JRCPTB

Joint Royal Colleges of Physicians Training Board

Curriculum for Gastroenterology Training

Implementation August 2022

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An application has been made to change the name of the specialty General Internal Medicine (GIM) to Internal Medicine (IM). These terms are used interchangeably in this document except where there is direct reference to the Certificate of Completion of Training (CCT). The curriculum will be referred to as GIM/IM stage 2.

1. Introduction

Gastrointestinal and liver diseases may present at any age. The UK population is increasing and there are a growing number of people of all ages with gastrointestinal disease. Adolescent patients are increasingly diagnosed with inflammatory bowel disease and obesity, whilst older patients are prone to cancer and degenerative diseases and have a rising life expectancy.

Gastroenterology is unique among the medical specialties in that it deals with multiple organs and is also an interventional 'craft' specialty. The demand for gastrointestinal and liver specialists has significantly increased in recent years due to the development of new care pathways, new technologies, and treatments. In addition, there has also been an increase in the prevalence of inflammatory bowel disease and chronic liver disease.

There are a number of political imperatives impacting on the specialty. Colorectal cancer is the third commonest cancer worldwide and the second cause of cancer death. The lifetime risk of this cancer in men and women is 1:20 in the UK and its incidence increases with age. Increased capacity for colonoscopy is required, because in addition to diagnostic and therapeutic work, colorectal cancer is a preventable disease and gastroenterologists will play the most significant part in the delivery of the Bowel Cancer Screening Programmes in the four countries of the UK (1,2).

Direct access to diagnostic tests for upper gastrointestinal conditions reduces time to diagnosis and is cost-effective (3). The availability of these diagnostic investigations is also required to try to improve the outlook for patients with upper GI cancers, which at present are often detected too late to be treatable (4). Inflammatory bowel disease has also increased in incidence, especially in young people and the treatment has greatly increased in complexity (5).

Upper gastrointestinal bleeding is a common cause of acute admission to hospital with a mortality of around 10% (6,7). There is evidence that rapid access to endoscopic diagnosis and therapy is beneficial for patients suffering gastrointestinal (GI) bleeding and it is recommended that upper GI endoscopy is provided by a consultant within 24 hours of admission for all patients and within two hours of haemodynamic stabilisation for those with severe acute upper GI bleeding (7). This service is in addition to the contribution of the gastroenterologists to the future hospital commission's recommendations for seven days working (8).

Liver disease is the only major cause of death that is still increasing each year in the UK, with mortality rates having risen by 400% since the 1970s. The rates of liver disease in the UK are substantially higher than in Western Europe (9). Socially disadvantaged groups are affected disproportionately. Alcoholic liver disease will shortly overtake ischaemic heart disease as the leading cause of premature mortality (9). Emergency admissions due to decompensated cirrhosis have increased and deaths from cirrhosis, especially due to alcohol have increased by more than 50% since the 1990s. Up to 60% of the UK population are obese and obesity-related liver disease is an increasingly recognised cause of cirrhosis and associated morbidity. With increased migration, the incidence of chronic liver disease due to hepatitis B and C has risen in the UK (10). Liver disease is often asymptomatic and is diagnosed at a late stage in 75% of patients, when few treatment options are available (9). The need for better care for patients with liver disease has been recognised (10,11)

and this care needs to be provided both in district hospitals and specialist centres by doctors with training in the complex hepatology branch of this programme.

Training in Hepatology within this programme is necessary in order that training is efficient and modelled to the needs of both patients and providers of healthcare (10,11). Stakeholder consultation has emphasised the view that patient safety and effective care are paramount considerations in the design of this curriculum and the continued training of doctors with skills to deal with patients with more complex liver disease is one of the ways this can be delivered.

2. Purpose

2.1 Purpose of the curriculum

The purpose of this curriculum is to produce doctors with the generic and specialty specific capabilities to diagnose and manage adult patients with the full range of acute and chronic conditions affecting the gastrointestinal system and liver. The curriculum will equip a fully trained gastroenterologist to provide high quality, holistic, patient centred care, both as an individual practitioner and as part of a team. The fully trained gastroenterologist will also be accredited in the generic and specific capabilities defined in the Internal Medicine (IM) curriculum.

The philosophy of this curriculum is to support and encourage trainees to learn through work and to take responsibility for their own learning. In addition to supported experiential learning in the workplace, doctors in training will learn in a variety of settings using a range of methods, including, feedback from formative work place-based assessments, formal postgraduate teaching and simulation-based learning.

The objective of the curriculum will be to ensure that doctors in training in gastroenterology develop the full range of generic professional capabilities underpinned by knowledge and skills, applicable in the practice of IM as well as luminal gastroenterology and hepatology. It will ensure that trainees develop the full range of speciality-specific core capabilities, together with one area of more complex specific practice (either luminal gastroenterology or hepatology). Specialists with one of either of the optional training module capabilities will be required to train within the training envelope and for the workforce. It will not be possible to attain all of the capabilities in both areas of complex practice and the nature of consultant job plans would require a consultant either to make a significant contribution to the endoscopy service, especially colonoscopy or to offer care to patients with complex liver disease, not both of these activities.

The objectives of the curriculum are:

- to set out a range of specific professional capabilities (CiPs) that encompass all knowledge, skills and activities needed to practice gastroenterology and internal medicine at consultant level.
- to set expected standards of knowledge and performance of various professional skills and activities at each stage which will be assessed as Generic Professional Capabilities.
- to suggest indicative training times and experiences needed to achieve the required standards.
- to set out a programme of evidence-based assessment procedures to be used, such as multi-source feedback and ACAT. To ensure that gastroenterologists reach the required proficiency in endoscopy.

- the completion of one specific training module in either complex luminal gastroenterology or complex hepatology, is designed to address these specialty -specific pressures within the shortened training programme.

Gastroenterology higher specialty training will be an indicative four- year programme that will begin following completion of the IM stage 1 curriculum. It will incorporate continued training in IM (in line with the IM stage 2 curriculum) during this period. All gastroenterologists will be competent to deal with any acute luminal gastroenterological or hepatological presentation, whilst also having specific modular training in more complex care in one of these areas of practice. The training will usually require participation in specialty specific on call rotas as well as involvement in the unselected medical take. Continued training in IM will ensure specialists are able to contribute the triage of acute presentations, identify those requiring on-going specialty input and also ensure they can recognise and manage the common co-morbidities. Following the IM curriculum will also ensure delivery of training encompassing the GMC's Generic Professional Capability framework. This will enable the development of the necessary skills to deliver the full range of care required by patients in such a broad-based and procedural specialty.

All gastroenterologists will be equipped to deal with any acute presentation and common chronic conditions in the specialty and have more specific modular training in either complex luminal gastroenterology or hepatology. Gastroenterologists will also need to be competent to participate in an upper gastrointestinal bleeding rota. This will require a concentration on endoscopy skills in the first two years of higher specialty training and the four-year training programme will include an indicative 25% (or one year) of IM to enable trainees to achieve all the required specialty capabilities. Trainees will be expected to gain competency in common therapeutic endoscopic interventions particularly endoscopic management of upper GI bleeding which is an essential part of a consultant gastroenterologist's practice. Training in this capability will be supported by participation (where possible) in a GI bleeding rota for an indicative minimum period of 6 months during ST6 or ST7. The capabilities may also be attained through participation in 'registrar of the week' duties and/or regular involvement with daytime emergency bleeding lists (which run in most endoscopy units), as well as by the optional attendance at approved training courses in therapeutic and GI bleeding endoscopy. There are geographical differences in services and resources throughout the four nations and there will be a need to be flexibility in the way in which this training may be delivered.

