SPECIALTY TRAINING CURRICULUM

FOR

GERIATRIC MEDICINE CURRICULUM

AUGUST 2010
(AMENDMENTS AUGUST 2013)

Administrative changes 14 May 2015

Joint Royal Colleges of Physicians Training Board

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1 Introduction

Geriatric medicine is concerned with the specialist medical care of the frail older person and in the promotion of better health in old age.

This curriculum is designed to cover all the areas of specialist medical care that an older person will experience from care at home or in a care home; in the outpatient clinic or day hospital or day care; in the accident and emergency and medical assessment unit; in the acute ward and specialist areas of acute care such as coronary care, high dependency care, intensive care, acute stroke care etc; in the rehabilitation ward or intermediate care or in long term care.

Trainees will be required to learn to manage the whole range of medical conditions at a generalist level for adults of all ages. Some trainees may opt to undertake additional stroke training to the higher level required by the Stroke Medicine sub-speciality curriculum. Because trainees may opt for this having started specialty training in Geriatric Medicine, it is advised that wherever possible all geriatric medicine training programmes include the option to receive this additional training. There are other optional modules for higher level training in other areas of the curriculum for trainees who wish to demonstrate a higher level of ability in certain areas of the curriculum because they wish to consider sub-specialising in these areas as a consultant.

This document will enable postgraduate deans, regional specialty training committees, and educational supervisors to ensure that the required standards of clinical care are being met by having structured training programmes and objective assessment procedures within each region.

The curriculum has been produced using the standards specified by the General Medical Council (GMC).

2 Rationale

2.1 Purpose of the Curriculum

The primary purpose of this curriculum is to provide detailed guidance for trainers and trainees in obtaining the appropriate level of knowledge, clinical skills, and competence to be awarded a certificate of completion of training (CCT) in geriatric medicine which is a prerequisite to a career as a consultant geriatrician working in hospital and/or community settings capable of working independently and effectively. It also specifies how the acquisition of the necessary knowledge, skills and behaviours are to be verified by assessment.

The curriculum covers training for all four nations of the UK.

All trainees are expected to acquire the competencies necessary for a CCT in General (Internal) Medicine and sub specialty recognition in Stroke Medicine. The competencies required will follow on from those required for Foundation and Core Medical Training.

Patient-centred approaches, patient safety and team working are of vital importance. Training should be enjoyable in order to facilitate the learning of the trainee. Trainees and trainers are required to have full knowledge of the curriculum.

2.2 Development

This curriculum was developed by the Specialty Advisory Committee for Geriatric Medicine under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB). It replaces the previous version of the curriculum dated January 2009, with changes to ensure the curriculum meets all GMC's standards for Curricula and Assessment, and to incorporate revisions to the content and delivery of the training programme.

There has been wide discussion on the content of the curriculum with trainees and geriatricians through the deanery representative structure of the SAC (guidance was given by the Joint Royal Colleges Physicians Training Board (JRCPTB) and the Education and Training Committee of the British Geriatrics Society). Consensus was achieved through this discussion on these committees following work by the Curriculum and Assessment Working Group of the SAC which comprises teachers, trainees, professional advisers and lay representatives. Teaching/ learning and assessment methods were chosen with guidance from the JRCPTB.

The members of the SAC at the time of its production were:

Professor SC Allen MD FRCP (Chair of SAC), Dr CJ Turnbull FRCP (Secretary of SAC and Chair Curriculum and Assessment Group), Professor T Masud MD FRCP (Chair of the British Geriatrics Society (BGS) Education and Training Committee), Dr O J Corrado (Former Chair of British Geriatrics Society Education & Training Committee and Chair of the Specialist Certificate Examination Board in Geriatric Medicine), Professor D Black MD FRCP (Lead Dean for Geriatric Medicine), Professor JM Starr MD FRCP (Academic representative), Dr K Kelleher FRCP (British Geriatrics Society Representative, Associate Dean London Deanery), Dr BJ Martin FRCP (Royal College of Physicians and Surgeons of Glasgow representative), Dr WR Primrose FRCP (Royal College of Physicians of Edinburgh representative), Dr Z Wyrko MRCP(UK) (trainee representative), Dr AL Gordon MRCP(UK) (trainee representative), Dr CJ Steves MRCP(UK) (trainee representative), Dr P Burbridge MRCP(UK) (trainee representative) Dr IR Hastie MD FRCP (Union of European Medical Societies representative, Postgraduate Dean London Deanery), Dr A Moore FRCP (Royal College of Physicians of Ireland representative - Observer), Dr KB Dynan MD FRCP (Northern Ireland), Dr RE Morse FRCP (Former Chair of British Geriatrics Society Education and Training Committee and Wales representative), Professor JA Barrett MD FRCP (e-portfolio adviser), Professor P Baker MD FRCP (North West), Dr DS Fairweather MD FRCP (Oxford representative), Dr R Wears FRCP (West Midlands representative), Dr RD Barber FRCP (South Western representative), Dr JE Clague MD FRCP (North West representative), Dr MA Cottee FRCP (London Deanery), Dr RH Jay (Northern representative and Deputy Chair BGS Education and Training Committee), Dr CG Nicholl FRCP (Eastern representative), Mr Jack Pilgrim (Lay representative), Hannah Watts (Project Manager, JRCPTB), Winnie Wade (Director of Education, RCP London), Joe Booth (Project Manager, Education Department, RCP London), Felicity Stuart (SAC Committee Support, JRCPTB), Sarah Allport and Alex Mair (British Geriatrics Society Lay Representatives). Non-SAC members who took part in writing the curriculum including Dr Eileen Burns (Leeds), Dr Stuart Bruce (East Sussex), Dr Peter Fletcher (Cheltenham), Dr Jonathan Treml (Birmingham), Dr Adrian Wagg (University College, London)

Major changes from the previous curriculum include the incorporation of leadership, health inequalities and common competencies and clarifies the relationships with Stroke Medicine. It also includes more specific statements about competence in

dementia, tissue viability, nutrition and homeostasis (including fluid balance and thermoregulation). Furthermore it includes optional additional higher level competency grids in falls; orthogeriatrics and bone health; continence; movement disorders; dementia and psychogeriatric services; and intermediate care with community practice. The work on all these additional components to the syllabus has been completed by members of the SAC in conjunction with senior members of the relevant special interest groups of the British Geriatrics Society.

2.3 Training Pathway and Entry Requirements

Specialty training in Geriatric Medicine consists of core and higher speciality training. Core training provides physicians with: the ability to investigate, treat and diagnose patients with acute and chronic medical symptoms; and with high quality review skills for managing inpatients and outpatients. Higher speciality training then builds on these core skills to develop the specific competencies required to practise independently as a consultant Geriatric Medicine.

Core training may be completed in either a Core Medical Training (CMT) or Acute Care Common Stem (ACCS) programme. The full curriculum for specialty training in Geriatric Medicine therefore consists of the curriculum for either CMT or ACCS plus this specialty training curriculum for Geriatric Medicine.

There are common competencies that should be acquired by all physicians during their training period starting within the undergraduate career and developed throughout the postgraduate career, for example communication, examination and history taking skills. These are initially defined for CMT and then developed further in the specialty. This part of the curriculum supports the spiral nature of learning that underpins a trainee's continual development. It recognises that for many of the competences outlined there is a maturation process whereby practitioners become more adept and skilled as their career and experience progresses. It is intended that doctors should recognise that the acquisition of basic competences is often followed by an increasing sophistication and complexity of that competence throughout their career. This is reflected by increasing expertise in their chosen career pathway.

The approved curriculum for CMT is a sub-set of the Curriculum for General (Internal) Medicine (G(I)M). A "Framework for CMT" has been created for the convenience of trainees, supervisors, tutors and programme directors. The body of the Framework document has been extracted from the approved curriculum but only includes the syllabus requirements for CMT and not the further requirements for acquiring a CCT in G(I)M.

For ST3 or above entry to Geriatric Medicine, it is desirable that trainees have undertaken a work placement of at least 4 months post-qualification in Geriatric Medicine and if possible some further experience in Geriatric Medicine beyond that achieved in the foundation programme as well as a range of experiences of other acute medical specialties. It is also desirable that the trainee has experience of the unselected acute medical take of at least 12 months during core training or other post foundation training by the time of entering specialty training in geriatric medicine. 'Unselected take' is defined as acute medical intake encompassing the broad generality of medicine, i.e. not restricted to any single or small group of specialities. If any major component of acute medicine (e.g. patients with stroke or myocardial infarction) is excluded from the take, this experience must be obtained in other posts. In order to ensure an adequate breadth of experience to supervise more junior trainees, on average at least 40 acutely ill patients should have been seen during each month of involvement in the acute take.

The trainee will be expected to demonstrate a commitment to Geriatric Medicine training.

The majority of trainees in Geriatric medicine will normally undertake a programme of combined training using this curriculum, with the General (Internal) Medicine (G(I)M) curriculum but trainees do have the option to undertake a single CCT in Geriatric Medicine only. The CMT framework or ACCS curriculum contains the content of training required during specialty training years one and two. Training then continues with a specialty emphasis from ST3 to ST7. For those also completing the higher level stroke curriculum aiming for sub specialty recognition in stroke there will also be an ST8 year. See fig.1 for details of the programme.

The curriculum will be achieved by completing the necessary specialty posts within training programmes. Trainees are described as Specialty Registrars (StRs).

Fig.1
Diagrammatic representation of Geriatric Medicine and G(I)M curricula

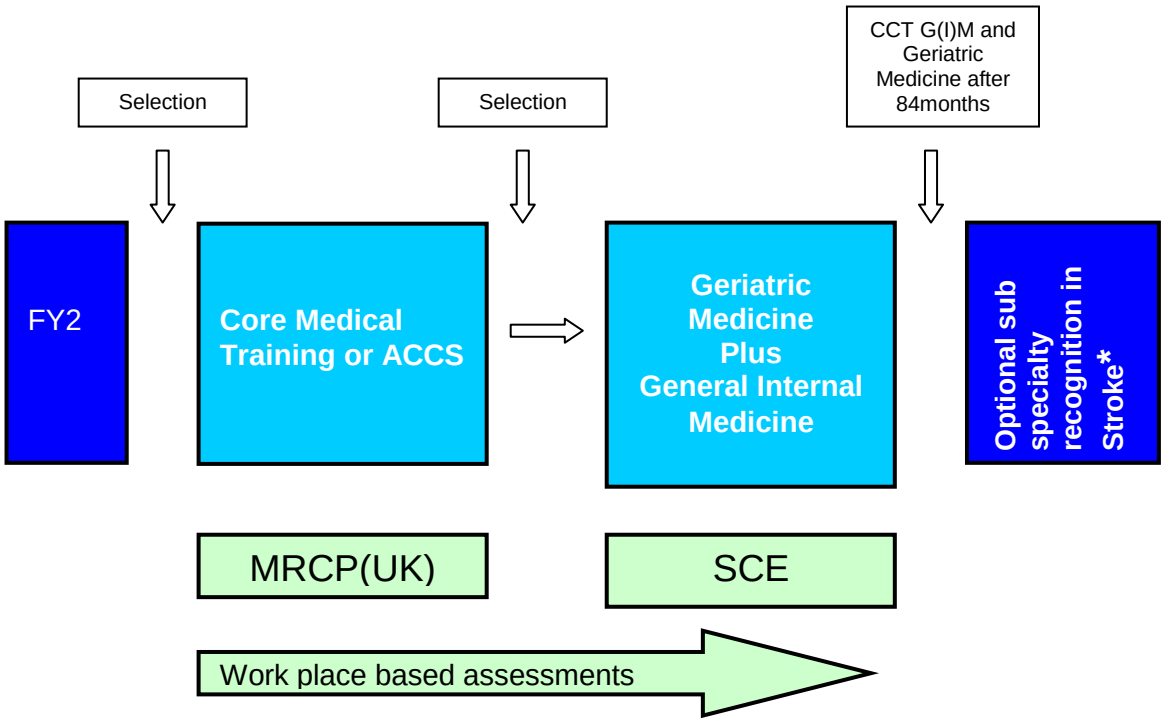
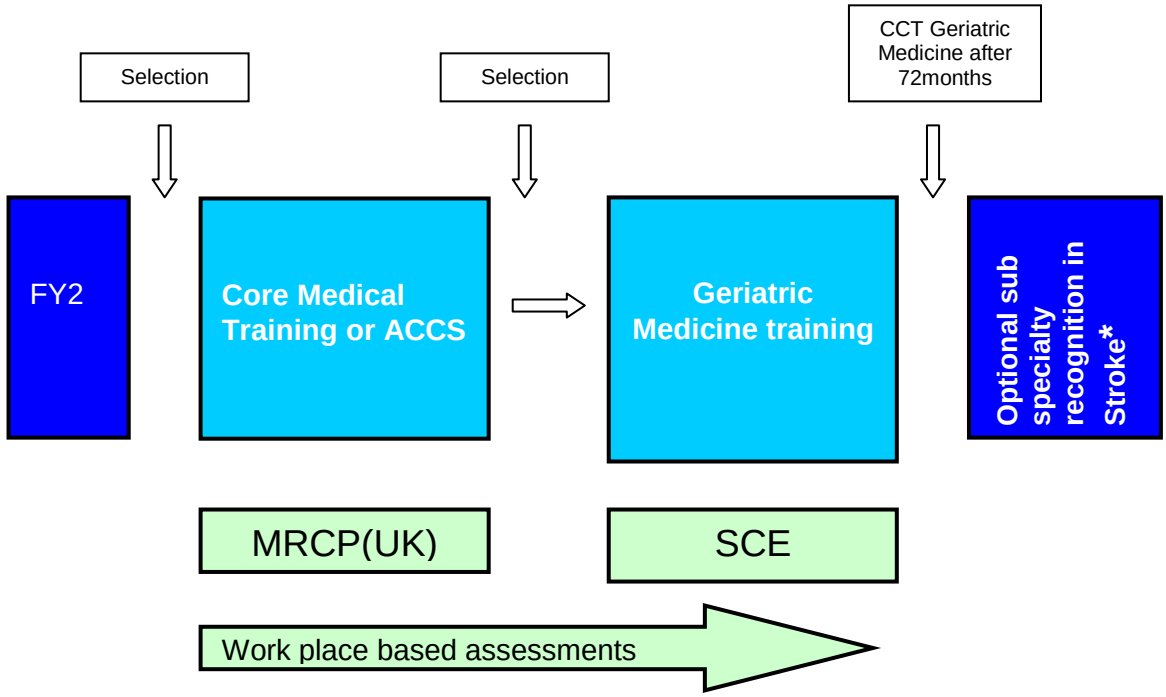


Fig.2
Diagrammatic representation of Geriatric medicine pathway



***Those trainees undertaking a year of Stroke training with their Geriatric Medicine speciality training will receive their sub speciality recognition in Stroke training and their Geriatric Medicine CCT when they have completed both their Geriatric Medicine and Stroke training.

