br>— Demonstrating the attitudes and behaviours expected of a good doctor<br>— Managing the factors that influence your performance<br>**2. Maintaining an ethical approach**<br>— Treating others fairly and with respect and acting without discrimination<br>— Providing care with compassion and kindness<br>**3. Communication and consultation**<br>— Establishing an effective partnership with patients<br>— Maintaining a continuing relationship with patients, carers and families |
| B. Applying clinical knowledge and skill | **4. Data gathering and interpretation**<br>— Applying a structured approach to data gathering and investigation<br>— Interpreting findings accurately to reach a diagnosis<br>**5. Clinical examination and procedural skills**<br>— Demonstrating a proficient approach to clinical examination<br>— Demonstrating a proficient approach to the performance of procedures<br>**6. Making decisions**<br>— Adopting appropriate decision-making principles<br>— Applying a scientific and evidence-based approach<br>**7. Clinical management**<br>— Providing general clinical care to patients of all ages and backgrounds<br>— Adopting a structured approach to clinical management |

| | |
|---|---|
| | — Making appropriate use of other professionals and services<br>— Providing urgent care when needed |
| C. Managing complex and long-term care | **8. Managing medical complexity**<br>– Enabling people living with long-term conditions to improve their health<br>– Managing concurrent health problems within an individual patient<br>– Adopting safe and effective approaches for patients with complex needs<br>**9. Working with colleagues and in teams**<br>– Working as an effective team member<br>– Coordinating a team-based approach to the care of patients |
| D. Working well in organisations and in systems of care | **10. Improving performance, learning and teaching**<br>– Continuously evaluating and improving the care you provide<br>– Adopting a safe and scientific approach to improve quality of care<br>– Supporting the education and development of colleagues<br>**11. Organisational management and leadership**<br>– Applying leadership skills to improve your organisation's performance<br>– Making effective use of information and communication systems<br>– Developing the financial and business skills required for your role |
| E. Caring for the whole person and the wider community | **12. Practising holistically, promoting health and safeguarding**<br>– Demonstrating the holistic mindset of a generalist medical practitioner<br>– Supporting people through experiences of health, illness and recovery<br>– Safeguarding individuals, families and local populations<br>**13. Community orientation**<br>– Understanding the health service and your role within it<br>– Building relationships with the communities in which you work |

## Psychiatry

### Curriculum documents

All Royal College of Psychiatry GMC approved curricula
Core Training in Psychiatry: CT1-3 (April 2020).
High-Level Learning Outcomes of the Core Psychiatry Curriculum (2020)
Core Psychiatry Curriculum (2021)

Table A3. Psychiatry high-level learning outcomes (n=9)

| High Level learning outcome |
| --- |
| HLO1: Demonstrate the professional values and behaviours required of a medical doctor in Psychiatry, with reference to Good Medical Practice and Core Values for Psychiatrists. |
| HLO2: Recognise, assess and diagnose mental disorders. Construct a formulation and deliver a range of psychological, biomedical, and social treatments for mental disorder tailoring them to meet the individual patients needs in a wide range of clinical contexts under supervision.<br>Demonstrate advanced communication skills to nurture therapeutic relationships as a fundamental part of person-centred psychiatric care within the above framework.<br>Describe the various factors that are inherent to the complexity and uncertainty within psychiatric practice and the impact that they have on self, patients, carers of all ages, and colleagues. |
| HLO3: Apply the relevant legislative frameworks across the UK to safeguard patients with mental disorder and safely manage risk to themselves and others under supervision.<br>Outline the structure and organisation of the NHS as well as the independent sector and the wider health and social care landscape. |
| HLO4: Recognise the importance of mental and physical health promotion and illness prevention for your patients and their wider community. Demonstrate how this is applied in your daily practice. |
| HLO5: Recognise the personal qualities, team dynamics and human factors that are relevant in psychiatric practice. Apply these to work constructively within a team whilst developing personal leadership skills appropriate for your level and role. |
| HLO6: Participate in and promote activity to improve the safety and quality of patient care and clinical outcomes in your psychiatric practice. |

| |
|---|
| HLO7: Recognise and assess the factors that contribute to vulnerability. Identify those patients and relevant others who may be vulnerable and work collaboratively in safeguarding their welfare in a timely and appropriate manner. |
| HLO8: Plan and provide effective education and training. |
| HLO9: Demonstrate knowledge of research methodology, critical appraisal and best practice guidance and apply it to your clinical practice. |

## Internal medicine

### Curriculum documents

Curriculum for Internal Medicine: Stage 1 Training (2019)

Table A4. Internal medicine capabilities in practice (n=14)

| Generic CiPs |
|---|
| Able to successfully function 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 |
| 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 in-patients, 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 |

# Appendix 2: Paediatric Assessment strategy notes

Key notes from the Paediatric Assessment strategy (Point 1 below is for information only on Paediatric training times).

The statutory minimum training times are 24 months at Level 1, 12 months at Level 2, and 24 months at Level 3 (all whole time equivalent [WTE]; therefore, the training years in parentheses (ST3, ST5 and ST8) might not be undertaken by all trainees, depending upon the individual's progress.