A broad view of the first two years of specialty training would be that the trainee would be involved in IM (including on-call) for approximately 25% of their time. They would be involved in in-patient care of acute admissions, including specialty patients, and usually expected to attend two outpatient clinics and two endoscopy training lists per week. There is evidence that 'front loading' endoscopy training is beneficial for the achievement of competencies (ref) and where possible, trainees may spend a period of the first year of higher training with a focus on endoscopy. The second year would continue with similar training and during this two-year period, trainees would be placed in posts that allow them relevant experience to gain the general capabilities in luminal gastroenterology, hepatology and nutrition. Defined centres for core hepatology training have been identified in every region and experience in these posts will allow all trainees to develop core capabilities in the management of patients with liver disease.

There will be a critical progression point at the end of the second year of training. At this point, progress in training, including successful ARCP outcomes and appropriate progress in endoscopy (sign-off for diagnostic upper gastrointestinal endoscopy) will be reviewed in line with expectations for a trainee at that stage. Due consideration will be made in this process to ensure that LTFT trainees and those with protected characteristics are not disadvantaged by the process. In the final

part of the programme, more focused training in one specific complex module will then continue alongside completion of core gastroenterology competencies and continued exposure to emergency general gastroenterology and IM. Most trainees will complete the training module in luminal gastroenterology including competence in colonoscopy in accordance with service need. The trainees who are completing this module will have exposure to more complex inflammatory bowel disease patients in clinic and as in-patients, develop further knowledge and skills in nutrition and complete training in colonoscopy and polypectomy. A luminal gastroenterologist will have additional experience in the management of inflammatory bowel disease and nutrition and will see patients with luminal problems in outpatients. They will be the major contributors to the diagnostic and therapeutic endoscopy service for the hospital.

Those training in hepatology (in designated posts) will be equipped to deal with the care of patients with more complex liver disease, who currently constitute a large proportion of in-patients in the specialty. The areas of practice include specialty clinics, understanding the complexity of inpatient care of patients with decompensated cirrhosis and the indications for transplant with the pre-operative assessment and post-operative follow up. The numbers of hepatology trainees required will need to be determined locally and agreed nationally. The number of required training posts in hepatology varies geographically in the UK and national recruitment to the designated hepatology training posts allows applications from regions with few hepatologists and hepatology training opportunities and is aimed at increasing the number of consultants with experience of complex hepatology to meet the service requirements for consultants.

Gastroenterologists need the ability to work as leaders of, or within, teams and systems involving other healthcare professionals to effectively provide optimal patient care. Gastroenterologists currently work primarily as hospital-based specialists as part of a large inter-professional team. Demonstration of involvement with other professionals in the multidisciplinary team throughout training will be required as this is integral to the work of a gastroenterologist. Gastroenterologists will also have a wide variety of opportunities for research and the training is designed to facilitate opportunities for academic careers.

This curriculum has been developed with the input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the JRCPTB, the Gastroenterology Specialist Advisory Committee, the British Society of Gastroenterology Society Training Committee, and the British Association for the Study of the Liver.

The implementation of this curriculum will require great focus from trainers and LETBs, to deliver all the outcomes within the training envelope. It will be necessary to support effective and efficient training in endoscopy (including the management of GI bleeding) through the continued resourcing of the regional endoscopy academies in England and Scotland if trainees are to become competent colonoscopists by the end of the programme. Gastroenterology trainees will also need to have adequate time for training in specialty, as well as IM and this will require an indicative 25% of time spent in IM, which potentially could have rota implications in some Trusts, heavily reliant on Gastroenterology trainees to support the medical take. There may need to be some adjustments to rotations and clinical placements, but these should be achievable without implications for the clinical service.

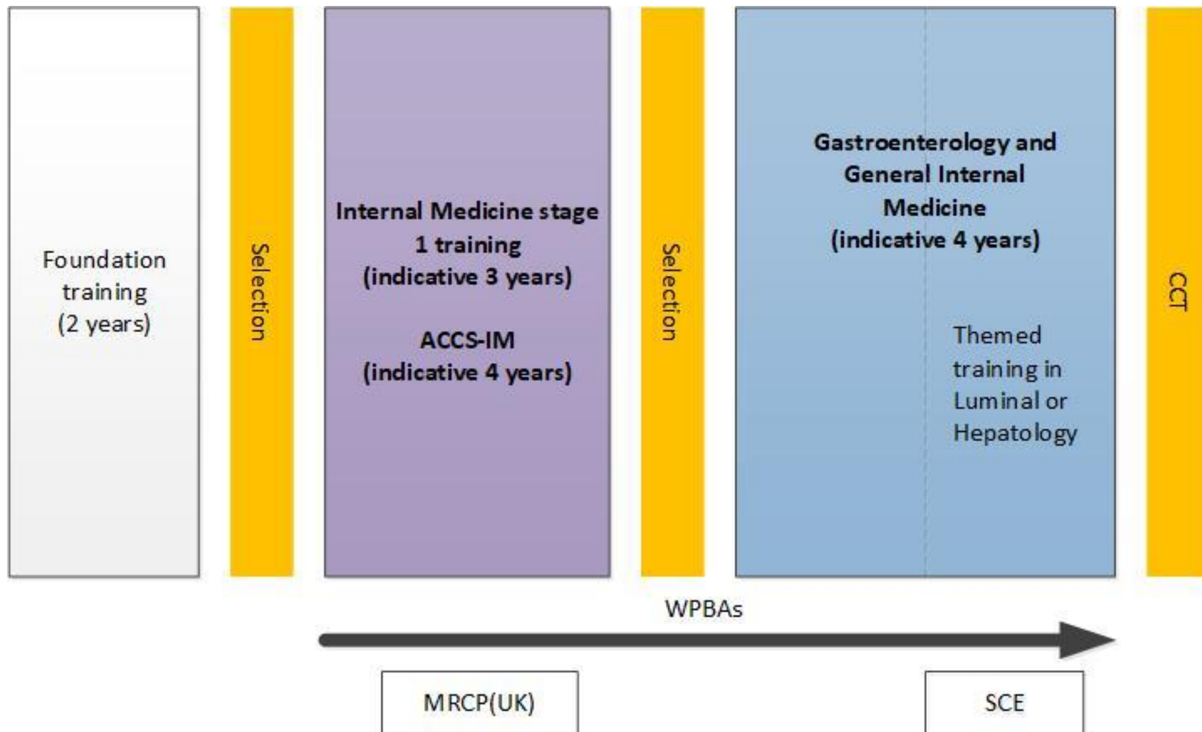
This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