Non-UK graduates

Non-UK graduates who apply for specialty training in geriatric medicine must provide alternative evidence of appropriate knowledge, training and experience, particularly in the care of acute medical conditions and success in an equivalent knowledge based examination to MRCP (UK) and a minimum of 4 months post-qualification experience in geriatric medicine. These trainees should apply to GMC for a CESR through Article 14(4) of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 as amended. For further information and application guidance please go to the current CESR guidance and application page at www.gmc-uk.org .

UK graduates who have not completed core medical or acute care core stem training

UK graduates who have not been through the core medical or acute care core stem training schemes will be expected to have a similar level of competence and experience of acute general internal medicine and a minimum of 4 months post-qualification experience in geriatric medicine. Such individuals will not be eligible for a CCT as they have not completed all their training in posts approved by GMC for entry to Geriatric Medicine.

Therefore, these trainees will have completed a “combined programme”, (a combination of training in a GMC approved programme from the point of their entry to the programme to successful completion and training/experience in posts prior to

appointment which were not GMC approved posts). For further information and application guidance please go to the current CESR (CP) guidance and application page at www.gmc-uk.org .

Trainees entering geriatric medicine training after year 3

Rarely trainees may enter the programme after ST3 if it can be demonstrated that the trainee has already achieved the necessary outcomes of training suitable for advanced entry. They will be expected to have an appropriate level of competence and experience in the management of acute medical conditions and experience from at least a 4 month post in geriatric medicine. This will be at the recommendation of the programme director/regional specialty adviser but will require approval by the SAC who will base their decision on the qualifications, training and experience of the applicant and references from former senior supervisors.

2.4 Enrolment with JRCPTB

Trainees are required to register for specialist training with JRCPTB at the start of their training programmes. Enrolment with JRCPTB, including the complete payment of enrolment fees, is required before JRCPTB will be able to recommend trainees for a CCT/Certificate of Completion of CMT. Trainees can enrol online at www.jrcptb.org.uk

2.5 Duration of Training

Although this curriculum is competency based, the duration of training must meet the European minimum of 4 years for full time specialty training adjusted accordingly for flexible training (EU directive 2005/36/EC). The SAC has advised that training from ST1 (ST1) will usually be completed in 7 years in full time training (2 years core plus 5 years specialty training) when training in Geriatric Medicine with General (Internal) Medicine and 6 years in Geriatric Medicine alone (2 years core plus 4 years specialty training) provided all the competencies can be achieved in this time. Stroke Training to Certificate level will require an additional one year of training (ST8).

2.6 Less Than Full Time Training (LTFT)

Trainees who are unable to work full-time are entitled to opt for less than full time training programmes. EC Directive 2005/36/EC requires that:

- LTFT shall meet the same requirements as full-time training, from which it will differ only in the possibility of limiting participation in medical activities.
- The competent authorities shall ensure that the competencies achieved and the quality of part-time training are not less than those of full-time trainees.

The above provisions must be adhered to. LTFT 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.

EC Directive 2005/36/EC states that there is no longer a minimum time requirement on training for LTFT trainees. In the past, less than full time trainees were required to work a minimum of 50% of full time. With competence-based training, in order to retain competence, in addition to acquiring new skills, less than full time trainees would still normally be expected to work a minimum of 50% of full time. If you are returning or converting to training at less than full time please complete the LTFT application form on the JRCPTB website www.jrcptb.org.uk .

Funding for LTFT is from deaneries and these posts are not supernumerary. Ideally therefore 2 LTFT trainees should share one post to provide appropriate service cover.

To date LTFT training has inevitably been prolonged so that the duration has been the exact pro rata equivalent of full time. With competency based training, proof of completion of competencies may enable LTFT trainees to finish their training in a shorter time. This will be the decision of the trainers in discussion with the SAC.

Sick and Maternity/Paternity leave

Trainees who have had more than 12 weeks sick or maternity/paternity leave in large blocks of time during their training programme will have their CCT date postponed such that any training time lost over 12 weeks is added to the total training time. For those on maternity leave it is optional for trainees to decide whether all the maternity leave time is added to their CCT date or whether the total time less the 12 weeks maternity/sick allowance is taken.

2.7 Dual CCT

It is anticipated that most trainees will wish to undertake a dual CCT in General (Internal) Medicine (G(I)M) and Geriatric Medicine. Trainees who wish to achieve a dual a CCT in Geriatric Medicine as well as General (Internal) Medicine (G(I)M), must have applied for and successfully entered a training programme, which was advertised openly as a dual training programme.

Dual CCTs in Geriatric Medicine and G(I)M are obtainable if the trainee can demonstrate achievement of the competencies/outcomes of both GMC approved curricula. The assessments required and blueprinted for both curricula must be completed though as there are some overlaps in competencies some assessments can count towards both the Geriatric Medicine and the General (Internal) Medicine curricula.

On rare occasions on an ad personam basis as agreed by the programme director, deanery and SAC, trainees may be approved to continue with the Geriatric Medicine curriculum but not the G(I)M curriculum. This will not usually reduce the normal training period or allow trainees to withdraw from on call rotas.

Postgraduate deans advertising a training programme in Geriatric Medicine should ensure that it also meets the requirements of the SAC in General (Internal) Medicine. All training programmes in Geriatric Medicine should include the option for certificate level stroke training so all advertisements for training programmes in Geriatric Medicine should include this as a potential training option.

2.8 Transitional Arrangements for Trainees after Implementation of this Curriculum

In case of any programme director, trainer or trainee having uncertainty about the implications of the new curriculum this should be brought to the attention of the SAC who will adjudicate on the arrangements for the training programme of the individual trainee. All trainees will be encouraged to undertake the new assessment methods. For existing trainees this will not be insisted on except where the new methods are needed to verify the competence of the trainee. All trainees appointed from August 2010 will be expected to follow this version of the curriculum and its assessment methods.

3 Content of Learning

This section lists the primary learning objectives, core knowledge areas, skills, attitudes and behaviours to be attained throughout training in Geriatric medicine.

3.1 Principal Learning Objectives

The principle learning objectives represent a summary of what the trainee should be able to achieve at completion of specialty training. Each objective requires specific knowledge and skills that are provided in detail. Assessment will be based on the demonstration that a trainee has achieved competence in these objectives. The syllabus further on in this curriculum are designed to summarise the necessary level of performance required for each competency.

The following are the **principal** learning objectives which will provide the trainee with the expertise to practise as a specialist in geriatric medicine:

1. Perform a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient or community setting, including day hospitals

2. Diagnose and manage acute illness in old age in an in-patient setting, out-patient setting and community setting where appropriate

3. Diagnose and manage those with chronic disease and disability in an in-patient, out-patient, day hospital and community setting

4. Provide rehabilitation with the multidisciplinary team to an older patient in an in-patient, out-patient, day hospital and community setting

5. Plan the transfer of care of frail older patients from hospital

6. Assess a patient's suitability for and provide appropriate care to those in long term (continuing care) in the NHS or community

7. Be able to apply the knowledge and skills of a competent geriatrician in an intermediate care and/or community setting

8. Assess and manage older patients presenting with the common geriatric problems (syndromes) in an in- or out-patient setting (or where appropriate, in a community setting):
    a. Falls with or without fracture
    b. Delirium
    c. Incontinence
    d. Poor mobility

9. To demonstrate competence in the following Special Topic areas:
    a. Palliative care
    b. Orthogeriatrics
    c. Old Age Psychiatry
    d. Specialist Stroke care

10. To be competent in basic research methodology, ethical principles of research, comprehensive scrutiny of medical literature and preferably to have

personal experience of involvement in basic science or clinical (health services) research.

Overview:
Expertise in some areas will develop throughout training, while others may require specific full time or sessional attachments to achieve the appropriate level of knowledge and skills.

At the completion of training by a process of consolidation through the years of the training programme acquiring a variety of experience, the trainee should have acquired the following knowledge, skills and attitudes to function as a consultant geriatrician:

1. The ability to establish a diagnostic formulation for older patients presenting with specific and non-specific clinical features by appropriate use of history, clinical examination and investigation.

2. The knowledge, skills, and experience to develop management plans for each patient, such as education of patient and carer including treatment, rehabilitation, health promotion, disease prevention, and longer term management.

3. The appropriate attitudes and communication skills to effectively manage patients and their relatives/carers, and working colleagues.

4. To work effectively within a multidisciplinary team to promote the optimal recovery of patients and plan their safe transfer of care between all relevant settings.

3.2 Core Knowledge Objectives

The following list is intended to underpin the principle learning objectives above. They should act as a guide for areas specific to geriatric medicine in which trainees should gain experience during the course of their training:

3.2.1 Basic Science and Biology of Ageing

Trainees should be able to explain:

- The process of normal ageing in humans
- The effect of ageing on the different organ systems and homeostasis
- The effect of ageing on functional ability
- Demographic trends in UK society
- The basic elements of the psychology of ageing
- Changes in pharmacokinetics and pharmacodynamics in older people
- Ageism and strategies to counteract this

3.2.2 Common Geriatric Problems (Syndromes)

Trainees should be able to describe the types of multiple pathology encountered particularly in older people and the effect this has on the presentation (e.g. specific or non-specific) and management of illness in old age. This is of particular importance in the following areas where non-specific presentation may occur:

- Falls and syncope assessment - including fractures and osteoporosis
- Immobility - including locomotor disorders and Parkinson’s disease
- Incontinence - urinary and faecal
- Delirium and dementia

or where presentation may be more specific:

- Cerebrovascular disease - stroke and transient ischaemic attack (TIA)

3.2.3 Presentations of Other Illnesses in Older Persons

Older people can present with a wide array of symptoms. Trainees should be able to define the causes, pathophysiology, clinical features, laboratory findings, treatments, prognosis and preventative measures for the following common problems and presentations in old age. This list is a suggested, but by no means exhaustive range of presentations that trainees should encounter during their training, and be able to demonstrate competence in managing them.

- **Cardiovascular** e.g. chest pain, arrhythmias, hypertension, heart failure
- **Respiratory** e.g. dyspnoea, haemoptysis, infection
- **Gastrointestinal** e.g. dysphagia, vomiting, altered bowel habit, jaundice
- **Endocrine** e.g. hyperglycaemia, thyroid dysfunction, hypothermia
- **Renal** e.g. fluid and electrolyte imbalance, renal failure, infection, lower urinary tract symptoms
- **Neurological** e.g. seizures, tremor, altered conscious level, movement disorders, speech disturbance
- **Sensory loss** e.g. impaired vision and hearing, neuropathy
- **Psychiatric** e.g. dementia, depression, delirium, anxiety, sleep disturbance
- **Dermatologica**l e.g. pruritus, rashes, leg ulcers and pressure sores
- **Musculoskeletal** e.g. joint pain and stiffness, degenerative joint disease
- **Non-specific** e.g. dizziness, fatigue, anaemia, suspected abuse
- **Weight loss and Malnutrition**

3.2.4 Drug Therapy

Trainees should be able to explain the indications, effectiveness, potential adverse effects, potential drug interactions and alternatives for medications commonly used in older patients. A working knowledge of the basic principles of therapeutics including adverse drug reactions, drug interactions, and effects of disease states on drug pharmacokinetics is important. The following list provides examples of these but is not intended to be exhaustive:

- Gastrointestinal: ulcer healing drugs and laxatives
- Cardiovascular: inotropes, diuretics, anti-arrhythmics, anti-hypertensives, drugs for heart failure and angina, antiplatelet agents, lipid lowering agents, anticoagulants
- Respiratory: bronchodilators
- CNS: hypnotics and anxiolytics, antipsychotics, antidepressants, analgesics, antiepileptics, drugs for Parkinson's disease, drugs for dementia
- Infections: antibiotics
- Endocrine: insulin and oral hyoglycaemics, drugs for thyroid disease, steroids, drugs for osteoporosis
- Urinary Tract: drugs for incontinence
- Nutrition: vitamins and mineral supplements
- Vaccines

3.2.5 Rehabilitation in Older Persons

Trainees should be able to explain the:

- Principles of rehabilitation in older people and importance of comprehensive geriatric assessment (CGA)
- Different measures (assessment scales) used to assess functional status and outcome of rehabilitation and their limitations: to include objective evaluation

of ADL ability and level of activity limitation and participation restriction, cognitive status, and mood
- Requirements, roles and expertise of the different members of a multidisciplinary team
- Knowledge of the range of interventions such as physical treatments, aids, appliances and adaptations, and a knowledge of specialist rehabilitation services available
- Specific requirements of stroke and orthopaedic rehabilitation
- An appreciation of the medical and social models of management of functional limitation due to ageing and disease
- Knowledge of the method of prevention and management of complications of acute illness such as pressure sores, venous thromboembolism, contractures and aspiration pneumonia

3.2.6 Planning Transfers of Care and Ongoing Care Outside Hospital

Trainees should be able to explain the:

- Determinants of successful transfers of care outside hospital which meet patient and carer perspectives and needs
- Suitability for different levels of care within the community
- Roles of the multidisciplinary team with regard to planning
- Liaison with primary care and social services to facilitate successful transfer of care from hospital
- Systems of provision of social care, day care, respite care and carer support
- Legislation surrounding long and intermediate term care

3.2.7 Ethical and Legal Issues

Trainees should be able to explain:

Relevant medico-legal issues such as

- Assessment of competence
- Appointment of Power of Attorney
- Guardianship
- Advance Decisions
- Procedure for sectioning, assessment and treatment under the Mental Health Act
- The current legal framework for management of adults with mental incapacity in the country of training, including Deprivation of Liberty (Mental Capacity Act 2005 England & Wales, Adults with Incapacity Act 2000(Scotland)

Relevant ethical issues such as

- Decisions regarding life-prolonging treatments
- Resuscitation following cardio-respiratory arrest
- Consent procedures

3.2.8 Management

Trainees should be able to explain the:

- Structure of the NHS, its financing and organisation
- The framework and dynamics of inter-agency and partnership working between the NHS and Social Services
- Roles of NICE and Care Quality Commission (CQC)
- Clinical governance and its relevance in geriatric medicine
- Principles of the appraisal process

- Administrative duties relevant to a consultant geriatrician; including the workings of committees, service development and relevant employee law
- Methods of dealing with complaints

3.2.9 Health Promotion

Trainees should be able to explain the:

- Benefits of a healthy lifestyle in older age, including adequate nutrition, exercise, smoking cessation and moderating alcohol intake
- Specific techniques for disease prevention in older persons
- Techniques of risk reduction for relevant syndromes (e.g. stroke)

3.3 Good Medical Practice

In preparation for the introduction of licensing and revalidation, the General Medical Council has translated Good Medical Practice into a Framework for Appraisal and Assessment which provides a foundation for the development of the appraisal and assessment system for revalidation. The Framework can be accessed at http://www.gmc-uk.org/Framework_4_3.pdf_25396256.pdf

The Framework for Appraisal and Assessment covers the following domains:
Domain 1 – Knowledge, Skills and Performance
Domain 2 – Safety and Quality
Domain 3 – Communication, Partnership and Teamwork
Domain 4 – Maintaining Trust

The "GMP" column in the syllabus defines which of the 4 domains of the Good Medical Practice Framework for Appraisal and Assessment are addressed by each competency. Most parts of the syllabus relate to "Knowledge, Skills and Performance" but some parts will also relate to other domains.