## Supervised Learning Events

1. The purpose of SLEs is as a means of engaging in formative learning; therefore, a trainee who presents evidence of SLEs that only cover a restricted area of the curriculum runs the risk of being judged as having poor strategic learning skills.
2. Trainees should use SLEs to demonstrate that they have engaged in formative feedback. They should record any learning objectives that arise in their Personal Development Plan (PDP) and show evidence that these objectives have subsequently been achieved.
3. There is no minimum number of SLEs (other than the mandatory assessments described in note 7). Trainees and supervisors should aim for quality over quantity; a useful SLE will stretch the trainee, act as a stimulus and mechanism for reflection, uncover learning needs, and provide an opportunity for the trainee to receive developmental feedback. Trainees do not need to achieve a prescribed ratio of Mini Clinical Evaluation (ePaed Mini-CEX) to Case-based Discussion (ePaed CbD) assessments; it is anticipated that more junior trainees might undertake relatively more ePaed Mini-CEXs and more senior trainees undertake more ePaed CbDs, reflecting the increasing complexity of decision making and so forth.
4. Trainees are also encouraged to undertake the assessments indicated as optional.
5. The numbers of SLEs given for the Acute Care Assessment Tool (ACAT), Handover Assessment Tool (HAT), clinical Leadership skills assessment (LEADER) and Safeguarding CbD are minimum requirements; senior trainees in particular should bear in mind that each of the SLEs is designed for the formative assessment of different aspects of the curriculum and more than this minimum number of some SLEs might be required, depending upon the specific requirements and clinical context of a sub-specialty. Trainees are therefore advised to consult their relevant sub-specialty syllabus in case there are additional specified assessment requirements.
6. At least one of each of these SLEs must be assessed by a senior supervisory clinician (e.g. a consultant or senior Specialty and Associate Specialist Grade [SASG] / specialty doctor), that is, ACAT and HAT during Level 2, LEADER during Level 2 and Level 3, and at least one of the five Discussions of Correspondence (DOC) during Level 2 and Level 3.

## Assessment of Performance

7. The compulsory procedural skills are listed on the RCPCH website: www.rcpch.ac.uk

8. The ePortfolio skills log should be used to demonstrate development and continued capability.

## Additional requirements

1. Trainees must also complete accredited neonatal and paediatric life support training during Level 1 training - after 3 years Paediatrics (NLS, EPALS, APLS or equivalent).
2. Trainees must achieve the Level 1 and 2 Intercollegiate Safeguarding Competences by the end of ST3, the majority of Level 3 capabilities by the end of ST5, and all Level 3 capabilities along with the additional paediatrician capabilities by the end of ST8.
3. Trainees can complete up to 25% of assessments during simulation, but they are required to complete a non-simulated assessment for each of the mandatory Directly Observed Practical Skills (DOPS).

# Glossary

| | |
|---|---|
| ACAT | Acute care assessment tool |
| ACCS | Acute care common stem |
| ACE | Assessment of clinical expertise / Assessed clinical encounter |
| AKP | Applied knowledge in practice |
| ALS | Advanced life support |
| AoT | Assessment of teaching |
| APLS | Advanced paediatric life support |
| ARCP | Annual review of competency progression |
| BBT | Broad based training |
| CAMHS | Child and adolescent mental health services |
| CAT | Care assessment tool |
| CBD | Case-based discussion |
| CbDGA | Case based discussion group assessment |
| CCF | Children and carer's feedback assessment |
| CEPS | Clinical examination and procedural skills |
| CEX | Clinical evaluation exercise |
| CiPs | Capabilities in practice |
| COT | Consultation observation tool |
| CP | Case presentation |
| CS | Clinical supervisor |
| CSA | Clinical skills assessment |
| CSR | Clinical supervisor's report |
| CT | Core training |
| DOC | Discussion of c orrespondence |
| DONCS | Direct observation of non-clinical skills |
| DOPS | Direct observation of procedural skills |
| ECT | Electro convulsive therapy |
| EPA | Entrustable professional activity |
| EPALS | European paediatric advanced life support |
| ES | Educational supervisor |
| ESR | Educational supervisor's review |
| FOP | Foundation of practice (exam) |
| GCP | Good clinical practice |
| GMC | General Medical Council |
| GP | General practice |

| | |
|---|---|
| GPC | Generic professional capabilities |
| HAT | Handover assessment tool |
| HEE | Health Education England |
| HLOs | High level learning outcomes |
| IM | Internal medicine |
| JCP | Journal club presentation |
| JRCPTB | Joint Royal College of Physicians Training Board |
| LEADER | Clinical leadership skills assessment |
| LETBs | Local education and training boards |
| LP | Lumbar puncture |
| LTFT | Less than full time training |
| MCR | Multiple-consultant report |
| MSF | Multi-source feedback |
| MRCP | Member of Royal College of Physicians |
| MRCPCH | Member of Royal College of Paediatrics and Child Health |
| MRCPsych | Member of Royal College of Psychiatrists |
| NLS | Neonatal life support |
| PA | Programmed activities |
| PACES | Practical assessment of clinical examination skills |
| PAT | Patient assessment tool |
| PDP | Personal development plan |
| PS | Patient survey |
| PSQ | Patient satisfaction questionnaire |
| PSR | Psychiatry supervisor report |
| QIP | Quality improvement project |
| QIPAT | Quality improvement project assessment tool |
| RCGP | Royal College of General Practitioners |
| RCPCH | Royal College of Paediatrics and Child Health |
| RCPsych | Royal College of Psychiatrists |
| SAPE | Structured assessment of psychotherapy expertise |
| SLEs | Supervised learning events |
| ST | Specialty training |
| TAS | Theory and science (exam) |
| TO | Teaching observation |
| TPD | Training programme director |
| WBA | Work-based assessments |
| WPBA | Workplace-based assessments |

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