2.2 High level learning outcomes – capabilities in practice (CiPs)

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within NHS organisational and management systems 2. Able to deal with ethical and legal issues related to clinical practice 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement 4. Is focused on patient safety and delivers effective quality improvement in patient care 5. Carrying out research and managing data appropriately 6. Acting as a clinical teacher and clinical supervisor
Clinical CiPs (Internal Medicine)
1. Managing an acute unselected take 2. Managing the acute care of patients within a medical specialty service 3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment 4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions 5. Managing medical problems in patients in other specialties and special cases 6. Managing a multidisciplinary team including effective discharge planning 7. Delivering effective resuscitation and managing the acutely deteriorating patient 8. Managing end of life and applying palliative care skills
Specialty CiPs Gastroenterology
1. Managing care of Gastroenterology and Hepatology in-patients 2. Managing care of Gastroenterology and Hepatology patients in an out-patient environment 3. Managing care of patients with complex disease across multiple care settings, including interaction with primary care and community networks 4. Managing care pathways for patients with suspected and confirmed gastrointestinal and hepatic malignancy 5. The ability to practice diagnostic and therapeutic upper GI endoscopy and in other practical skills undertaken/overseen by a Gastroenterology Consultant 6. Contributing to the prevention of gastrointestinal and liver disease
Gastroenterology Specialty CiPs (themed for service)
Trainees will complete one additional higher-level outcome from the list below according to service theme. For academic trainees appropriate timetabling will facilitate integration of this training with academic research and capability-based clinical assessment.
1. Managing complex problems in luminal gastroenterology

2. Managing complex problems in hepatology

2.3 Training pathway



2.4 Duration of training

Training in Gastroenterology will comprise three years of IM training followed by four years of specialty training incorporating complex hepatology as one of two optional themes for service alongside complex luminal gastroenterology. The first two years will be largely general gastroenterology training alongside IM Stage 2 training. During the final two years trainees will be selected into either one of the themes for service whilst maintaining their training in general gastroenterology and IM. The specialty will be seeking to change its name on the Medical Act to Gastroenterology & Hepatology.

There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training more rapidly than the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good physician (guidance on completing training early will be available on the JRCPTB website). There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)[1].

2.5 Flexibility and accreditation of transferrable capabilities

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). GPCs will promote flexibility in postgraduate training as these common capabilities can be

[1] A Reference Guide for Postgraduate Specialty Training in the UK

transferred from specialty to specialty. In addition, the IM generic CiPs will be shared across all physicianly curricula and the IM clinical CiPs will be shared across all group 1 specialities, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training. The curriculum supports the accreditation of transferrable competencies (using the Academy framework).

Standards for endoscopic services are demanding in all four nations and have resulted in the UK being regarded as having the highest standards for endoscopy in the world. The main interdependency of the gastroenterology curriculum relates to training in endoscopy. There is a national drive to train endoscopists from other professional backgrounds due to the enormous increase in demand for endoscopy for symptomatic patients as well as the national screening agenda (2,3). However, as well as a shortage of medical endoscopists, there is a national shortfall in recruitment of nurses and other professionals to take up extended roles and those non-medical endoscopists who have been recruited have been found to have different training needs. There are significant capacity issues and currently no accelerated programmes for colonoscopy training, making it certain that even though new training programmes and pathways may be developed, gastroenterologists will continue to play a leading role in providing endoscopic services in the coming years.

The key interdependency will be with Acute and Internal Medicine, with Gastroenterology being a major contributor to the acute take, and many of the clinical skills learnt will be transferable to these curricula. The work of Gastroenterologists is also closely integrated with community based primary care and public health colleagues, as well as other hospital-based medical specialties, including acute medicine, geriatrics, palliative medicine, medical and clinical oncology. The specialty also has close links with many other specialties, especially gastrointestinal and HPB surgery, radiology, histopathology and psychiatry

2.6 Less than full time training

Trainees are entitled to opt for less than full time training (LTFT) programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide. We are committed to ensure that LTFT trainees have access to as many opportunities as their full-time colleagues and wherever possible, adjustments will be made to accommodate LTFT training.

2.7 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework[2] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about

[2] Generic professional capabilities framework

patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

Good medical practice (GMP)[3] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

The nine domains and subsections of the GPC framework are directly identifiable in the IM curriculum. They are mapped to each of the generic and clinical CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

3 Content of Learning

The curriculum is spiral and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from needing direct supervision to able to be entrusted to act unsupervised.

[3] Good Medical Practice

3.1 Capabilities in practice

CiPs describe the professional tasks or work within the scope of the specialty and internal medicine. CiPs are based on the concept of entrustable professional activities[4] which use the professional judgement of appropriately trained, expert assessors as a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the knowledge, skills and attitudes which should be demonstrated. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.

In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP if capability is maintained (in line with standard professional conduct).

This section of the curriculum details the six generic CiPs, eight clinical CiPs for internal medicine (stage 2) and seven specialty CiPs for Gastroenterology (six core and a choice of one out of two options for complex care). The expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision are given for each CiP. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

3.2 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

[4] Nuts and bolts of entrustable professional activities

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP there is a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

KEY

ACAT/ OPCAT	Acute care assessment tool/ Outpatient care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	SCE	Specialty Certificate Examination
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within NHS organisational and management systems	
Descriptors	• Aware of and adheres to the GMC professional requirements • Aware of public health issues including population health, social detriments of health and global health perspectives • Demonstrates effective clinical leadership • Demonstrates promotion of an open and transparent culture • Keeps practice up to date through learning and teaching • Demonstrates engagement in career planning • Demonstrates capabilities in dealing with complexity and uncertainty • Aware of the role of and processes for operational structures within the NHS • Aware of the need to use resources wisely
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures Management course

	End of placement reports
2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups • Behaves in accordance with ethical and legal requirements • Demonstrates ability to offer apology or explanation when appropriate • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX ALS certificate End of life care and capacity assessment End of placement reports
Category 2: Communication, teamworking and leadership	
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings • Communicates effectively with clinical and other professional colleagues • Identifies and manages barriers to communication (eg cognitive impairment, speech and hearing problems, capacity issues) • Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills • Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations • Shares decision making with children and young people • Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking

Evidence to inform decision	MCR MSF PS End of placement reports Educational supervisor's report
Category 3: Safety and quality	
4. Is focused on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: Wider professional practice	
5. Carrying out research and managing data appropriately	
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients

	• Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act as clinical supervisor to doctors in earlier stages of training
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO Relevant training course End of placement reports

3.3 Clinical capabilities in practice

The eight IM Clinical CiPs describe the clinical tasks or activities which are essential to the practice of Internal Medicine. The clinical CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Clinical CiPs – Internal Medicine	
1. Managing an acute unselected take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately selects, manages and interprets investigations • Recognises need to liaise with specialty services and refers where appropriate
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT Logbook of cases Simulation training with assessment
2. Managing the acute care of patients within a medical specialty service	
Descriptors	• Able to manage patients who have been referred acutely to a specialised medical service as opposed to the acute unselected take (eg cardiology and respiratory medicine acute admissions • Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making

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- Takes a relevant patient history including patient symptoms, concerns, priorities and preferences
- Performs accurate clinical examinations
- Shows appropriate clinical reasoning by analysing physical and psychological findings
- Formulates an appropriate differential diagnosis
- Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required
- Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues
- Appropriately selects, manages and interprets investigations
- Demonstrates appropriate continuing management of acute medical illness in a medical specialty setting
- Refers patients appropriately to other specialties as required

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<tr><td>GPCs</td><td>

Domain 1: Professional values and behaviours
Domain 2: Professional skills:

- practical skills
- communication and interpersonal skills
- dealing with complexity and uncertainty
- clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)*

Domain 3: Professional knowledge

- professional requirements
- national legislation
- the health service and healthcare systems in the four countries

Domain 4: Capabilities in health promotion and illness prevention
Domain 5: Capabilities in leadership and teamworking
Domain 6: Capabilities in patient safety and quality improvement

- patient safety
- quality improvement

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<tr><td>Evidence to inform decision</td><td>MCR
MSF
CbD
ACAT
Logbook of cases
Simulation training with assessment</td></tr>
<tr><td colspan="2">3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment</td></tr>
<tr><td>Descriptors</td><td>

- Demonstrates professional behaviour with regard to patients, carers, colleagues and others
- Delivers patient centred care including shared decision making
- Demonstrates effective consultation skills
- Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required
- Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues
- Demonstrates appropriate continuing management of acute medical illness inpatients admitted to hospital on an acute unselected take or selected take

</td></tr>
</table>

	• Recognises need to liaise with specialty services and refers where appropriate Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions) • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF ACAT Mini-CEX DOPS
4. Managing patients in an outpatient clinic, ambulatory or community setting (including management of long term conditions)	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately manages comorbidities in outpatient clinic, ambulatory or community setting • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation

	• the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	MCR ACAT mini-CEX PS Letters generated at outpatient clinics OPCAT
5. Managing medical problems in patients in other specialties and special cases	
Descriptors	• Demonstrates effective consultation skills (including when in challenging circumstances) • Demonstrates management of medical problems in inpatients under the care of other specialties • Demonstrates appropriate and timely liaison with other medical specialty services when required
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR ACAT CbD
6. Managing a multidisciplinary team including effective discharge planning	
Descriptors	• Applies management and team working skills appropriately, including influencing, negotiating, continuously re-assessing priorities and effectively managing complex, dynamic situations • Ensures continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover • Effectively estimates length of stay • Delivers patient centred care including shared decision making • Identifies appropriate discharge plan • Recognises the importance of prompt and accurate information sharing with primary care team following hospital discharge
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking

<table>
<tr><td>Evidence to inform decision</td><td>MCR
MSF
ACAT
Discharge summaries</td></tr>
<tr><td colspan="2">7. Delivering effective resuscitation and managing the acutely deteriorating patient</td></tr>
<tr><td>Descriptors</td><td>• Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious
• Demonstrates the professional requirements and legal processes associated with consent for resuscitation
• Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families
• Demonstrates competence in carrying out resuscitation</td></tr>
<tr><td>GPCs</td><td>Domain 1: Professional values and behaviours
Domain 2: Professional skills
• practical skills
• communication and interpersonal skills
• dealing with complexity and uncertainty
• clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)
Domain 3: Professional knowledge
• professional requirements
• national legislation
• the health service and healthcare systems in the four countries
Domain 5: Capabilities in leadership and teamworking
Domain 6: Capabilities in patient safety and quality improvement
• patient safety
• quality improvement
Domain 7: Capabilities in safeguarding vulnerable groups</td></tr>
<tr><td>Evidence to inform decision</td><td>MCR
DOPS
ACAT
MSF
ALS certificate
Logbook of cases
Reflection
Simulation training with assessment</td></tr>
<tr><td colspan="2">8. Managing end of life and applying palliative care skills</td></tr>
<tr><td>Descriptors</td><td>• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs
• Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life
• Demonstrates safe and effective use of syringe pumps in the palliative care population
• Able to manage non-complex symptom control including pain
• Facilitates referrals to specialist palliative care across all settings
• Demonstrates effective consultation skills in challenging circumstances</td></tr>
</table>

	• Demonstrates compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries
Evidence to inform decision	MCR CbD Mini-CEX MSF Regional teaching Reflection

3.4 Specialty capabilities in practice

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

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

KEY

ACAT/ OPCAT	Acute care assessment tool Outpatient care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	SCE	Specialty Certificate Examination
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Specialty CiPs	
1. Manage care of Gastroenterology and Hepatology in-patients	
Descriptors	• Demonstrates behaviour appropriately with regard to patients

	• demonstrates behaviour appropriately with regard to clinical and other professional colleagues • demonstrates effective communication skills including challenging circumstances • demonstrates ability to negotiate shared decision making • demonstrates leadership skills • demonstrates effective skills in managing patients on home ward/through outreach within the organisation • demonstrates timely involvement with other clinicians as appropriate
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR ACAT CBD mini-CEX MSF/patient survey Discharge summaries QIPAT/audit assessment SCE ALS
2. Managing care of Gastroenterology and Hepatology patients in an out-patient environment	
Descriptors	Demonstration of: • Appropriate professional behaviours with regard to patients • Appropriate professional behaviours with regard to clinical and other professional colleagues • Effective communication skills including challenging circumstances • Ability to negotiate shared decision making • Leadership skills • Appropriate liaison with other services
GPCs	Domain 1: Professional values and behaviours

	Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR OPCAT CBD mini-CEX MSF/patient survey Clinic letters QIPAT/audit assessment SCE
3. Managing care of patients with complex disease across multiple care settings, including interaction with primary care and community networks	
Descriptors	Demonstration of: • Appropriate professional behaviours with regard to patients • Appropriate professional behaviours with regard to clinical and other professional colleagues • Effective communication skills including challenging circumstances • Ability to negotiate shared decision making • Leadership skills • Appropriate liaison with other services
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge

	• professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	SCE CBD Clinic letters Reflection
4. Managing care pathways for patients with suspected and confirmed gastrointestinal and hepatic malignancy	
Descriptors	Demonstration of: • Appropriate professional behaviours with regard to patients • Appropriate professional behaviours with regard to clinical and other professional colleagues • Effective communication skills including challenging circumstances • Ability to negotiate shared decision making • Leadership skills • Appropriate liaison with other services
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	SCE CBD Clinic letters Reflection

5. The ability to practice diagnostic and therapeutic upper GI endoscopy and in other practical skills undertaken/overseen by a Gastroenterology Consultant	
Descriptors	Demonstration of: • Appropriate professional behaviours with regard to patients • Appropriate professional behaviours with regard to clinical and other professional colleagues • Competence in assessing patients for endoscopic and other interventional procedures • Competence in undertaking diagnostic and therapeutic endoscopic procedures • Competence in performing other practical procedures • Ability to teach skills to others
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge o professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Disease prevention and health promotion Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	DoPs in JETs portfolio (or portfolio of procedures performed) Simulation training JAG accreditation (or equivalent from a national accrediting body) QIPAT/audit assessment DoPs for non-endoscopic procedures
6. Contributing to the prevention of gastrointestinal and liver disease	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking patient preferences into account • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues

	• Applies knowledge of prevention and screening to individual patients and the local health system • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Disease prevention and health promotion Domain 5: Capabilities in leadership and teamworking
Evidence to inform decision	ESR MSF SCE QIPAT/audit assessment Reflection
Gastroenterology CiPs Themed for service One of two options:	
1. Managing complex problems in luminal gastroenterology	
Descriptors	Demonstration of: • Appropriate professional behaviours with regard to patients • Appropriate professional behaviours with regard to clinical and other professional colleagues • Effective communication skills including challenging circumstances • Ability to negotiate shared decision making • Leadership skills • Effective skills in managing patients on home ward/through outreach within the organisation • Timely involvement with other clinicians as appropriate • Ability to work within networks of care to deliver optimal outcomes • Competence in assessing patients for colonoscopy and other interventional procedures • Competence in undertaking diagnostic and therapeutic colonoscopy
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

	• clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	SCE MCR ACAT OPCAT CBD mini-CEX MSF/patient survey Discharge summaries DoPs in JETs portfolio (portfolio of procedures performed) Simulation training JAG accreditation (or equivalent) QIPAT/audit assessment
2. Managing complex problems in hepatology	
Descriptors	Demonstration of: • Appropriate professional behaviours with regard to patients • Appropriate professional behaviours with regard to clinical and other professional colleagues • Effective communication skills including challenging circumstances • Ability to negotiate shared decision making • Leadership skills • Effective skills in managing patients on home ward/through outreach within the organisation • Timely involvement with other clinicians as appropriate • Ability to work within networks of care to deliver optimal outcomes
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements

	• national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	SCE MCR ACAT OPCAT CBD mini-CEX MSF/patient survey DoPs in JETs portfolio (portfolio of procedures performed) Simulation training JAG accreditation (or equivalent) Discharge summaries QIPAT/audit assessment

3.5 Presentations and conditions

The table below details the key presentations and conditions of Gastroenterology. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate CiPs and GPCs. In this spiral curriculum, trainees will expand and develop the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate core bedside skills, including information gathering through history and physical examination and information sharing with patients, families and colleagues.

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether care is focused mainly on curative intent or whether the main focus is on symptomatic relief. It also covers broader aspects of care, including involvement of other professionals or services.

Particular presentations, conditions and issues are listed either because they are common or serious (having high morbidity, mortality and/or serious implications for treatment or public health).

For each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. Our approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Genomics	Has knowledge of common and rare hereditary gastrointestinal and liver diseases Has understanding of principles of Pharmacogenomics and impact on Gastrointestinal disease Consent and family counselling Genomic investigations	Family history of common and rare diseases Lifelong disease surveillance e.g., colonoscopy ad prescription of prophylactic medications Requesting and interpretation of genomic tests/ Early onset cancers <50 years Requesting and interpretation of genomic tests	Monogenic diseases e.g., Lynch syndrome, hereditary pancreatitis Polygenic/ multifactorial diseases e.g., Crohn's, coeliac disease Early onset disease e.g., Cancer <50 Viral hepatitis genotype Personalised care	
Epidemiology and Public Health	Understands principles of screening and surveillance in GI diseases including cancer	Barrett's oesophagus Inflammatory Bowel Disease	Knowledge of surveillance guidelines in GI malignancies	

GI Physiology	Recognises risk factors for GI cancers Understands principles of Risk stratification Recognises importance of health promotion and preventative strategies for GI disease including cancer Population-based care Familiar with the principles of GI physiology and how they underpin clinical practice	Bowel Cancer Screening Programme Non-Alcoholic Fatty Liver Disease (NAFLD) and obesity Alcohol GI motility disorders	Knowledge of advanced diagnostic methods for detection of dysplasia and methods of ablation	
LUMINAL GASTROENTEROLOGY **Significant Gastrointestinal symptoms**	Understands the range of symptoms (including functional and extra-intestinal), arising from the GI tract and their causes Able to initiate appropriate investigation and management of common GI symptoms	Nausea and vomiting Abdominal pain Diarrhoea Weight loss Gastro-oesophageal reflux Dysphagia Odynophagia Bloating Constipation Incontinence Disordered defecation	Organic GI disorders Functional GI disorders Extra intestinal disorders	

Upper GI disease	Understands the physiology of the upper GI tract and how it is modified by drugs Recognises the clinical presentations of gastro-oesophageal reflux disease (GORD) Understands the causes of dysphagia and their assessment, including oesophageal manometry and pH studies Knows the range of medical and endoscopic therapeutic options for dysphagia Is competent in the Investigation and management of peptic ulcer disease and non-ulcer dyspepsia Understands the significance of alarm symptoms Is competent in the emergency management of GI bleeding	Dyspepsia Heartburn Dysphagia Symptomatic anaemia Vomiting Weight loss GI bleeding	GORD Peptic ulcer disease and role of *Helicobacter pylori* Barrett's oesophagus Eosinophilic oesophagitis Oesophageal motility disorders	management of Gastro outpatient Management of GI emergencies

Functional GI disorders	Understands the pathophysiology and presentation of functional gut disorders Understands the need for judicious use of investigations Understand the range of presentations as per the ROME Classification Recognises the contribution of psychosocial factors in functional GI disorders Demonstrates skill in communication of functional diagnoses Skilled in the management of chronic symptoms	Abdominal pain Disturbance of bowel habit Dysphagia Vomiting Bloating	Functional upper GI syndromes Gastroparesis Non cardiac chest pain Irritable bowel syndrome Functional abdominal pain Opioid related GI disturbance Constipation and disordered defaecation	Management of gastro outpatient Multidisciplinary involvement

Management of Gastrointestinal Bleeding	Skilled in the investigation and management of acute overt GI blood loss Understands the causes of GI bleeding Able to assess and manage hypovolaemia and resuscitation Knows the principles of using the various risk stratification tools Able to arrange appropriate investigations to assess the cause of bleeding Knows the appropriate therapeutic interventions to control bleeding including role of interventional radiology, and surgery	Haematemesis Melaena Hypovolaemic shock	Upper GI bleeding including peptic ulcer, and variceal bleeding Lower GI bleeding	

Inflammatory bowel disease	Understands the role of imaging modalities in the diagnosis and assessment of disease severity. Understands the principles of management of acute severe colitis Works effectively within a multidisciplinary team to manage chronic disease Understands the role and timing of surgery Has knowledge and understanding of the available pharmacological treatment options and their monitoring Able to recognise and manage disease complications Understands the management of perianal Crohn's disease Understands the management of extra-intestinal manifestations Preconception counselling and management of IBD in pregnancy Nutritional support in IBD	Diarrhoea Abdominal pain Anaemia Weight loss	Crohn's disease Ulcerative colitis Microscopic colitis Awareness of differential diagnosis including bacterial, viral, or parasitic infection, drug induced inflammation, ischaemic or diverticular inflammation	

	Surveillance for cancer in IBD			
Malabsorption	Diagnosis and management of malabsorption Management of fluid and electrolyte disturbance and micronutrient deficiency	Diarrhoea Abdominal pain Anaemia Weight loss	Coeliac disease Bile salt malabsorption SIBO Pancreatic insufficiency Short bowel syndrome High output stoma	

GI Cancer	Able to use appropriate Investigation modalities for early cancer diagnosis Understands role of Multidisciplinary management and works effectively within the team Understands the range of treatment options, their effectiveness and their possible complications Skilled in the communication of cancer diagnosis Understands the principles of palliative care including endoscopic options such as stenting Understands the role of family history and genetic testing Understands the role of risk stratification for Cancer screening and surveillance programmes Understands the role of chemoprevention Understands the role of advanced diagnostic modalities for dysplasia and methods of ablation/therapy Recognition of non-invasive markers for cancer screening	Weight loss Anaemia Abdominal pain Vomiting Dysphagia Rectal bleeding Change in bowel habit FIT positive	Oesophageal cancer Gastric cancer Pancreato-biliary cancer Colorectal cancer Neuroendocrine tumours Hereditary cancer syndromes Barrett’s oesophagus Advanced Cancer palliative management	