3.4 Syllabus

In the tables below, the "Assessment Methods" shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed for every trainee. Neither is it necessary for every listed assessment to be used for every trainee for each item in each grid. See section 5.2 for more details.

"GMP" defines which of the 4 domains of the Good Medical Practice Framework for Appraisal and Assessment are addressed by each competency. See section 3.3 for more details.

The Medical Leadership Competency Framework, developed by the Academy of Medical Royal Colleges and the NHS Institute for Innovation and Improvement, has informed the inclusion of leadership competencies in this curriculum. The Framework identified possible assessment methods, but in reviewing these we identified a need for more specific methods. JRCPTB and the RCP Education Department has established a working group to develop and evaluate leadership assessment methods. These may include variants of CbD and ACAT, as well as the Case Conference Assessment Tool currently being piloted.

The syllabus starts with grids covering the common competencies expected of all physicians, followed by the core geriatric curriculum grids covering comprehensive geriatric assessment, acute illness care, chronic illness care, rehabilitation, transfers of care, continuing/community/intermediate care, dementia, delirium, continence,

falls, poor mobility, tissue viability, nutrition and homeostasis which cover the basic specialty areas, followed by 4 grids representing geriatric medicine subspecialty areas of stroke, palliative care, psychiatry of old age and orthogeriatrics. Finally there are the optional higher level grids for those wishing to demonstrate additional competencies in continence, movement disorders, orthogeriatrics and bone health, falls and syncope, dementia and psychogeriatric services, and intermediate and community care.

Syllabus Contents

Common Competencies

The common competencies are those that should be acquired by all physicians during their training period starting within the undergraduate career and developed throughout the postgraduate career. As it is expected that specialist trainees in geriatric medicine will also be training in G(I)M, the common competencies are listed in the same format as in the G(I)M curriculum for ease of linkage with work-based assessments and to ensure comprehensive coverage of all the common competencies. Aspects of these common competencies that are particularly pertinent to geriatric training are also embedded in the relevant geriatric medicine grid.

Assessment of acquisition of the common competencies

There are four descriptor levels describing achievement of the common competencies. Knowledge of all the common competencies to at least level 2 descriptors is expected prior to progression into specialty training and is tested in the three parts of the MRCP (UK) examination. The level 1 & 2 descriptors are included here to remind specialist trainees of the competencies that they should already have gained. It is anticipated that geriatric medicine trainees will achieve competencies to level 4 as assessed by workplace-based assessments.

The first three common competencies cover the principles of history taking, clinical examination and therapeutics and prescribing. These are competencies with which the trainee should be well acquainted from Foundation training. It is vital that these competencies are practised to a high level by all specialty trainees who should be able to achieve competencies to the highest descriptor level early in their specialty training career.

1. History Taking

To progressively develop the ability to obtain a relevant focussed history from increasingly complex patients and challenging circumstances

To record accurately and synthesise history with clinical examination and formulation of management plan according to likely clinical evolution

Knowledge	Assessment Methods	GMP Domains
Recognise the importance of different elements of history	mini-CEX	1
Recognise the importance of clinical, psychological, social, cultural and nutritional factors particularly those relating to ethnicity, race, cultural or religious beliefs and preferences, sexual orientation, gender and disability	mini-CEX	1
Recognise that patients do not present history in structured fashion	ACAT, mini-CEX	1,3
Know likely causes and risk factors for conditions relevant to mode of presentation	mini-CEX	1
Recognise that history should inform examination, investigation and management	mini-CEX	1
Skills		
Identify and overcome possible barriers to effective communication	mini-CEX	1,3
Manage time and draw consultation to a close appropriately	mini-CEX	1,3
Supplement history with standardised instruments or questionnaires when relevant	ACAT, mini-CEX	1
Manage alternative and conflicting views from family, carers and friends	ACAT, mini-CEX	1,3
Assimilate history from the available information from patient and other sources	ACAT, mini-CEX	1,3
Recognise and interpret the use of non verbal communication from patients and carers	mini-CEX	1,3
Focus on relevant aspects of history	ACAT, mini-CEX	1,3
Behaviours		
Show respect and behave in accordance with Good Medical Practice	ACAT, mini-CEX	3,4

Level Descriptor	
1	Obtains, records and presents accurate clinical history relevant to the clinical presentation Elicits most important positive and negative indicators of diagnosis Starts to ignore irrelevant information
2	Demonstrates ability to obtain relevant focussed clinical history in the context of limited time e.g. outpatients, ward referral Demonstrates ability to target history to discriminate between likely clinical diagnoses Records information in most informative fashion
3	Demonstrates ability to rapidly obtain relevant history in context of severely ill patients Demonstrates ability to obtain history in difficult circumstances e.g. from angry or distressed patient / carers Demonstrates ability to keep interview focussed on most important clinical issues

4	Able to quickly focus questioning to establish working diagnosis and relate to relevant examination, investigation and management plan in most acute and common chronic conditions in almost any environment

2. Clinical Examination

To progressively develop the ability to perform focussed and accurate clinical examination in increasingly complex patients and challenging circumstances

To relate physical findings to history in order to establish diagnosis and formulate a management plan

Knowledge	Assessment Methods	GMP Domains
Understand the need for a valid clinical examination	CbD, mini-CEX	1
Understand the basis for clinical signs and the relevance of positive and negative physical signs	ACAT, CbD, mini-CEX	1
Recognise constraints to performing physical examination and strategies that may be used to overcome them	CbD, mini-CEX	1
Recognise the limitations of physical examination and the need for adjunctive forms of assessment to confirm diagnosis	ACAT, CbD, mini-CEX	1
Skills		
Perform an examination relevant to the presentation and risk factors that is valid, targeted and time efficient	ACAT, CbD, mini-CEX	1
Recognise the possibility of deliberate harm in vulnerable patients and report to appropriate agencies	ACAT, CbD, mini-CEX	1,2
Interpret findings from the history, physical examination and mental state examination, appreciating the importance of clinical, psychological, religious, social and cultural factors	mini-CEX, CbD	1
Actively elicit important clinical findings	CbD, mini-CEX	1
Perform relevant adjunctive examinations	CbD, mini-CEX	1
Behaviours		
Show respect and behaves in accordance with Good Medical Practice	CbD, mini-CEX, MSF	1,4

Level Descriptor	
1	Performs, accurately records and describes findings from basic physical examination Elicits most important physical signs Uses and interprets findings adjuncts to basic examination e.g. internal examination, blood pressure measurement, pulse oximetry, peak flow
2	Performs focussed clinical examination directed to presenting complaint e.g. cardiorespiratory, abdominal pain Actively seeks and elicits relevant positive and negative signs Uses and interprets findings adjuncts to basic examination e.g. electrocardiography, spirometry, ankle brachial pressure index, fundoscopy
3	Performs and interprets relevance advanced focussed clinical examination e.g. assessment of less common joints, neurological examination Elicits subtle findings Uses and interprets findings of advanced adjuncts to basic examination e.g. sigmoidoscopy, bedside ultrasound, echocardiography

4	Rapidly and accurately performs and interprets focussed clinical examination in challenging circumstances e.g. acute medical or surgical emergency

3. Therapeutics and Safe Prescribing

To progressively develop your ability to prescribe, review and monitor appropriate medication relevant to clinical practice including therapeutic and preventative indications

Knowledge	Assessment Methods	GMP Domains
Recall indications, contraindications, side effects, drug interactions and dosage of commonly used drugs	ACAT, CbD, mini-CEX	1
Recall range of adverse drug reactions to commonly used drugs, including complementary medicines	ACAT, CbD, mini-CEX	1
Recall drugs requiring therapeutic drug monitoring and interpret results	ACAT, CbD, mini-CEX	1
Outline tools to promote patient safety and prescribing, including IT systems	ACAT, CbD, mini-CEX	1,2
Define the effects of age, body size, organ dysfunction and concurrent illness on drug distribution and metabolism relevant to the trainees practice	ACAT, CbD, mini-CEX	1,2
Recognise the roles of regulatory agencies involved in drug use, monitoring and licensing (e.g. National Institute for Clinical Excellence (NICE), Committee on Safety of Medicines (CSM), and Healthcare Products Regulatory Agency and hospital formulary committees	ACAT, CbD, mini-CEX	1,2
Skills		
Review the continuing need for long term medications relevant to the trainees clinical practice	ACAT, CbD, mini-CEX	1,2
Anticipate and avoid defined drug interactions, including complementary medicines	ACAT, CbD, mini-CEX	1
Advise patients (and carers) about important interactions and adverse drug effects	ACAT, CbD, mini-CEX	1,3
Make appropriate dose adjustments following therapeutic drug monitoring, or physiological change (e.g. deteriorating renal function)	ACAT, CbD, mini-CEX	1
Use IT prescribing tools where available to improve safety	ACAT, CbD, mini-CEX	1,2
Employ validated methods to improve patient concordance with prescribed medication	ACAT, mini-CEX	1,3
Provide comprehensible explanations to the patient, and carers when relevant, for the use of medicines	ACAT, CbD, mini-CEX	1,3
Behaviours		
Recognise the benefit of minimising number of medications taken by a patient	ACAT, CbD, mini-CEX	1
Appreciate the role of non-medical prescribers	ACAT, CbD, mini-CEX	1,3
Remain open to advice from other health professionals on medication issues	ACAT, CbD, mini-CEX	1,3

Recognise the importance of resources when prescribing, including the role of a Drug Formulary	ACAT, CbD, mini-CEX	1,2
Ensure prescribing information is shared promptly and accurately between a patient's health providers, including between primary and secondary care	ACAT, CbD	1,3
Remain up to date with therapeutic alerts, and respond appropriately	ACAT, CbD	1

Level Descriptor	
1	Understands the importance of patient compliance with prescribed medication Outlines the adverse effects of commonly prescribed medicines Uses reference works to ensure accurate, precise prescribing
2	Takes advice on the most appropriate medicine in all but the most common situations Makes sure an accurate record of prescribed medication is transmitted promptly to relevant others involved in an individuals care Knows indications for commonly used drugs that require monitoring to avoid adverse effects Modifies patient's prescriptions to ensure the most appropriate medicines are used for any specific condition Maximises patient compliance by minimising the number of medicines required that is compatible with optimal patient care Maximises patient compliance by providing full explanations of the need for the medicines prescribed Is aware of the precise indications, dosages, adverse effects and modes of administration of the drugs used commonly within their specialty Uses databases and other reference works to ensure knowledge of new therapies and adverse effects is up to date Knows how to report adverse effects and take part in this mechanism
3/4	Is aware of the regulatory bodies relevant to prescribed medicines both locally and nationally Ensures that resources are used in the most effective way for patient benefit

This part of the generic competencies relate to direct clinical practice; the importance of patient needs at the centre of care and of promotion of patient safety, team working, and high quality infection control. Furthermore, the prevalence of long term conditions in patient presentation to general internal medicine means that specific competencies have been defined that are mandated in the management of this group of patients. Many of these competencies will have been acquired during the Foundation programme and core training but as part of the maturation process for the physician these competencies will become more finely honed and all trainees should be able to demonstrate the competencies as described by the highest level descriptors by the time of their CCT

4. Time Management and Decision Making

To become increasingly able to prioritise and organise clinical and clerical duties in order to optimise patient care

To become increasingly able to make appropriate clinical and clerical decisions in order to optimise the effectiveness of the clinical team resource

Knowledge	Assessment Methods	GMP Domains
Understand that organisation is key to time management	ACAT, CbD	1
Understand that some tasks are more urgent or more important than	ACAT, CbD	1

others		
Understand the need to prioritise work according to urgency and importance	ACAT, CbD	1
Understand that some tasks may have to wait or be delegated to others	ACAT, CbD	1
Outline techniques for improving time management	ACAT, CbD	1
Understand the importance of prompt investigation, diagnosis and treatment in disease management	ACAT, CbD, mini-CEX	1,2
Skills		
Identify clinical and clerical tasks requiring attention or predicted to arise	ACAT, CbD, mini-CEX	1,2
Estimate the time likely to be required for essential tasks and plan accordingly	ACAT, CbD, mini-CEX	1
Group together tasks when this will be the most effective way of working	ACAT, CbD, mini-CEX	1
Recognise the most urgent / important tasks and ensure that they are managed expediently	ACAT, CbD, mini-CEX	1
Regularly review and re-prioritise personal and team work load	ACAT, CbD, mini-CEX	1
Organise and manage workload effectively	ACAT, CbD, mini-CEX	1
Behaviours		
Ability to work flexibly and deal with tasks in an effective fashion	ACAT, CbD, MSF	3
Recognise when you or others are falling behind and take steps to rectify the situation	ACAT, CbD, MSF	3
Communicate changes in priority to others	ACAT, MSF	1
Remain calm in stressful or high pressure situations and adopt a timely, rational approach	ACAT, MSF	1

Level Descriptor	
1	Recognises the need to identify work and compiles a list of tasks Works systematically through tasks with little attempt to prioritise Needs direction to identify most important tasks Sometimes slow to perform important work Does not use other members of the clinical team Finds high workload very stressful
2	Organises work appropriately but does not always respond to or anticipate when priorities should be changed Starting to recognise which tasks are most urgent Starting to utilise other members of the clinical team but not yet able to organise their work Requires some direction to ensure that all tasks completed in a timely fashion
3	Recognises the most important tasks and responds appropriately Anticipates when priorities should be changed Starting to lead and direct the clinical team in effective fashion Supports others who are falling behind Requires minimal organisational supervision

4	Automatically prioritises and manages workload in most effective fashion Communicates and delegates rapidly and clearly Automatically responsible for organising the clinical team Calm leadership in stressful situations

5. Decision Making and Clinical Reasoning

To progressively develop the ability to formulate a diagnostic and therapeutic plan for a patient according to the clinical information available

To progressively develop the ability to prioritise the diagnostic and therapeutic plan

To be able to communicate the diagnostic and therapeutic plan appropriately

Knowledge	Assessment Methods	GMP Domains
Define the steps of diagnostic reasoning:	ACAT, CbD, mini-CEX	1
Interpret history and clinical signs	ACAT, CbD, mini-CEX	1
Conceptualise clinical problem	ACAT, CbD, mini-CEX	1
Generate hypothesis within context of clinical likelihood	ACAT, CbD, mini-CEX	1
Test, refine and verify hypotheses	ACAT, CbD, mini-CEX	1
Develop problem list and action plan	ACAT, CbD, mini-CEX	1
Recognise how to use expert advice, clinical guidelines and algorithms	ACAT, CbD, mini-CEX	1
Recognises the need to determine the best value and most effective treatment both for the individual patient and for a patient cohort	ACAT, CbD, mini-CEX	1,2
Define the concepts of disease natural history and assessment of risk	ACAT, CbD, mini-CEX	1
Recall methods and associated problems of quantifying risk e.g. cohort studies	ACAT, CbD	1
Outline the concepts and drawbacks of quantitative assessment of risk or benefit e.g. numbers needed to treat	ACAT, CbD	1
Describe commonly used statistical methodology	CbD, mini-CEX	1
Know how relative and absolute risks are derived and the meaning of the terms predictive value, sensitivity and specificity in relation to diagnostic tests	CbD, mini-CEX	1
Skills		
Interpret clinical features, their reliability and relevance to clinical scenarios including recognition of the breadth of presentation of common disorders	ACAT, CbD, mini-CEX	1
Recognise critical illness and respond with due urgency	ACAT, CbD, mini-CEX	1
Generate plausible hypothesis(es) following patient assessment	ACAT, CbD, mini-CEX	1
Construct a concise and applicable problem list using available	ACAT, CbD, mini-	1

information	CEX	
Construct an appropriate management plan and communicate this effectively to the patient, parents and carers where relevant	ACAT, CbD, mini-CEX	1,3,4
Define the relevance of an estimated risk of a future event to an individual patient	ACAT, CbD, mini-CEX	1
Use risk calculators appropriately	ACAT, CbD, mini-CEX	1
Apply quantitative data of risks and benefits of therapeutic intervention to an individual patient	ACAT, CbD, mini-CEX	1
Search and comprehend medical literature to guide reasoning	AA, CbD	1
Behaviours		
Recognise the difficulties in predicting occurrence of future events	ACAT, CbD, mini-CEX	1
Show willingness to discuss intelligibly with a patient the notion and difficulties of prediction of future events, and benefit/risk balance of therapeutic intervention	ACAT, CbD, mini-CEX	3
Be willing to facilitate patient choice	ACAT, CbD, mini-CEX	3
Show willingness to search for evidence to support clinical decision making	ACAT, CbD, mini-CEX	1,4
Demonstrate ability to identify one's own biases and inconsistencies in clinical reasoning	ACAT, CbD, mini-CEX	1,3
Level Descriptor		
1	In a straightforward clinical case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others Takes account of the patients wishes	
2	In a difficult clinical case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others Takes account of the patients wishes	
3	In a complex, non-emergency case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others Takes account of the patients wishes	
4	In a complex, non-emergency case: Develops a provisional diagnosis and a differential diagnosis on the basis of the clinical evidence Institutes an appropriate investigative plan Institutes an appropriate therapeutic plan Seeks appropriate support from others	

	Takes account of the patients wishes and records them accurately and succinctly

6. The Patient as Central Focus of Care

To be able to prioritise the patient's wishes encompassing their beliefs, concerns expectations and needs

Knowledge	Assessment Methods	GMP Domains
Recall health needs of particular populations e.g. ethnic minorities and recognise the impact of culture and ethnicity in presentations of physical and psychological conditions	ACAT, CbD	1
Skills		
Give adequate time for patients to express ideas, concerns and expectations	ACAT, mini-CEX	1,3,4
Respond to questions honestly and seek advice if unable to answer	ACAT, CbD, mini-CEX	3
Encourage the health care team to respect the philosophy of patient focussed care	ACAT, CbD, mini-CEX, MSF	3
Develop a self-management plan including investigation, treatments and requests/instructions to other healthcare professionals, in partnership with the patient	ACAT, CbD, mini-CEX	1,3
Support patients, parents and carers where relevant to comply with management plans	ACAT, CbD, mini-CEX, PS	3
Encourage patients to voice their preferences and personal choices about their care	ACAT, mini-CEX, PS	3
Behaviours		
Support patient self-management	ACAT, CbD, mini-CEX, PS	3
Recognise the duty of the medical professional to act as patient advocate	ACAT, CbD, mini-CEX, MSF, PS	3,4
Level Descriptor		
1	Responds honestly and promptly to patient questions but knows when to refer for senior help Recognises the need for disparate approaches to individual patients	
2	Recognises more complex situations of communication, accommodates disparate needs and develops strategies to cope	
3	Deals rapidly with more complex situations, promotes patients self care and ensures all opportunities are outlined	
4	Is able to deal with all cases to outline patient self care and to promote the provision of this when it is not readily available	

7. Prioritisation of Patient Safety in Clinical Practice

To understand that patient safety depends on the organisation of care and health care staff working well together

To never compromise patient safety

To understand the risks of treatments and to discuss these honestly and openly with patients so that patients are able to make decisions about risks

To ensure that all staff are aware of risks and work together to minimise risk

Knowledge	Assessment Methods	GMP Domains
Outline the features of a safe working environment	ACAT, CbD, mini-CEX	1
Outline the hazards of medical equipment in common use	ACAT, CbD	1
Recall side effects and contraindications of medications prescribed	ACAT, CbD, mini-CEX	1
Recall principles of risk assessment and management	CbD	1
Recall the components of safe working practice in the personal, clinical and organisational settings	ACAT, CbD	1
Recall local procedures for optimal practice e.g. GI bleed protocol, safe prescribing	ACAT, CbD, mini-CEX	1
Skills		
Recognise when a patient is not responding to treatment, reassess the situation, and encourage others to do so	ACAT, CbD, mini-CEX	1
Ensure the correct and safe use of medical equipment, ensuring faulty equipment is reported appropriately	ACAT, CbD, mini-CEX	1
Improve patients' and colleagues' understanding of the side effects and contraindications of therapeutic intervention	ACAT, CbD, mini-CEX	1,3
Sensitively counsel a colleague following a significant event, or near incident, to encourage improvement in practice of individual and unit	ACAT, CbD	3
Recognise and respond to the manifestations of a patient's deterioration (symptoms, signs, observations, and laboratory results) and support other members of the team to act similarly	ACAT, CbD, mini-CEX, MSF	1
Behaviours		
Continue to maintain a high level of safety awareness and consciousness at all times	ACAT, CbD, mini-CEX	2
Encourage feedback from all members of the team on safety issues	ACAT, CbD, mini-CEX, MSF	3
Show willingness to take action when concerns are raised about performance of members of the healthcare team, and act appropriately when these concerns are voiced to you by others	ACAT, CbD, mini-CEX, MSF	3
Continue to be aware of one's own limitations, and operate within them competently	ACAT, CbD, mini-CEX	1

Level Descriptor	
1	Discusses risks of treatments with patients and is able to help patients make decisions about their treatment Does not hurry patients into decisions Promotes patients safety to more junior colleagues

	Always ensures the safe use of equipment. Follows guidelines unless there is a clear reason for doing otherwise Acts promptly when a patient's condition deteriorates Recognises untoward or significant events and always reports these Leads discussion of causes of clinical incidents with staff and enables them to reflect on the causes Able to undertake a root cause analysis
2	Demonstrates ability to lead team discussion on risk assessment and risk management and to work with the team to make organisational changes that will reduce risk and improve safety
3	Able to assess the risks across the system of care and to work with colleagues from different department or sectors to ensure safety across the health care system
4	Shows support for junior colleagues who are involved in untoward events Is fastidious about following safety protocols and encourages junior colleagues to do the same

8. Team Working and Patient Safety

To develop the ability to work well in a variety of different teams – for example the ward team and the infection control team - and to contribute to discussion on the team's role in patient safety

To develop the leadership skills necessary to lead teams so that they are more effective and able to deliver better safer care

Knowledge	Assessment Methods	GMP Domains
Outline the components of effective collaboration	ACAT, CbD	1
Describe the roles and responsibilities of members of the healthcare team	ACAT, CbD	1
Outline factors adversely affecting a doctor's performance and methods to rectify these	CbD	1
Skills		
Practise with attention to the important steps of providing good continuity of care	ACAT, CbD, mini-CEX	1,3,4
Accurate attributable note-keeping	ACAT, CbD, mini-CEX	1,3
Preparation of patient lists with clarification of problems and ongoing care plan	ACAT, CbD, mini-CEX, MSF	1
Detailed hand over between shifts and areas of care	ACAT, CbD, mini-CEX , MSF	1,3
Demonstrate leadership and management in the following areas: • Education and training • Deteriorating performance of colleagues (e.g. stress, fatigue) • High quality care • Effective handover of care between shifts and teams	ACAT, CbD, mini-CEX	1,2,3
Lead and participate in interdisciplinary team meetings	ACAT, CbD, mini-CEX	3
Provide appropriate supervision to less experienced colleagues	ACAT, CbD, MSF	3
Behaviours		

Encourage an open environment to foster concerns and issues about the functioning and safety of team working	ACAT, CbD, MSF	3
Recognise and respect the request for a second opinion	ACAT, CbD, MSF	3
Recognise the importance of induction for new members of a team	ACAT, CbD, MSF	3
Recognise the importance of prompt and accurate information sharing with Primary Care team following hospital discharge	ACAT, CbD, mini-CEX , MSF	3

Level Descriptor	
1	Works well within the multidisciplinary team and recognises when assistance is required from the relevant team member Demonstrates awareness of own contribution to patient safety within a team and is able to outline the roles of other team members Keeps records up-to-date and legible and relevant to the safe progress of the patient Hands over care in a precise, timely and effective manner
2	Demonstrates ability to discuss problems within a team to senior colleagues. Provides an analysis and plan for change Demonstrates ability to work with the virtual team to develop the ability to work well in a variety of different teams – for example the ward team and the infection control team - and to contribute to discussion on the team's role in patient safety To develop the leadership skills necessary to lead teams so that they are more effective and able to deliver better safer care
3	Leads multidisciplinary team meetings but promotes contribution from all team members Recognises need for optimal team dynamics and promotes conflict resolution Demonstrates ability to convey to patients after a handover of care that although there is a different team, the care is continuous
4	Leads multi-disciplinary team meetings allowing all voices to be heard and considered. Fosters an atmosphere of collaboration Demonstrates ability to work with the virtual team Ensures that team functioning is maintained at all times Promotes rapid conflict resolution

9. Principles of Quality and Safety Improvement

To recognise the desirability of monitoring performance, learning from mistakes and adopting no blame culture in order to ensure high standards of care and optimise patient safety

Knowledge	Assessment Methods	GMP Domains
Understand the elements of clinical governance	CbD, MSF	1
Recognise that governance safeguards high standards of care and facilitates the development of improved clinical services	CbD, MSF	1,2
Define local and national significant event reporting systems relevant to specialty	ACAT, CbD, mini-CEX	1
Recognise importance of evidence-based practice in relation to clinical effectiveness	CbD	1
Outline local health and safety protocols (fire, manual handling etc)	CbD	1
Understand risk associated with the trainee's specialty work including biohazards and mechanisms to reduce risk	CbD	1
Outline the use of patient early warning systems to detect clinical	ACAT, CbD, mini-	1

deterioration where relevant to the trainees clinical specialty	CEX	
Keep abreast of national patient safety initiatives including National Patient Safety Agency , NCEPOD reports, NICE guidelines etc	ACAT, CbD, mini-CEX	1
Skills		
Adopt strategies to reduce risk e.g. surgical pause	ACAT, CbD	1,2
Contribute to quality improvement processes e.g. Audit of personal and departmental performance Errors / discrepancy meetings Critical incident reporting Unit morbidity and mortality meetings Local and national databases	AA, CbD	2
Maintain a folder of information and evidence, drawn from your medical practice	CbD	2
Reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation	AA	1,2,3,4
Behaviours		
Show willingness to participate in safety improvement strategies such as critical incident reporting	CbD, MSF	3
Engage with an open no blame culture	CbD, MSF	3
Respond positively to outcomes of audit and quality improvement	CbD, MSF	1,3
Co-operate with changes necessary to improve service quality and safety	CbD, MSF	1,2

Level Descriptor	
1	Understands that clinical governance is the over-arching framework that unites a range of quality improvement activities. This safeguards high standards of care and facilitates the development of improved clinical services Maintains personal portfolio
2	Able to define key elements of clinical governance Engages in audit
3	Demonstrates personal and service performance Designs audit protocols and completes audit loop
4	Leads in review of patient safety issues Implements change to improve service Engages and guides others to embrace governance

10. Infection Control

To develop the ability to manage and control infection in patients. Including controlling the risk of cross-infection, appropriately managing infection in individual patients, and working appropriately within the wider community to manage the risk posed by communicable diseases

Knowledge	Assessment Methods	GMP Domains
Understand the principles of infection control as defined by the GMC	ACAT, CbD, mini-CEX	1
Understand the principles of preventing infection in high risk groups (e.g. managing antibiotic use to prevent Clostridium difficile) including understanding the local antibiotic prescribing policy	ACAT, CbD, mini-CEX	1
Understand the role of Notification within the UK and identify the principle notifiable diseases for UK and international purposes	ACAT, CbD, mini-CEX	1
Understand the role of the Health Protection Agency and Consultants in Health Protection (previously Consultants in Communicable Disease Control – CCDC)	ACAT, CbD	1
Understand the role of the local authority in relation to infection control	ACAT, CbD, mini-CEX	1
Skills		
Recognise the potential for infection within patients being cared for	ACAT, CbD	1,2
Counsel patients on matters of infection risk, transmission and control	ACAT, CbD, mini-CEX, PS	2,3
Actively engage in local infection control procedures	ACAT, CbD	1
Actively engage in local infection control monitoring and reporting processes	ACAT, CbD	1,2
Prescribe antibiotics according to local antibiotic guidelines	ACAT, CbD, mini-CEX	1
Recognise potential for cross-infection in clinical settings	ACAT, CbD, mini-CEX	1,2
Practice aseptic technique whenever relevant	CbD	1
Behaviours		
Encourage all staff, patients and carers to observe infection control principles	ACAT, CbD, MSF	1,3