Other inflammatory and infective conditions	Investigation and management of acute colitis Recognises the importance of infection as a cause of gastrointestinal and liver disease and the role and consequences of disordered immunity in both gastrointestinal and liver diseases Recognition and management of acute bowel ischaemia	Abdominal pain Disturbance of bowel habit Bloody diarrhoea	Infective gastroenteritis Ischaemic colitis Diverticular disease and its complications Acute and chronic mesenteric ischaemia	

Nutrition	Nutrition screening and assessment Recognition of consequences of under nutrition Multidisciplinary management Management of re-feeding risks Roles of artificial nutritional support: Understanding the indications contraindications and relative risks of enteral vs parenteral feeding Ethical and legal implications of provision and withdrawal of artificial nutritional support Insertion of enteral feeding tubes	Weight loss Anorexia Anaemia Obesity	Malnutrition in the context of chronic disease Eating disorders Intestinal failure Short bowel syndrome High output stomas Enterocutaneous fistula Obesity and metabolic syndrome	

Hepatology	Liver anatomy and physiology Public health aspects: obesity, alcohol and viral hepatitis Evaluation and investigation of chronic liver disease Fibrosis assessment Adolescent liver disease Role of nutrition in chronic liver disease management Screening, diagnosis and management of hepatocellular carcinoma Liver disease in pregnancy Investigation and management of acute liver injury and acute liver failure Management of cirrhosis complications	Abnormal LFTs Pruritis/fatigue Alcohol withdrawal Sarcopenia Abnormal liver imaging Confusion Jaundice Cholangitis Ascites Hydrothorax Variceal bleeding	Alcohol-related liver disease/brain dysfunction/ dependence/relapse therapy/ community teams/national measures/deprivation Non-alcoholic fatty liver disease/obesity services Viral hepatitis including antiviral regimens/ vaccination/ODNs/drug services Immune-mediated/cholestatic liver disease Drug induced liver injury Vascular liver disease Mongenic liver disease, gene testing/panels, genetic factors in other liver disease Non-invasive fibrosis methods, liver biopsy Role of liver histopathology and radiology MDT Role of paediatric transition services MDT working with dietician/nutrition teams Diffuse change, benign/malignant liver lesions HCC treatment modalities/MDT working Pregnancy specific liver conditions, managing cirrhosis in pregnancy Acute alcoholic hepatitis Acute liver failure/ACLF Hepatic encephalopathy	Hepatology

	Enhanced supportive care for decompensated cirrhosis When to refer for liver transplantation	Renal failure Hyponatraemia Hypoxia	Spontaneous bacterial peritonitis/ HRS HPS/ portopulmonary hypertension Cirrhotic/alcoholic cardiomyopathy Sepsis in cirrhosis Multidisciplinary input Role of endoscopy, HVPG/TIPSS Linking with palliative care/MDT Therapeutic paracentesis/indwelling devices UKELD, transplant assessment basics	

	Transplantation: Assessment decision making Waiting list management Perioperative care Postoperative care	Decompensated cirrhosis Acute liver failure Hepatocellular carcinoma Variant syndromes	Detailed transplant assessment Indications, contraindications, MDT working Optimisation/prioritisation/ suspension/ removal Donor types/organ allocation/ perfusion techniques Early complications - surgical/rejection/infection Late - immunosuppression/ recurrent disease/ malignancy/ metabolic	
Pancreatic and Biliary disorders		Abdominal pain Obstructive jaundice Weight loss Sepsis	Investigative pathway Indications for Endoscopic Ultrasound/ ERCP/ cholangioscopy/ percutaneous transhepatic cholangiography Gall bladder disease Acute and chronic pancreatitis Pancreato-biliary malignancy	

Endoscopy	Indications for endoscopy Patient-centred approach and shared decision making Non-technical endoscopic skills Understands principles of quality, safety and clinical governance in endoscopy Recognition and management of Complications of endoscopy Lesion recognition Knowledge and understanding of the role of Video Capsule Endoscopy, ERCP and endoscopic ultrasound and other advanced endoscopic techniques. Other novel procedures	GI Bleeding	UGI endoscopy to equivalent of JAG accreditation Therapeutic UGI endoscopy for GI Bleeding Colonoscopy to equivalent of JAG accreditation (complex luminal) including level 2 polypectomy Use of advanced imaging techniques	

3.6 Practical procedures

Therapeutic Paracentesis
Gastroenterology trainees must become proficient in therapeutic large-volume paracentesis in addition to the required endoscopic competencies.

Trainees must be able to outline the indications for diagnostic and therapeutic (large volume) paracentesis and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting help when appropriate. The trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Trainees should receive training in procedural skills in a clinical skills lab if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct). Trainees will usually be expected to be signed off for Paracentesis by the end of ST4.

Procedure	ST4	ST5	ST6	ST7
Minimum level required				
Large-volume paracentesis	Able to perform the procedure with limited supervision	Competent to perform the procedure unsupervised	Maintain	Maintain

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries'. A training programme director (TPD) will be responsible for coordinating the specialty training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Progression through the programme will be determined by the Annual Review of Competency Progression (ARCP) process and the training requirements for each indicative year of training are summarised in the ARCP decision aid (available on the JRCPTB website).

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the curriculum requirements are met and also that unnecessary duplication and educationally unrewarding experiences are avoided.

Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person. It will be best practice for trainees to have an educational supervisor who practises internal medicine for periods of IM stage 2 training. Educational supervisors of IM trainees who do not themselves practise IM must take particular care to ensure that they obtain and consider detailed feedback from clinical supervisors who are knowledgeable about the trainees' IM performance and include this in their educational reports.

The following provides a guide on how training programmes should be focused in order for trainees to gain the experience and develop the capabilities to the level required.

Ideally, trainees should complete core hepatology in the first two years of training.

Palliative and end of life care

Palliative and end of life care is a core component of the Internal Medicine (IM) curriculum and trainees will continue to develop their knowledge and skills throughout specialty training. Palliative and end of life care is one of the eight clinical Capabilities in Practice (CiPs, CiP8), with specialist palliative care experience recommended.

Gastroenterologists care for many patients with gastrointestinal cancer and end-stage liver disease and so familiarity with the indications for palliative care and the direct delivery of this care to some patients is a part of regular practice of most Gastroenterologists. Gastroenterologists will routinely be involved in end-of-life care of patients with cancer and cirrhosis (CiPs 2,3 and 4). Trainees will be encouraged to undertake relevant work-place based assessments to evidence entrustment decisions for CiP8 in the IM curriculum as well as CiPs 2, 3 and 4 in Gastroenterology. This will include:

- Managing difficult physical symptoms
- Managing psychological, spiritual and existential distress for patients and those close to them
- Addressing complex social issues for patients at the end of life (including facilitating preferences for place of care and death)
- Managing challenging symptoms in the dying patient
- Identifying those in need of proactive or enhanced bereavement support
- Managing palliative care patients out of hours, including in non-acute settings

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities described in the syllabus through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the

job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn.