Level Descriptor	
1	Always follows local infection control protocols. Including washing hands before and after seeing all patients Is able to explain infection control protocols to students and to patients and their carers. Always defers to the nursing team about matters of ward management Aware of infections of concern – including MRSA and C difficile Aware of the risks of nosocomial infections Understands the links between antibiotic prescription and the development of nosocomial infections Always discusses antibiotic use with a more senior colleague
2	Demonstrate ability to perform simple clinical procedures utilising aseptic technique Manages simple common infections in patients using first-line treatments. Communicating effectively to the patient the need for treatment and any prevention messages to prevent re-

	infection or spread Liaise with diagnostic departments in relation to appropriate investigations and tests
3	Demonstrate an ability to perform more complex clinical procedures whilst maintaining aseptic technique throughout Identify potential for infection amongst high risk patients obtaining appropriate investigations and considering the use of second line therapies Communicate effectively to patients and their carers with regard to the infection, the need for treatment and any associated risks of therapy Work effectively with diagnostic departments in relation to identifying appropriate investigations and monitoring therapy Working in collaboration with external agencies in relation to reporting common notifiable diseases, and collaborating over any appropriate investigation or management
4	Demonstrates an ability to perform most complex clinical procedures whilst maintaining full aseptic precautions, including those procedures which require multiple staff in order to perform the procedure satisfactorily Identify the possibility of unusual and uncommon infections and the potential for atypical presentation of more frequent infections. Managing these cases effectively with potential use of tertiary treatments being undertaken in collaboration with infection control specialists Work in collaboration with diagnostic departments to investigate and manage the most complex types of infection including those potentially requiring isolation facilities Work in collaboration with external agencies to manage the potential for infection control within the wider community including communicating effectively with the general public and liaising with regional and national bodies where appropriate

11. Managing Long-Term Conditions and Promoting Patient Self-care

To work with patients and use their expertise to manage their condition collaboratively and in partnership, with mutual benefit

To pursue a holistic and long term approach to the planning and implementation of patient care, in particular to identify and facilitate the patient's role in their own care

To be able to manage long term conditions supporting and enabling patient independence

Knowledge	Assessment Methods	GMP Domains
Recall the natural history of diseases that run a chronic course	ACAT, CbD, mini-CEX	1
Define the role of rehabilitation services and the multi-disciplinary team to facilitate long-term care	ACAT, CbD, mini-CEX	1
Outline the concept of quality of life and how this can be measured	CbD	1
Outline the concept of patient self-care	CbD, mini-CEX	1
Know, understand and be able to compare medical and social models of disability	CbD	1
Understand the relationship between local health, educational and social service provision including the voluntary sector	CbD	1
Skills		
Develop and agree a management plan with the patient (and carers), ensuring comprehension to maximise self-care within care pathways when relevant	ACAT, CbD, mini-CEX	1,3
Develop and sustain supportive relationships with patients with whom care will be prolonged	CbD, mini-CEX	1,4

Provide effective patient education, with support of the multi-disciplinary team	ACAT, CbD, mini-CEX	1,3,4
Promote and encourage involvement of patients in appropriate support networks, both to receive support and to give support to others	CbD, PS	1,3
Encourage and support patients in accessing appropriate information	CbD, PS	1,3
Provide the relevant and evidence based information in an appropriate medium to enable sufficient choice, when possible	CbD, PS	1,3
Behaviours		
Show willingness to act as a patient advocate	ACAT, CbD, mini-CEX	3,4
Recognise the impact of long term conditions on the patient, family and friends	ACAT, CbD, mini-CEX	1
Ensure equipment and devices relevant to the patient's care are discussed	ACAT, CbD, mini-CEX	1
Put patients in touch with the relevant agency including the voluntary sector from where they can procure the items as appropriate	ACAT, CbD, mini-CEX	1,3
Provide the relevant tools and devices when possible	ACAT, CbD, mini-CEX	1,2
Show willingness to facilitate access to the appropriate training and skills in order to develop the patient's confidence and competence to self care	ACAT, CbD, mini-CEX, PS	1,3,4
Show willingness to maintain a close working relationship with other members of the multi-disciplinary team, primary and community care	ACAT, CbD, mini-CEX, MSF	3
Recognise and respect the role of family, friends and carers in the management of the patient with a long term condition	ACAT, CbD, mini-CEX, PS	1,3

Level Descriptor	
1	Describes relevant long term conditions Understands the meaning of quality of life Is aware of the need for promotion of patient self care Helps the patient with an understanding of their condition and how they can promote self management
2	Demonstrates awareness of management of relevant long term conditions Is aware of the tools and devices that can be used in long term conditions Is aware of external agencies that can improve patient care Teaches the patient and within the team to promote excellent patient care
3	Develops management plans in partnership with the patient that are pertinent to the patients long term condition Can use relevant tools and devices in improving patient care Engages with relevant external agencies to promote patient care
4	Provides leadership within the multidisciplinary team that is responsible for management of patients with long term conditions Helps the patient networks develop and strengthen

Issues of communication both with patients and carers and within the healthcare team are often causes of complaint and inadequate communication can lead to poorer standards of patient care. Specific issues are highlighted within this section to promote better communication generally and within certain situations

12. Relationships with Patients and Communication within a Consultation

To communicate effectively and sensitively with patients, relatives and carers		
Knowledge	**Assessment Methods**	**GMP Domains**
Structure an interview appropriately	ACAT, CbD, mini-CEX, PS	1
Understand the importance of the patient's background, culture, education and preconceptions (ideas, concerns, expectations) to the process	ACAT, CbD, mini-CEX, PS	1
Skills		
Establish a rapport with the patient and any relevant others (e.g. carers)	ACAT, CbD, mini-CEX, PS	1,3
Listen actively and question sensitively to guide the patient and to clarify information	ACAT, mini-CEX, PS	1,3
Identify and manage communication barriers, tailoring language to the individual patient and using interpreters when indicated	ACAT, CbD, mini-CEX, PS	1,3
Deliver information compassionately, being alert to and managing their and your emotional response (anxiety, antipathy etc)	ACAT, CbD, mini-CEX	1,3,4
Use, and refer patients to, appropriate written and other information sources	ACAT, CbD, mini-CEX	1,3
Check the patient's/carer's understanding, ensuring that all their concerns/questions have been covered	ACAT, CbD, mini-CEX	1,3
Indicate when the interview is nearing its end and conclude with a summary	ACAT, CbD, mini-CEX	1,3
Make accurate contemporaneous records of the discussion	ACAT, CbD, mini-CEX	1,3
Manage follow-up effectively	ACAT, CbD, mini-CEX	1
Behaviours		
Approach the situation with courtesy, empathy, compassion and professionalism, especially by appropriate body language - act as an equal not a superior	ACAT, CbD, mini-CEX, MSF, PS	1,3,4
Ensure that the approach is inclusive and patient centred and respect the diversity of values in patients, carers and colleagues	ACAT, CbD, mini-CEX, MSF, PS	1,3
Be willing to provide patients with a second opinion	ACAT, CbD, mini-CEX, MSF, PS	1,3
Use different methods of ethical reasoning to come to a balanced decision where complex and conflicting issues are involved	ACAT, CbD, mini-CEX, MSF	1,3
Be confident and positive in one’s own values	ACAT, CbD, mini-CEX	1,3
Level Descriptor		

1	Conducts simple interviews with due empathy and sensitivity and writes accurate records thereof
2	Conducts interviews on complex concepts satisfactorily, confirming that accurate two-way communication has occurred
3	Handles communication difficulties appropriately, involving others as necessary; establishes excellent rapport
4	Shows mastery of patient communication in all situations, anticipating and managing any difficulties which may occur

13. Breaking Bad News

To recognise the fundamental importance of breaking bad news. To develop strategies for skilled delivery of bad news according to the needs of individual patients and their relatives / carers

Knowledge	Assessment Methods	GMP Domains
Recognise that the way in which bad news is delivered irretrievably affects the subsequent relationship with the patient	ACAT, CbD, mini-CEX, MSF, PS	1
Recognise that every patient may desire different levels of explanation and have different responses to bad news	ACAT, CbD, mini-CEX, PS	1,4
Recognise that bad news is confidential but the patient may wish to be accompanied	ACAT, CbD, mini-CEX, PS	1
Recognise that breaking bad news can be extremely stressful for the doctor or professional involved	ACAT, CbD, mini-CEX	1,3
Understand that the interview may be an educational opportunity	ACAT, CbD, mini-CEX	1
Recognise the importance of preparation when breaking bad news by: Setting aside sufficient uninterrupted time Choosing an appropriate private environment Having sufficient information regarding prognosis and treatment Structuring the interview Being honest, factual, realistic and empathetic Being aware of relevant guidance documents	ACAT, CbD, mini-CEX	1,3
Understand that “bad news” may be expected or unexpected	ACAT, CbD, mini-CEX	1
Recognise that sensitive communication of bad news is an essential part of professional practice	ACAT, CbD, mini-CEX	1
Understand that “bad news” has different connotations depending on the context, individual, social and cultural circumstances	ACAT, CbD, mini-CEX, PS	1
Recall that a post mortem examination may be required and understand what this involves	ACAT, CbD, mini-CEX, PS	1
Recall the local organ retrieval process	ACAT, CbD, mini-CEX	1
Skills		
Demonstrate to others good practice in breaking bad news	CbD, mini-CEX, MSF	1,3
Involve patients and carers in decisions regarding their future management	CbD, mini-CEX, MSF	1,3,4

Encourage questioning and ensure comprehension	CbD, mini-CEX, MSF	1,3
Respond to verbal and visual cues from patients and relatives/carers	CbD, mini-CEX, MSF	1,3
Act with empathy, honesty and sensitivity avoiding undue optimism or pessimism	CbD, mini-CEX, MSF	1,3
Structure the interview e.g.: • Set the scene • Establish understanding • Discuss; diagnosis, implications, treatment, prognosis and subsequent care	CbD, mini-CEX, MSF	1,3
Behaviours		
Take leadership in breaking bad news	CbD, mini-CEX, MSF	1
Respect the different ways people react to bad news	CbD, mini-CEX, MSF	1
Level Descriptor		
1	Recognises when bad news must be imparted Recognises the need to develop specific skills Requires guidance to deal with most cases	
2	Able to break bad news in planned settings Prepares well for interview Prepares patient to receive bad news Responsive to patient reactions	
3	Able to break bad news in unexpected and planned settings Clear structure to interview Establishes what patient wants to know and ensures understanding Able to conclude interview	
4	Skilfully delivers bad news in any circumstance including adverse events Arranges follow up as appropriate Able to teach others how to break bad news	

14. Complaints and Medical Error

To know how to respond appropriately to complaints and medical errors		
Knowledge	**Assessment Methods**	**GMP Domains**
Basic consultation techniques and skills described for Foundation programme and to include: Define the local complaints procedure Recognise factors likely to lead to complaints (poor communication, dishonesty etc) Adopt behaviour likely to prevent complaints Dealing with dissatisfied patients or relatives/carers Recognise when something has gone wrong and identify appropriate staff to communicate this with Act with honesty and sensitivity in a non-confrontational manner	CbD, mini-CEX, MSF	1
Outline the principles of an effective apology	CbD, mini-CEX, MSF	1

Identify sources of help and support when a complaint is made about yourself or a colleague	CbD, mini-CEX, MSF	1
Skills		
Contribute to processes whereby complaints are reviewed and learned from	CbD, mini-CEX, MSF	1
Explain comprehensibly to the patient the events leading up to a medical error	CbD, mini-CEX, MSF	1,3
Deliver an appropriate apology	CbD, mini-CEX, MSF	1,3,4
Distinguish between system and individual errors	CbD, mini-CEX, MSF	1
Show an ability to learn from previous error	CbD, mini-CEX, MSF	1
Behaviours		
Take leadership over complaint issues	CbD, mini-CEX, MSF	1
Recognise the impact of complaints and medical error on staff, patients, and the National Health Service	CbD, mini-CEX, MSF	1,3
Contribute to a fair and transparent culture around complaints and errors	CbD, mini-CEX, MSF	1
Recognise the rights of patients, family members and carers to make a complaint	CbD, mini-CEX, MSF	1,4

Level Descriptor	
1	Defines the local complaints procedure Recognises need for honesty in management of complaints Responds promptly to concerns that have been raised Understands the importance of an effective apology Learns from errors
2	Manages conflict without confrontation Recognises and responds to the difference between system failure and individual error
3	Recognises and manages the effects of any complaint within members of the team
4	Provides timely accurate written responses to complaints when required Provides leadership in the management of complaints

15. Communication with Colleagues and Cooperation

To be able to recognise and accept the responsibilities and role of the doctor in relation to other healthcare professionals. Communicate succinctly and effectively with other professionals as appropriate

Knowledge	Assessment Methods	GMP Domains
Understand the section in "Good Medical Practice" on Working with Colleagues, in particular:	CbD, MSF	1
The roles played by all members of a multi-disciplinary team	CbD, MSF	1
The features of good team dynamics	CbD, MSF	1
The principles of effective inter-professional collaboration to optimise patient, or population, care	CbD, MSF	1
Skills		
Communicate accurately, clearly, promptly and comprehensively	ACAT, CbD, mini-	1,3

with relevant colleagues by means appropriate to the urgency of a situation (telephone, email, letter etc), especially where responsibility for a patient's care is transferred	CEX	
Utilise the expertise of the whole multi-disciplinary team as appropriate, ensuring when delegating responsibility that appropriate supervision is maintained	ACAT, CbD, mini-CEX, MSF	1,3
Participate in, and co-ordinate, an effective hospital at night team when relevant	ACAT, CbD, mini-CEX, MSF	1
Communicate effectively with administrative bodies and support organisations	CbD, mini-CEX, MSF	1,3
Employ behavioural management skills with colleagues to prevent and resolve conflict	ACAT, CbD, mini-CEX, MSF	1, 3
Behaviours		
Be aware of the importance of, and take part in, multi-disciplinary work, including adoption of a leadership role when appropriate	ACAT, CbD, mini-CEX, MSF	3
Foster a supportive and respectful environment where there is open and transparent communication between all team members	ACAT, CbD, mini-CEX, MSF	1,3
Ensure appropriate confidentiality is maintained during communication with any member of the team	ACAT, CbD, mini-CEX, MSF	1,3
Recognise the need for a healthy work/life balance for the whole team, including yourself, but take any leave yourself only after giving appropriate notice to ensure that cover is in place	CbD, mini-CEX, MSF	1
Be prepared to accept additional duties in situations of unavoidable and unpredictable absence of colleagues	CbD, MSF	1

Level Descriptor	
1	Accepts his/her role in the healthcare team and communicates appropriately with all relevant members thereof
2	Fully recognises the role of, and communicates appropriately with, all relevant potential team members (individual and corporate)
3	Able to predict and manage conflict between members of the healthcare team
4	Able to take a leadership role as appropriate, fully respecting the skills, responsibilities and viewpoints of all team members

For all hospital based physicians there is a need to be aware of public health issues and health promotion. Competencies that promote this awareness are defined in the next section

16. Health Promotion and Public Health

To progressively develop the ability to work with individuals and communities to reduce levels of ill health, remove inequalities in healthcare provision and improve the general health of a community

Knowledge	Assessment Methods	GMP Domains
Understand the factors which influence the incidence of and prevalence of common conditions	CbD, mini-CEX	1
Understand the factors which influence health – psychological, biological, social, cultural and economic especially poverty	CbD, mini-CEX	1
Understand the influence of lifestyle on health and the factors that influence an individual to change their lifestyle	CbD, mini-CEX	1
Understand the purpose of screening programmes and know in outline the common programmes available within the UK	CbD, mini-CEX	1
Understand the relationship between the health of an individual and that of a community	CbD, mini-CEX	1
Know the key local concerns about health of communities such as smoking and obesity	CbD, mini-CEX	1
Understand the role of other agencies and factors including the impact of globalisation in protecting and promoting health	CbD, mini-CEX	1
Demonstrate knowledge of the determinants of health worldwide and strategies to influence policy relating to health issues including the impact of the developed world strategies on the third world	CbD, mini-CEX	1
Outline the major causes of global morbidity and mortality and effective, affordable interventions to reduce these	CbD, mini-CEX	1
Recall the effect of addictive behaviours, especially substance misuse and gambling, on health and poverty	CbD, mini-CEX	1
Skills		
Identify opportunities to prevent ill health and disease in patients	CbD, mini-CEX, PS	1,2
Identify opportunities to promote changes in lifestyle and other actions which will positively improve health	CbD, mini-CEX	1,2
Identify the interaction between mental, physical and social wellbeing in relation to health	CbD, mini-CEX	1
Counsel patients appropriately on the benefits and risks of screening	CbD, mini-CEX, PS	1,3
Work collaboratively with other agencies to improve the health of communities	CbD, mini-CEX	1
Behaviours		
Engage in effective team-working around the improvement of health	CbD, MSF	1,3
Encourage where appropriate screening to facilitate early intervention	CbD	1
Level Descriptor		
1	Discuss with patients and others factors which could influence their personal health Maintains own health is aware of own responsibility as a doctor for promoting healthy approach to life	

2	Communicate to an individual, information about the factors which influence their personal health Support an individual in a simple health promotion activity (e.g. smoking cessation)
3	Communicate to an individual and their relatives/carers, information about the factors which influence their personal health Support small groups in a simple health promotion activity (e.g. smoking cessation) Provide information to an individual about a screening programme and offer information about its risks and benefits
4	Discuss with small groups the factors that have an influence on their health and describe initiatives they can undertake to address these Provide information to an individual about a screening programme offering specific guidance in relation to their personal health and circumstances concerning the factors that would affect the risks and benefits of screening to them as an individual Engage with local or regional initiatives to improve individual health and reduce inequalities in health between communities

The legal and ethical framework associated with healthcare must be a vital part of the practitioner's competencies if safe practice is to be sustained. Within this the ethical aspects of research must be considered. The competencies associated with these areas of practice are defined in the following section.

17. Principles of Medical Ethics and Confidentiality

To know, understand and apply appropriately the principles, guidance and laws regarding medical ethics and confidentiality

Knowledge	Assessment Methods	GMP Domains
Demonstrate knowledge of the principles of medical ethics	ACAT, CbD, mini-CEX	1
Outline and follow the guidance given by the GMC on confidentiality	ACAT, CbD, mini-CEX	1
Define the provisions of the Data Protection Act and Freedom of Information Act	ACAT, CbD, mini-CEX	1
Define the role of the Caldicott Guardian within an institution, and outline the process of attaining Caldicott approval for audit or research	ACAT, CbD, mini-CEX	1,4
Outline situations where patient consent, while desirable, is not required for disclosure e.g. communicable diseases, public interest	ACAT, CbD, mini-CEX	1,4
Outline the procedures for seeking a patient's consent for disclosure of identifiable information	ACAT, CbD, mini-CEX	1
Recall the obligations for confidentiality following a patient's death	ACAT, CbD, mini-CEX	1,4
Recognise the problems posed by disclosure in the public interest, without patient's consent	ACAT, CbD, mini-CEX	1,4
Recognise the factors influencing ethical decision making: religion, moral beliefs, cultural practices	ACAT, CbD, mini-CEX	1
Do not resuscitate: Define the standards of practice defined by the GMC when deciding to withhold or withdraw life-prolonging treatment	ACAT, CbD, mini-CEX	1
Outline the principles of the Mental Capacity Act	ACAT, CbD, mini-	1

	CEX	
Skills		
Use and share information with the highest regard for confidentiality, and encourage such behaviour in other members of the team	ACAT, CbD, mini-CEX, MSF	1,2,3
Use and promote strategies to ensure confidentiality is maintained e.g. anonymisation	CbD	1
Counsel patients on the need for information distribution within members of the immediate healthcare team	ACAT, CbD, MSF	1,3
Counsel patients, family, carers and advocates tactfully and effectively when making decisions about resuscitation status, and withholding or withdrawing treatment	ACAT, CbD, mini-CEX, PS	1,3
Behaviours		
Encourage ethical reflection in others	ACAT, CbD, MSF	1
Show willingness to seek advice of peers, legal bodies, and the GMC in the event of ethical dilemmas over disclosure and confidentiality	ACAT, CbD, mini-CEX, MSF	1
Respect patient's requests for information not to be shared, unless this puts the patient, or others, at risk of harm	ACAT, CbD, mini-CEX, PS	1,4
Show willingness to share information about their care with patients, unless they have expressed a wish not to receive such information	ACAT, CbD, mini-CEX	1,3
Show willingness to seek the opinion of others when making decisions about resuscitation status, and withholding or withdrawing treatment	ACAT, CbD, mini-CEX, MSF	1,3

Level Descriptor	
1	Use and share information with the highest regard for confidentiality adhering to the Data Protection Act and Freedom of Information Act in addition to guidance given by the GMC Familiarity with the principles of the Mental Capacity Act Participate in decisions about resuscitation status and withholding or withdrawing treatment
2	Counsel patients on the need for information distribution within members of the immediate healthcare team and seek patients' consent for disclosure of identifiable information
3	Define the role of the Caldicott Guardian within an institution, and outline the process of attaining Caldicott approval for audit or research
4	Able to assume a full role in making and implementing decisions about resuscitation status and withholding or withdrawing treatment

18. Valid Consent

To obtain valid consent from the patient

Knowledge	**Assessment Methods**	**GMP Domains**
Outline the guidance given by the GMC on consent, in particular: Understand that consent is a process that may culminate in, but is not limited to, the completion of a consent form Understand the particular importance of considering the patient's level of understanding and mental state (and also that of the parents, relatives/carers when appropriate) and how this may impair their capacity for informed consent	CbD, MSF	1
Skills		

Present all information to patients (and carers) in a format they understand, allowing time for reflection on the decision to give consent	ACAT, CbD, mini-CEX, PS	1,3
Provide a balanced view of all care options	ACAT, CbD, mini-CEX, PS	1,3,4
Behaviours		
Respect a patient's rights of autonomy even in situations where their decision might put them at risk of harm	ACAT, CbD, mini-CEX, PS	1
Avoid exceeding the scope of authority given by a patient	ACAT, CbD, mini-CEX, PS	1
Avoid withholding information relevant to proposed care or treatment in a competent adult	ACAT, CbD, mini-CEX	1,3,4
Show willingness to seek advance directives	ACAT, CbD, mini-CEX	1,3
Show willingness to obtain a second opinion, senior opinion, and legal advice in difficult situations of consent or capacity	ACAT, CbD, mini-CEX, MSF	1,3
Inform a patient and seek alternative care where personal, moral or religious belief prevents a usual professional action	ACAT, CbD, mini-CEX, PS	1,3,4

Level Descriptor	
1	Obtains consent for straightforward treatments with appropriate regard for patient's autonomy
2	Able to explain complex treatments meaningfully in layman's terms and thereby to obtain appropriate consent
3	Obtains consent in "grey-area" situations where the best option for the patient is not clear
4	Obtains consent in all situations even when there are problems of communication and capacity

19. Legal Framework for Practice

To understand the legal framework within which healthcare is provided in the UK in order to ensure that personal clinical practice is always provided in line with this legal framework

Knowledge	Assessment Methods	GMP Domains
All decisions and actions must be in the best interests of the patient	ACAT, CbD, mini-CEX	1
Understand the legislative framework within which healthcare is provided in the UK – in particular death certification and the role of the Coroner/Procurator Fiscal; child protection legislation; mental health legislation (including powers to detain a patient and giving emergency treatment against a patient's will under common law); advanced directives and living Wills; withdrawing and withholding treatment; decisions regarding resuscitation of patients; surrogate decision making; organ donation and retention; communicable disease notification; medical risk and driving; Data Protection and Freedom of Information Acts; provision of continuing care and community nursing care by a local authorities	ACAT, CbD, mini-CEX	1,2
Understand the differences between legislation in the four countries of the UK	CbD	1
Understand sources of medical legal information	ACAT, CbD, mini-CEX	1
Understand disciplinary processes in relation to medical malpractice	ACAT, CbD, mini-	1

	CEX, MSF	
Understand the role of the medical practitioner in relation to personal health and substance misuse, including understanding the procedure to be followed when such abuse is suspected	ACAT, CbD, mini-CEX, MSF	1
Skills		
Ability to cooperate with other agencies with regard to legal requirements – including reporting to the Coroner's Officer or the proper officer of the local authority in relevant circumstances	ACAT, CbD, mini-CEX	1
Ability to prepare appropriate medical legal statements for submission to the Coroner's Court, Procurator Fiscal, Fatal Accident Inquiry and other legal proceedings	CbD, MSF	1
Be prepared to present such material in Court	CbD, mini-CEX	1
Incorporate legal principles into day to day practice	ACAT, CbD, mini-CEX	1
Practice and promote accurate documentation within clinical practice	ACAT, CbD, mini-CEX	1,3
Behaviours		
Show willingness to seek advice from the Healthcare Trust, legal bodies (including defence unions), and the GMC on medico-legal matters	ACAT, CbD, mini-CEX, MSF	1
Promote reflection on legal issues by members of the team	ACAT, CbD, mini-CEX, MSF	1,3

Level Descriptor	
1	Demonstrates knowledge of the legal framework associated with medical qualification and medical practice and the responsibilities of registration with the GMC. Demonstrates knowledge of the limits to professional capabilities - particularly those of pre-registration doctors.
2	Identify with Senior Team Members cases which should be reported to external bodies and where appropriate and initiate that report. Identify with Senior Members of the Clinical Team situations where you feel consideration of medical legal matters may be of benefit. Be aware of local Trust procedures around substance abuse and clinical malpractice.
3	Work with external strategy bodies around cases that should be reported to them. Collaborating with them on complex cases preparing brief statements and reports as required. Actively promote discussion on medical legal aspects of cases within the clinical environment. Participate in decision making with regard to resuscitation decisions and around decisions related to driving discussing the issues openly but sensitively with patients and relatives/carers
4	Work with external strategy bodies around cases that should be reported to them. Collaborating with them on complex cases providing full medical legal statements as required and present material in Court where necessary Lead the clinical team in ensuring that medical legal factors are considered openly and consistently wherever appropriate in the care of a patient. Ensuring that patients and relatives/carers are involved openly in all such decisions.

20. Ethical Research

To ensure that research is undertaken using relevant ethical guidelines		
Knowledge	**Assessment Methods**	**GMP Domains**
Outline the GMC guidance on good practice in research	ACAT, CbD	1
Outline the differences between audit and research	AA, CbD, mini-CEX	1
Describe how clinical guidelines are produced	CbD	1
Demonstrate a knowledge of research principles	CbD, mini-CEX	1
Outline the principles of formulating a research question and designing a project	CbD, mini-CEX	1
Comprehend principal qualitative, quantitative, bio-statistical and epidemiological research methods	CbD	1
Outline sources of research funding	CbD	1
Skills		
Develop critical appraisal skills and apply these when reading literature	CbD	1
Demonstrate the ability to write a scientific paper	CbD	1
Apply for appropriate ethical research approval	CbD	1
Demonstrate the use of literature databases	CbD	1
Demonstrate good verbal and written presentations skills	CbD	1
Understand the difference between population-based assessment and unit-based studies and be able to evaluate outcomes for epidemiological work	CbD	1
Behaviours		
Recognise the ethical responsibilities to conduct research with honesty and integrity, safeguarding the interests of the patient and obtaining ethical approval when appropriate	CbD, MSF	1
Follow guidelines on ethical conduct in research and consent for research	CbD	1
Show willingness to the promotion of involvement in research	CbD	1
Level Descriptor		
1	Defines ethical research and demonstrates awareness of GMC guidelines Differentiates audit and research Knows how to use databases	
2	Demonstrates ability to write a scientific paper Demonstrates critical appraisal skills	
3	Demonstrates ability to apply for appropriate ethical research approval Demonstrates knowledge of research funding sources Demonstrates good presentation and writing skills	
4	Provides leadership in research Promotes research activity Formulates and develops research pathways	

It is the responsibility of each practitioner to ensure that they are aware of relevant developments in clinical care and also ensure that their practice conforms to the highest standards of practice that may be possible. An awareness of the evidence base behind current practice and a need to audit one's own practice is vital for the physician training in general internal medicine

21. Evidence and Guidelines

To progressively develop the ability to make the optimal use of current best evidence in making decisions about the care of patients

To progressively develop the ability to construct evidence based guidelines in relation to medical practise