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

Gastroenterology and Hepatology Outpatient care
The educational objectives of attending clinics are:

- To understand the management of chronic diseases
- Be able to assess a patient in a defined time frame
- To interpret and act on the referral letter to clinic
- To propose an investigation and management plan in a setting different from the acute medical situation
- To review and amend existing investigation plans
- To write an acceptable letter back to the referrer
- To communicate with the patient and where necessary relatives and other health care professionals.

These objectives can be achieved in a variety of settings including hospitals, day care facilities and the community. The clinic might be primarily run by a specialist nurse (or other qualified health care professionals) rather than a consultant physician. After initial induction, trainees will review patients in clinic settings, under direct supervision. The degree of responsibility taken by the trainee will increase as competency increases. Trainees should see a range of new and follow-up patients and present their findings to their clinical supervisor. Clinic letters written by the trainee should also be reviewed and feedback given.

The number of patients that a trainee should see in each clinic is not defined, neither is the time that should be spent in clinic, but as a guide this should be a minimum of two hours.

Clinic experience should be used as an opportunity to undertake supervised learning events and reflection.

Reviewing patients with consultants
It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WPBA such as an ACAT, mini-CEX or CBD). This may be accomplished when working on a take shift along with a consultant, or on a post-take ward round with a consultant.

Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments
Every patient seen, on the ward or in outpatients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

Ward rounds by more senior doctors

Every time a trainee observes another doctor seeing a patient or their relatives there is an opportunity for learning. Ward rounds (including post-take) should be led by a more senior doctor and include feedback on clinical and decision-making skills.

Multidisciplinary team meetings
There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning.

Trainees have supervised responsibility for the care of inpatients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

Formal postgraduate teaching
The content of these sessions are determined by the Regional Training Programme Committee and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings. Many of these are organised by the British Society of Gastroenterology.

Suggested activities include:

- a programme of formal bleep-free regular teaching sessions to cohorts of trainees (eg a weekly training hour for IM teaching within a training site)
- case presentations
- research, audit and quality improvement projects
- lectures and small group teaching
- Grand Rounds
- clinical skills demonstrations and teaching
- critical appraisal and evidence-based medicine and journal clubs
- joint specialty meetings
- attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.
- access to online resources supporting curriculum outcomes
- simulation, focused on technical and non-technical aspects of endoscopy

Learning with peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions.

Independent self-directed learning
Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- reading journals

- achieving personal learning goals beyond the essential, core curriculum

Formal study courses
Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management and leadership courses and communication courses, which are particularly relevant to patient safety and experience. Gastroenterology trainees will be expected to attend endoscopy courses in order to complete their endoscopy training. Courses are one of the ways in which learning objectives can be demonstrated to have been achieved.

4.3 Academic training

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

Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the Deanery as to what is appropriate together with guidance from the appropriate SAC that the proposed period and scope of study is sensible.

4.4 Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the postgraduate dean in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

4.5 Acting up as a consultant

A trainee coming towards the end of their training may spend up to three months “acting-up” as a consultant, provided that a consultant supervisor is identified for the post and satisfactory progress is made. As long as the trainee remains within an approved training programme, the GMC does not need to approve this period of “acting up” and their original CCT date will not be affected. More information on acting up as a consultant can be found in the Gold Guide.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:
- assess trainees’ actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development

- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme
- inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme
- identify trainees who should be advised to consider changes of career direction

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different individual types of assessment. A range of assessments is needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (eg through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgement in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training. The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees continually to gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all SLEs and WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace-based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment anchor statements

- Below expectations for this year of training: may not meet the requirements for critical progression point
- Meeting expectations for this year of training: expected to progress to next stage of training
- Above expectations for this year of training: expected to progress to next stage of training

Towards the end of the training year, trainees will make a self-assessment of their progression for each CiP and record this in the eportfolio with signposting to the evidence to support their rating.

The educational supervisor (ES) will review the evidence in the e-portfolio including workplace-based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in the ES report, with commentary.

For **Generic CiPs**, the ES will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For **Clinical and Specialty CiPs**, the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Level descriptors for clinical and specialty CiPs

Level	Descriptor
Level 1	**Entrusted to observe only** – no provision of clinical care
Level 2	**Entrusted to act with direct supervision**: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3	**Entrusted to act with indirect supervision**: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4	**Entrusted to act unsupervised**

The ARCP will be informed by the ES report and the evidence presented in the e-portfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic

outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

Poor performance will be managed in line with the Gold Guide.

5.4 Critical progression points

There will be two critical progression points, one at the end of ST5 and one at the completion of specialty training. The ST5 critical progression point refers to sign off in UGI endoscopy only, and that although large volume paracentesis would usually be achieved by the end of ST4, this does not form part of the critical progression point. Trainees will be required to be entrusted at level 4 in all CiPs to achieve an ARCP outcome 6 and be recommended for a CCT.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

The outline grids below set out the expected level of supervision and entrustment for the IM clinical CiPs and the specialty CiPs and include the critical progression points across the whole training programme.

Table 1: Outline grid of levels expected for Internal Medicine clinical capabilities in practice (CiPs)

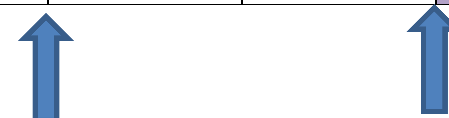
Level descriptors
Level 1: Entrusted to observe only – no clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

	Internal Medicine stage 2 + specialty training				CCT
Specialty CiP	**ST4**	**ST5**	**ST6**	**ST7**	
1. Managing an acute unselected take	3	3	3	4	CRITICAL PROGRESSION POINT
2. Managing the acute care of patients within a medical specialty service	2	3	3	4	
3. Providing continuity of care to medical inpatients	3	3	3	4	
4. Managing outpatients with long term conditions	3	3	3	4	
5. Managing medical problems in patients in other specialties and special cases	3	3	3	4	
6. Managing an MDT including discharge planning	3	3	3	4	
7. Delivering effective resuscitation and managing the deteriorating patient	4	4	4	4	
8. Managing end of life and applying palliative care skills	3	3	3	4	

Table 2: Outline grid of levels expected for Gastroenterology specialty capabilities in practice (CiPs)

Levels to be achieved by the end of each training year for specialty CiPs
Level descriptors
Level 1: Entrusted to observe only – no clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

Clinical CiP	ST4	ST5	ST6	ST7	
1. Managing care of gastroenterology and hepatology inpatients	3	3	3	4	CRITICAL PROGRESSION POINT
2. Managing care of gastroenterology and hepatology outpatients	2	3	3	4	
3. Managing care of patients with complex disease across multiple care settings	3	3	3	4	
4. Managing care pathways for patients with suspected and confirmed malignancy	2	2	3	4	
5. The ability to practice diagnostic and therapeutic UGI endoscopy and other practical skills	2	3	3	4	
6. Contributing to the prevention of GI and liver disease	2	2	3	4	
7a. Managing complex problems in luminal gastroenterology	2	2	3	4	
7b. Managing complex problems in hepatology	2	2	3	4	



Critical Progression Points
End ST5 Diagnostic UGI endoscopy sign-off
End ST7 Specialty certificate Examination (ESEGH)

5.5 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Examinations and certificates

- Advanced Life Support Certificate (ALS)
- Specialty Certificate Examination (SCE) - European Specialty Examination in Gastroenterology and Hepatology (ESEGH)

The ESEGH has become the General Medical Council (GMC, UK) approved mandatory summative assessment of knowledge for UK trainees in Gastroenterology and Hepatology. The examination tests the extra knowledge base that trainees have acquired since taking the MRCP(UK) diploma. The knowledge base itself must be associated with adequate use of such knowledge and passing this examination must be combined with satisfactory progress in workplace-based assessments for the trainee to successfully reach the end of training and be awarded the CCT in Gastroenterology. Information is available on the MRCPUK website.