Knowledge	Assessment Methods	GMP Domains
Understands of the application of statistics in scientific medical practice	CbD	1
Understand the advantages and disadvantages of different study methodologies (randomised control trials, case controlled cohort etc)	CbD	1
Understand the principles of critical appraisal	CbD	1
Understand levels of evidence and quality of evidence	CbD	1
Understand the role and limitations of evidence in the development of clinical guidelines	CbD	1
Understand the advantages and disadvantages of guidelines	CbD	1
Understand the processes that result in nationally applicable guidelines (e.g. NICE and SIGN)	CbD	1
Skills		
Ability to search the medical literature including use of PubMed, Medline, Cochrane reviews and the internet	CbD	1
Appraise retrieved evidence to address a clinical question	CbD	1
Apply conclusions from critical appraisal into clinical care	CbD	1
Identify the limitations of research	CbD	1
Contribute to the construction, review and updating of local (and national) guidelines of good practice using the principles of evidence based medicine	CbD	1
Behaviours		
Keep up to date with national reviews and guidelines of practice (e.g. NICE and SIGN)	CbD	1
Aim for best clinical practice (clinical effectiveness) at all times, responding to evidence based medicine	ACAT, CbD, mini-CEX	1
Recognise the occasional need to practise outside clinical guidelines	ACAT, CbD, mini-CEX	1
Encourage discussion amongst colleagues on evidence-based practice	ACAT, CbD, mini-CEX, MSF	1

Level Descriptor	
1	Participate in departmental or other local journal club Critically review an article to identify the level of evidence

2	Lead in a departmental or other local journal club Undertake a literature review in relation to a clinical problem or topic
3	Produce a review article on a clinical topic, having reviewed and appraised the relevant literature
4	Perform a systematic review of the medical literature Contribute to the development of local or national clinical guidelines

22. Audit

To progressively develop the ability to perform an audit of clinical practice and to apply the findings appropriately

Knowledge	Assessment Methods	GMP Domains
Understand the different methods of obtaining data for audit including patient feedback questionnaires, hospital sources and national reference data	AA, CbD	1
Understand the role of audit (developing patient care, risk management etc)	AA, CbD	1
Understand the steps involved in completing the audit cycle	AA, CbD	1
Understands the working and uses of national and local databases used for audit such as specialty data collection systems, cancer registries etc. The working and uses of local and national systems available for reporting and learning from clinical incidents and near misses in the UK	AA, CbD	1
Skills		
Design, implement and complete audit cycles	AA, CbD	1,2
Contribute to local and national audit projects as appropriate (e.g. NCEPOD, SASM)	AA, CbD	1,2
Support audit by junior medical trainees and within the multi-disciplinary team	AA, CbD	1,2
Behaviours		
Recognise the need for audit in clinical practice to promote standard setting and quality assurance	AA, CbD	1,2
Level Descriptor		
1	Attendance at departmental audit meetings Contribute data to a local or national audit	
2	Identify a problem and develop standards for a local audit	
3	Compare the results of an audit with criteria or standards to reach conclusions Use the findings of an audit to develop and implement change Organise or lead a departmental audit meeting	
4	Lead a complete clinical audit cycle including development of conclusions, implementation of findings and re-audit to assess the effectiveness of the changes Become audit lead for an institution or organisation	

A good physician will ensure that the knowledge possessed is communicated effectively. In the formal setting of teaching and training specific competencies will have to be acquired to ensure that the practitioner recognises the best practise and techniques

23. Teaching and Training

To progressively develop the ability to teach to a variety of different audiences in a variety of different ways

To progressively be able to assess the quality of the teaching

To progressively be able to train a variety of different trainees in a variety of different ways

To progressively be able to plan and deliver a training programme with appropriate assessments

Knowledge	Assessment Methods	GMP Domains
Outline adult learning principles relevant to medical education:	CbD,	1
Identification of learning methods and effective learning environments	CbD	1
Construction of educational objectives	CbD	1
Use of effective questioning techniques	CbD	1
Varying teaching format and stimulus	CbD	1
Demonstrate knowledge of relevant literature relevant to developments in medical education	CbD	1
Outline the structure of the effective appraisal interview	CbD	1
Define the roles to the various bodies involved in medical education	CbD	1
Differentiate between appraisal and assessment and aware of the need for both	CbD	1
Outline the workplace-based assessments in use and the appropriateness of each	CbD	1
Demonstrate the definition of learning objectives and outcomes	CbD	1
Outline the appropriate local course of action to assist the failing trainee	CbD	1
Skills		
Vary teaching format and stimulus, appropriate to situation and subject	CbD	1
Provide effective feedback after teaching, and promote learner reflection	CbD, MSF, TO	1
Conduct effective appraisal	CbD, MSF	1
Demonstrate effective lecture, presentation, small group and bed side teaching sessions	CbD, MSF	1,3
Provide appropriate career advice, or refer trainee to an alternative effective source of career information	CbD, MSF, TO	1,3
Participate in strategies aimed at improving patient education e.g. talking at support group meetings	CbD, MSF, TO	1
Be able to lead departmental teaching programmes including journal clubs	CbD, TO	1
Recognise the failing trainee	CbD	1
Behaviours		
In discharging educational duties acts to maintain the dignity and safety of patients at all times	CbD, MSF	1,4
Recognise the importance of the role of the physician as an educator within the multi-professional healthcare team and uses	CbD, MSF, TO	1

medical education to enhance the care of patients		
Balances the needs of service delivery with the educational imperative	CbD, MSF	1
Demonstrate willingness to teach trainees and other health and social workers in a variety of settings to maximise effective communication and practical skills	CbD, MSF, TO	1
Encourage discussions in the clinical settings to colleagues to share knowledge and understanding	CbD, MSF	1,3
Maintain honesty and objectivity during appraisal and assessment	CbD, MSF	1
Show willingness to participate in workplace-based assessments	CbD, MSF	1
Show willingness to take up formal tuition in medical education and respond to feedback obtained after teaching sessions	CbD, MSF, TO	1,3
Demonstrates a willingness to become involved in the wider medical education activities and fosters an enthusiasm for medical education activity in others	CbD, MSF	1
Recognise the importance of personal development as a role model to guide trainees in aspects of good professional behaviour	CbD, MSF	1
Demonstrates consideration for learners including their emotional, physical and psychological well being with their development needs	CbD, MSF	1

Level Descriptor	
1	Develops basic PowerPoint presentation to support educational activity Delivers small group teaching to medical students, nurses or colleagues Able to seek and interpret simple feedback following teaching
2	Able to supervise a medical student, nurse or colleague through a procedure Able to perform a workplace based assessment including being able to give effective feedback
3	Able to devise a variety of different assessments (e.g. multiple choice questions, work place based assessments) Able to appraise a medical student, nurse or colleague Able to act as a mentor to a medical student, nurses or colleague
4	Able to plan, develop and deliver educational activities with clear objectives and outcomes Able to plan, develop and deliver an assessment programme to support educational activities

The individual practitioner has to have appropriate attitudes and behaviours that help deal with complex situations and to work effectively providing leadership and working as part of the healthcare team

24. Personal Behaviour

To develop the behaviours that will enable the doctor to become a senior leader able to deal with complex situations and difficult behaviours and attitudes

To work increasingly effectively with many teams and to be known to put the quality and safety of patient care as a prime objective

To develop the attributes of someone who is trusted to be able to manage complex human, legal and ethical problem

To become someone who is trusted and is known to act fairly in all situations

Knowledge	Assessment Methods	GMP Domains
Recall and build upon the competencies defined in the Foundation Programme: Deal with inappropriate patient and family behaviour Respect the rights of children, elderly, people with physical, mental, learning or communication difficulties Adopt an approach to eliminate discrimination against patients from diverse backgrounds including age, gender, race, culture, disability, spirituality and sexuality Place needs of patients above own convenience Behave with honesty and probity Act with honesty and sensitivity in a non-confrontational manner	ACAT, CbD, mini-CEX, MSF, PS	1,2,3,4
The main methods of ethical reasoning: casuistry, ontology and consequentialist		
The overall approach of value based practice and how this relates to ethics, law and decision-making		
Define the concept of modern medical professionalism	CbD	1
Outline the relevance of professional bodies (Royal Colleges, JRCPTB, GMC, Postgraduate Dean, BMA, specialist societies, medical defence organisations)	CbD	1
Skills		
Practise with: • integrity • compassion • altruism • continuous improvement • excellence • respect of cultural and ethnic diversity • regard to the principles of equity	ACAT, CbD, mini-CEX, MSF, PS	1,2,3,4
Work in partnership with members of the wider healthcare team	ACAT, CbD, mini-CEX, MSF	3
Liaise with colleagues to plan and implement work rotas	ACAT, MSF	3
Promote awareness of the doctor's role in utilising healthcare resources optimally	ACAT, CbD, mini-CEX, MSF	1,3
Recognise and respond appropriately to unprofessional behaviour in others	ACAT, CbD	1
Be able to provide specialist support to hospital and community	ACAT, CbD, MSF	1

based services		
Be able to handle enquiries from the press and other media effectively	CbD	1,3
Behaviours		
Recognise personal beliefs and biases and understand their impact on the delivery of health services	ACAT, CbD, mini-CEX, MSF	1
Recognise the need to use all healthcare resources prudently and appropriately	ACAT, CbD, mini-CEX	1,2
Recognise the need to improve clinical leadership and management skill	ACAT, CbD, mini-CEX	1
Recognise situations when it is appropriate to involve professional and regulatory bodies	ACAT, CbD, mini-CEX	1
Show willingness to act as a mentor, educator and role model	ACAT, CbD, mini-CEX, MSF	1
Be willing to accept mentoring as a positive contribution to promote personal professional development	ACAT, CbD, mini-CEX	1
Participate in professional regulation and professional development	CbD, mini-CEX, MSF	1
Takes part in 360 degree feedback as part of appraisal	CbD, MSF	1,2,4
Recognise the right for equity of access to healthcare	ACAT, CbD, mini-CEX,	1
Recognise need for reliability and accessibility throughout the healthcare team	ACAT, CbD, mini-CEX, MSF	1

Level Descriptor	
1	Works work well within the context of multi-professional teams. Listens well to others and takes other view points into consideration. Supports patients and relatives/carers at times of difficulty e.g. after receiving difficult news. Is polite and calm when called or asked to help
2	Responds to criticism positively and seeks to understand its origins and works to improve. Praises staff when they have done well and where there are failings in delivery of care provides constructive feedback. To wherever possible involve patients in decision making
3	Recognises when other staff are under stress and not performing as expected and provides appropriate support for them. Takes action necessary to ensure that patient safety is not compromised
4	Helps patients who show anger or aggression with staff or with their care or situation and works with them to find an approach to manage their problem. Is able to engender trust so that staff feel confident about sharing difficult problems and feel able to pointing out deficiencies in care at an early stage

Working within the health service there is a need to understand and work within the organisational structures that are set. A significant knowledge of leadership principles and practice as defined in the Medical Leadership Competence Framework is an important part of this competence

25. Management and NHS Structure

To understand the structure of the NHS and the management of local healthcare systems in order to be able to participate fully in managing healthcare provision

Knowledge	Assessment Methods	GMP Domains
Understand the guidance given on management and doctors by the GMC	CbD	1
Understand the local structure of NHS systems in your locality recognising the potential differences between the four countries of the UK	ACAT, CbD	1
Understand the structure and function of healthcare systems as they apply to your specialty	ACAT, CbD	1
Understand the consistent debates and changes that occur in the NHS including the political, social, technical, economic, organisational and professional aspects that can impact on provision of service	CbD	1
Understand the importance of local demographic, socio-economic and health data and the use to improve system performance	CbD	1
Understand the principles of: Clinical coding European Working Time Regulations National Service Frameworks Health regulatory agencies (e.g., NICE, Scottish Government) NHS Structure and relationships NHS finance and budgeting Consultant contract and the contracting process Resource allocation The role of the Independent sector as providers of healthcare	ACAT, CbD, mini-CEX	1
Understand the principles of recruitment and appointment procedures	CbD	1
Skills		
Participate in managerial meetings	ACAT, CbD	1
Take an active role in promoting the best use of healthcare resources	ACAT, CbD, mini-CEX	1
Work with stakeholders to create and sustain a patient-centred service	ACAT, CbD, mini-CEX	1
Employ new technologies appropriately, including information technology	ACAT, CbD, mini-CEX	1
Conduct an assessment of the community needs for specific health improvement measures	CbD, mini-CEX	1
Behaviours		
Recognise the importance of just allocation of healthcare resources	CbD	1,2
Recognise the role of doctors as active participants in healthcare systems	ACAT, CbD, mini-CEX	1,2
Respond appropriately to health service targets and take part in the development of services	ACAT, CbD, mini-CEX	1,2
Recognise the role of patients and carers as active participants in healthcare systems and service planning	ACAT, CbD, mini-CEX, PS	1,2,3

Show willingness to improve managerial skills (e.g. management courses) and engage in management of the service	CbD, MSF	1

Level Descriptor	
1	Describes in outline the roles of primary care, including general practice, public health, community, mental health, secondary and tertiary care services within healthcare. Describes the roles of members of the clinical team and the relationships between those roles. Participates fully in clinical coding arrangements and other relevant local activities.
2	Can describe in outline the roles of primary care, community and secondary care services within healthcare. Can describe the roles of members of the clinical team and the relationships between those roles. Participates fully in clinical coding arrangements and other relevant local activities.
3	Can describe the relationship between PCTs/Health Boards, General Practice and Trusts including relationships with local authorities and social services. Participate in team and clinical directorate meetings including discussions around service development. Discuss the most recent guidance from the relevant health regulatory agencies in relation to the specialty.
4	Describe the local structure for health services and how they relate to regional or devolved administration structures. Be able to discuss funding allocation processes from central government in outline and how that might impact on the local health organisation. Participate fully in clinical directorate meetings and other appropriate local management structures in planning and delivering healthcare within the specialty. Participate as appropriate in staff recruitment processes in order to deliver an effective clinical team. Within the Directorate collaborate with other stake holders to ensure that their needs and views are considered in managing services.

26. Evaluating Performance and Developing and Leading Services (with Special Reference to Services for Older People)

This is an additional grid for Geriatric Medicine trainees to highlight the additional management and service development responsibilities characteristic of the specialty.