- JAG certification (or equivalent evidence of endoscopy competence)

Workplace based assessment (WPBA)

- Direct Observation of Procedural Skills (DOPS) – summative

Formative assessment

Supervised Learning Events (SLEs)

- Acute Care Assessment Tool (ACAT)
- Outpatient Care Assessment Tool (OPCAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Outpatient Care Assessment Tool (OPCAT)

WPBA

- Direct Observation of Procedural Skills (DOPS) – formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the e-portfolio and on the JRCPTB website (www.jrcptb.org.uk).

Assessment should be recorded in the trainee's e-portfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Acute Care Assessment Tool (ACAT)
The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take. It is primarily for assessment of their ability to prioritise, to work efficiently, to work with and lead a team, and to interact effectively with nursing and other colleagues. It can also be used for assessment and feedback in relation to care of individual patients. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT.

Case-based Discussion (CbD)
The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, and discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

mini-Clinical Evaluation Exercise (mini-CEX)
This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction, and an assessor is available.

Direct Observation of Procedural Skills (DOPS)
A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel are 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 several 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.

Outpatient Care Assessment Tool (OPCAT)
The Outpatient Care Assessment Tool (OPCAT) is designed to assess and facilitate feedback on a doctor's performance in outpatient settings to provide an indication of competence in areas such as confidentiality, history taking and examination, investigation and management plan and communication. The OPCAT is designed to be used in a single clinic whether that is face to face or

virtual and may be used during a direct observation if the trainer is present or as an assessment at the end of a clinic. There is no minimum number of patients that should be seen although for a post clinic assessment it would be unusual if the trainee has seen fewer than three patients.

Patient Survey (PS)
A trainee's interaction with patients should be continually observed and assessed. The Patient Survey provides a tool to assess a trainee during a consultation period. The Patient Survey assesses the trainee's performance in areas such as interpersonal skills, communication skills and professionalism.

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).

Supervisors' reports

Multiple Consultant Report (MCR)
The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisors report (ESR)
The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR will include the ES's summative judgement of the trainee's performance and the entrustment decisions given for the learning outcomes (CiPs). The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors (MCRs) and formative assessments demonstrating progress over time.

5.6 Decisions on progress (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in

training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the clinical and specialty CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year or training the requirements for each year of training are set out in the ARCP decision aid (www.jrcptb.org.uk).

The ARCP process is described in the Gold Guide. Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's e-portfolio.

As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal e-portfolio review either with their educational supervisor or arranged by the local school of medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

There should be review of the trainee's progress to identify any outstanding targets that the trainee will need to complete to meet all the learning outcomes for completion training approximately 12-18 months before CCT. This should include an external assessor from outside the training programme.

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To guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the JRCPTB website www.jrcptb.org.uk.

Poor performance should be managed in line with the Gold Guide.

5.7 Assessment blueprint

The table below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

KEY

ACAT	Acute care assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
SCE	Specialty Certificate Examination	TO	Teaching observation
OPCAT	Outpatient care assessment tool	ESR	Educational supervisor report

Blueprint of assessments mapped to the Gastroenterology Capabilities in Practice (CiPs)

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO	SCE	OPCAT
Generic CiPs											
Able to function successfully within NHS organisational and management systems				√		√					
Able to deal with ethical and legal issues related to clinical practice		√	√	√	√	√					
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	√			√		√	√		√		
Is focused 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 the acute care of patients within a medical specialty service	√	√		√		√					
Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	√		√	√	√	√					
Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions	√			√	√		√				√
Managing medical problems in patients in other specialties and special cases	√	√		√							
Managing a multidisciplinary team including effective discharge planning	√			√		√					
Delivering effective resuscitation and managing the acutely deteriorating patient	√		√	√		√					
Managing end of life and applying palliative care skills		√		√	√	√					
Practical procedural skills			√								
Gastroenterology specialty CiPs											
Manage care of Gastroenterology and Hepatology in-patients	√	√		√	√	√			√	√	
Managing care of Gastroenterology and Hepatology patients in an out-patient environment	√	√		√	√		√		√	√	

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO	SCE	OPCAT
Managing care of patients with complex disease across multiple care settings, including interaction with primary care and community networks		√				√				√	
Managing care pathways for patients with suspected and confirmed gastrointestinal and hepatic malignancy		√				√		√		√	
The ability to practice diagnostic and therapeutic upper GI endoscopy and in other practical skills undertaken/overseen by a Gastroenterology Consultant			√			√	√				
Contributing to the prevention of gastrointestinal and liver disease								√		√	
7a. Managing complex problems in luminal gastroenterology	√	√		√		√	√	√	√		
7b. Managing complex problems in hepatology	√	√		√		√	√	√	√		

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning[5].

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high-quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a

[5] Improving feedback and reflection to improve learning. A practical guide for trainees and trainers

single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[6].

Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements. Trainees on a dual training program may have a single educational supervisor responsible for their internal medicine and specialty training, or they may have two educational supervisors, one responsible for internal medicine and one for specialty.

Clinical supervisor

Consultants responsible for patients that a trainee looks after provides clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide a MCR for the trainee to inform the Educational Supervisor's report.

The educational and (if relevant) clinical supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors (as well as the trainee). These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles[7]. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

Trainees

Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their

[6] Promoting excellence: standards for medical education and training

[7] Recognition and approval of trainers

development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.1 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the e-portfolio

Induction Appraisal
The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

Mid-point Review
This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns, or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal
Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal, then the programme director should be informed. Supervisors should also identify areas where a trainee has performed about the level expected and highlight successes.

7 Quality Management

The organisation of training programs is the responsibility of the deaneries. The deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees into the specialty
- allocate trainees into particular rotations appropriate to their training needs
- oversee the quality of training posts provided locally

- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training.

Educational programmes to train educational supervisors and assessors in workplace-based assessment may be delivered by deaneries or by the colleges or both.

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB and the SAC. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

The JRCPTB has a role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. The SACs are actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its specialties and subspecialties to provide meaningful quality management. The datasets include the GMC national Training Survey (NTS) data, ARCP outcomes, examination outcomes, new consultant survey, external advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences.

8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an e-portfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the e-portfolio

On enrolling with JRCPTB trainees will be given access to the e-portfolio. The e-portfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainee's main responsibilities are to ensure the e-portfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use e-portfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

Deaneries, training programme directors, college tutors and ARCP panels may use the e-portfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous e-portfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace-based assessments (including MSF) should be recorded in the e-portfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the e-portfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other e-portfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

9 Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

Deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- Deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every three years
- Deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every three years
- ensuring trainees have an appropriate, confidential, and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. Deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
- monitoring of College Examinations
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.

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