To develop the skills to evaluate your own performance and the service in which you work, contribute to service development and develop leadership skills to improve services for older people

Knowledge	Assessment Methods	GMP
Be aware of the functions of national bodies, Royal Colleges, representative and regulatory bodies, education and training organisations	SCE	1
Understand the five domains pertinent to leadership and management in clinical settings: (See below:)	SCE, CbD, ACAT, MSF	1,3,4
Personal qualities: Recognise and articulate your own values, appreciating how these may differ from those of others Identify your strengths, limitations and the impact of your behaviour Identify your own emotions and prejudices and understand how these can affect behaviour		
Working with others: Understand the wide range of leadership styles, and their applicability to		

different situations and people		
Understand the reasons why people may find change uncomfortable		
Managing services:		
Understand how the service you are working in is run, how it relates to the rest of the organisation and the community		
Understand the principles of commissioning, funding and contracting		
Be familiar with a range of performance measures to evaluate a service e.g. mortality, length of stay, adverse events, patient and carer satisfaction, discharge destination and readmission rates, and comparisons with peer groups		
Improving services:		
Use information to challenge existing practices and processes that might be improved		
Understand business management principles and project management methodology, including how to produce a business plan		
Appraise options in terms of benefits and risk		
Be aware of effective communication strategies within organisations		
Understand the implications of change and possible barriers to change		
Setting direction:		
Look to the future by scanning for ideas, best practice and emerging trends		
Compare the different services you work in during your training programme, reflecting on their good and bad points		
Understand strategies to overcome barriers to implementation		
Skills		
Routinely practice critical self awareness and change behaviour accordingly	MSF	1,2
Balance personal and professional responsibilities, recognising what you can achieve, and what can be done by others	MSF	1,3
Lead a multidisciplinary team meeting, facilitating discussion, building rapport and resolving conflicts as they arise	CbD	1,3
Use clinical audit effectively to develop and implement protocols and guidelines	AA	1,2
Evaluate outcomes and proposals through research and audit	AA	1,2
Manage time and resources effectively	MSF	
Discuss local, national and UK health priorities and how they impact on the delivery of health care; identify trends, future options and strategy relevant to services for frail older people	SCE, CbD	1
Prepare for meetings: read agendas, understand minutes do background work on agenda items	MSF	1,3
Participate in discussion at meetings, evaluate different points of view and contribute to decision-making	CbD, MSF	1,3
Behaviours		
Demonstrate responsibility to self and patients, time management and an ability to delegate	ACAT,MSF	1,3
Show commitment to CPD and respond positively to assessments or appraisals	MSF	1,2
Respect the skills and contributions of others, leading when needed	MSF	3
Contribute to local management meetings	MSF	
Question the status quo and show willingness to act when resources are not	mini-CEX	

used effectively		
Demonstrate willingness to supervise the work of less experienced colleagues, encourage them to express ideas, communicate well and inspire confidence	MSF	1,2,3,4
Be willing to provide medical expertise and participate in decision making beyond the immediate clinical setting	CbD	2,3
Be open-minded to new ideas, technologies and treatments and have a positive attitude to improvement and change	MSF	1,2
Obtain evidence before declaring effectiveness of changes and show commitment to implementing proven improvements in clinical practice	AA	1,2
Strive for continuous improvement in delivering services but demonstrate the ability to understand issues and potential solutions before acting	mini-CEX	1,2
Articulate strategic ideas and use effective influencing skills and attitude and behaviours that assist dissemination of good practice	MSF	1,2

Core Curriculum Grids for the Specialty of Geriatric Medicine

27. Comprehensive Geriatric Assessment

To be able to perform a comprehensive geriatric assessment (CGA)		
Knowledge	**Assessment Methods**	**GMP**
Recognise that good health includes both physical and mental wellbeing and social, sexual and spiritual aspects	CbD, SCE	1
Factors influencing health status in older people	CbD, SCE	1
Measures employed in measuring health status and outcome	ACAT, CbD, mini-CEX, SCE	1,3
Models and concepts of frailty	CbD, mini-CEX	1
Evidence base for CGA	CbD, SCE	1,3
Be aware of and recognise age discrimination within healthcare systems, and the role that individuals and services can play in combating this	CbD	4
Have knowledge of the major sources of financial support, especially attendance allowance	CbD	1,2
Have knowledge of the range of agencies that can provide care and support both in and out of hospital and how they can be accessed	CbD	1,3
Be familiar with safeguarding legislation and actions needed when caring for vulnerable adults	CbD, SCE	2
Skills		
Communicate effectively with patients from diverse backgrounds and those with special communication needs such as hearing, visual and speech impairments and confusion and mental health issues	mini-CEX, MSF, PS	3
Diagnostic skills – particularly in the context of complex multi-system pathologies and associated social and psychological issues.	ACAT, mini-CEX	1,3
Functional status evaluation, including assessment of basic ADL and IADL, social support, mental health and cognitive status, mobility including gait and balance, and nutritional evaluation	ACAT, mini-CEX	1,2
Using the outputs of CGA to build individualised management plans, which make appropriate use of available resources.	ACAT, mini-CEX, MSF	1,2,3,4
Ensure appropriate time to perform CGA	CbD,mini-CEX	1
Behaviours		
Collaborative working with other professionals and agencies (health/social care/voluntary)	ACAT, CbD, mini-CEX, MSF	1,3
Championing the value of CGA amongst other professionals and health care providers	CbD, mini-CEX, MSF	1,3,4

28. Diagnosis and Management of Acute Illness

Note: since trainees are also training in General (Internal) Medicine, they will acquire the skills of in-hospital management of medical emergencies, and this section specifically refers to aspects pertaining to acute illness in older people

To be able to diagnose and manage acute illness in older patients in a variety of settings		
Knowledge	**Assessment Methods**	**GMP**
The emergency presentations and acute medical conditions which occur in older people*(see below) including the associated underlying Biology of Ageing	ACAT, CbD, mini-CEX, SCE	1
The non-specific acute presentations seen in older patients	ACAT, CbD, mini-CEX, SCE	1
Drugs, including compliance, interactions and unwanted effects, in older people	ACAT, CbD, mini-CEX, SCE	1,2
The ethical and legal framework for making decisions on behalf of patients who lack mental capacity	CbD, SCE	1,2,4
Secondary complications of acute illness in older people and strategies to prevent them	ACAT, CbD, SCE	1,2
Basic Biology of Ageing in relation to changes in fluid and electrolyte homeostasis, thermoregulation and hypothalamic-pituitary axis	SCE, CbD	1,2
Causes of hypothermia, including neuroleptic malignant syndrome	SCE, CbD	1
Skills		
To obtain relevant information rapidly about patients who are unable to give a clear history	ACAT, mini-CEX	1,3
To perform and interpret a focussed general clinical examination and basic practical procedures on a patient unable to co-operate fully	ACAT, mini-CEX	1
To assess acutely unwell older people in non-hospital settings, and to judge when hospitalisation is necessary	CbD, mini-CEX	1,2
To apply legal and ethical principles to patients lacking mental capacity in an emergency situation	CbD, mini-CEX	3,4
Appropriate investigation and treatment of hyperthermia, including neuroleptic malignant syndrome	SCE, CbD	1
Ability to contribute to older people's physiological management including fluid balance in multiple settings (acute medicine, trauma, post-surgical)	SCE, mini-CEX, CbD, ACAT	1,3
Management of older patients in Critical Care Units	Mini-CEX, CBD, MSF	1
Behaviours		
To work with non-medical colleagues and doctors from other specialties to devise and co-ordinate a plan of care for acutely ill older patients	ACAT, CbD, MSF	1,3
To communicate empathetically with carers of a seriously ill older patients regarding prognosis	mini-CEX, MSF	1,3,4
To make decisions about the appropriateness of resuscitation and other major interventions in an acute setting	ACAT, CbD, PS	1,3,4
To devise, monitor and revise management plans for patients where	ACAT, CbD, PS	1,2

there is instability or diagnostic uncertainty

***Emergency presentations and conditions particularly seen in older people**

- Exacerbations of known chronic conditions
- Acute confusion
- General deterioration in mobility, function and health
- Pressure sores/skin ulceration
- Complications of medication
- Incidental findings
- Stroke
- Heart failure, atrial fibrillation
- Urine retention, incontinence, infection
- Constipation, diarrhoea, faecal impaction
- Falls, fractures and other injuries
- Syncope, pre-syncope, dizziness

29. Diagnosis and Management of Chronic Disease and Disability

To be able to diagnose and manage chronic disease and disability in older patients in both hospital and community settings

To understand the process in which health beliefs, socio-economic circumstances and culture impact on health, and vice-versa

To understand that as doctors we have the opportunity and ability to address inequalities in healthcare

Knowledge	Assessment Methods	GMP
The major chronic illnesses and disabling conditions seen in older people* (see below) and the associated Biology of Ageing	CbD, SCE	1
Services available to support patients and carers	CbD, SCE	1
Drug and non-drug management of chronic conditions, including use of aids and appliances and technology	CbD, SCE	1
The ethical and legal framework for making decisions on behalf of patients who lack mental capacity	CbD, SCE	1,4
Principles of rehabilitation	CbD, SCE	1
Health promotion and preventive medicine	CbD, SCE	1
Influences of environment, culture and behaviour including poverty, poor housing and low expectations on access to healthcare and health outcomes	CbD	3
Skills		
To undertake a diagnostic assessment of disabling or chronic conditions in hospital and non-hospital settings	CbD, mini-CEX	1
To assess physical function, mood and cognition using appropriate scales e.g. Barthel ADL scale, Geriatric Depression Scale, Mini-mental state examination, CAM (confusion assessment method) and IQ-CODE (Informant Questionnaire on Cognitive Decline in the Elderly)	CbD, mini-CEX	1
To assess impact of chronic illness on the patient and carers	CbD, mini-CEX	1
Nutritional assessment and support	CbD, mini-CEX	1

End of life management	CbD, mini-CEX	1
Behaviours		
A multi-professional problem-solving approach appreciating the importance of regular review, continuity of care and fine tuning of treatments	CbD, mini-CEX	3
Appreciating the importance of active rehabilitation maintaining function	CbD	3
Recognition of the terminal stages of illness adjusting management plans	CbD, mini-CEX	1
A positive, pragmatic approach to management	CbD, mini-CEX, PS	1
Participation in audit of services for chronic diseases	AA	2
Use appropriate methods of ethical reasoning to come to a balanced decision where complex and conflicting issues are involved	CbD, MSF	1

*** Chronic conditions particularly seen in older patients**

- Ischaemic heart disease, heart failure, atrial fibrillation, hypertension
- Chronic lung disease including cancer
- Chronic liver disease, malnutrition, chronic bowel disorders including constipation and incontinence
- Chronic kidney disease, prostate disease, incontinence
- Sensory impairment, movement disorders, stroke
- Arthritis, polymyalgia rheumatica, osteoporosis
- Falls, dizziness, syncope
- Dementia, depression, anxiety
- Diabetes, thyroid disease
- Skin ulceration and chronic oedema
- Anaemia
- Weight loss, including sarcopenia
- Incurable cancer

30. Rehabilitation and Multidisciplinary Team Working

To have the knowledge and skills to provide rehabilitation to an older patient in an in-patient, outpatient and community based setting including day hospital and when to refer for further specialist advice

Knowledge	Assessment Methods	GMP
Basic Biology of Ageing	SCE	1
Principles of rehabilitation and comprehensive assessment	CbD, mini-CEX	1
Goal setting in rehabilitation	CbD, mini-CEX	1,3,4
Evidence Base for rehabilitation	SCE	1
Assessment Scales	SCE	1
Roles and expertise of different members of interdisciplinary team	CbD, mini-CEX	1,3,4
Physical therapies which improve muscle strength and function	CbD, mini-CEX, SCE	1
Therapeutic techniques/training to improve balance and gait	CbD, mini-CEX, SCE	1
Aids and appliances which reduce disability	CbD, mini-CEX, SCE	1,3
Specialist rehabilitation services	CbD, mini-CEX, SCE	1,3

Scope and nature of intermediate care approaches	CbD, mini-CEX, SCE	1,3
Role and referral to IMCAs	CbD, mini-CEX, SCE	1,3
Understand the structure, roles and responsibilities of the multi-disciplinary team including the importance of outside agencies, and the way in which individual behaviours can impact on a group	SCE	1
Skills		
Selection of patients for rehabilitation	CbD, mini-CEX, SCE	1,3,4
Continence Care- assessment and treatments	CbD, mini-CEX, SCE	1,3
Goal Setting according to expected disease prognosis /outcome	CbD, mini-CEX	1,3,4
Expertise in managing patients with multiple medical problems and disabilities	CbD, mini-CEX	1,3,4
Lead a multidisciplinary team meeting, facilitating discussion, building rapport and resolving conflicts as they arise	mini-CEX	1,3
Behaviour		
Recognition that older people take longer to recover from acute illness and frequently require rehabilitation	CbD, mini-CEX	1
Promoting a rehabilitation ethos	CbD, mini-CEX, MSF	1,2,3,4
Collaborative working to ensure that no individual should unnecessarily enter a system of domiciliary or institutionalised care	CbD, mini-CEX, MSF	1,3,4
Appreciation that small changes in disability can avoid long term care	CbD, mini-CEX	1,3
Be open minded to new ideas, technologies and treatments and have a positive attitude to improvement and change	MSF	1,2
Show understanding the needs and priorities of non-clinical staff	MSF	3
Respect the skills and contributions of others, using authority appropriately but willing to follow when appropriate.	MSF	3
Be aware of any deterioration in the performance of self or a colleague, and be able to deal appropriately with the situation within the team/organisational framework	CbD	3
Recognition of the needs and wishes of the patient and carers	mini-CEX, MSF	1,2
Specific Learning Methods		
Take part and lead rehabilitation MDT meetings in a variety of settings e.g. stroke, orthogeriatric and general rehabilitation		
Assess patients for rehabilitation in medical, orthopaedic and surgical wards		

31. Planning Transfers of Care, Including Discharge

To have the knowledge and skills to plan the successful transfer of care or discharge of frail older patients

Knowledge	Assessment Methods	GMP
The variety of resources available following discharge e.g intermediate care, community care, domiciliary care, voluntary sector support, respite care, institution-based long-term care, health service funded long-term care	CbD, mini-CEX	1
The current criteria (and processes) for health service-based continuing care	CbD, mini-CEX	1,2,3,4

A general awareness of the financial support available to patients and their carers	CbD, mini-CEX, SCE	1,2,3,4
The assessment methods/processes undertaken to access services (including the unified (single assessment process)	CbD, mini-CEX, SCE	1,3,4
Roles and rights of carers	CbD, mini-CEX	1,2,3,4
Role of the geriatrician and the multidisciplinary team in discharge planning	CbD, mini-CEX	1,2,3,4
Skills		
Planning skills	CbD, mini-CEX, SCE	1,2,3,4
Ability to assess and document mental capacity	CbD, mini-CEX, SCE	1,2,3,4
Behaviours		
To understand that discharge planning should be timely starting on admission	CbD, mini-CEX	1,2,3,4
To view the discharge of a frail older person as a *transfer* of care	CbD, mini-CEX	1,2,3,4
Recognition that the patient's wishes are important	CbD, mini-CEX, PS	1,2,3,4
To ensure medical involvement in all discharge planning, including where patients wish to self-charge	CbD, mini-CEX, SCE	1,2,3,4
To strike the right balance between opinion-seeking, discussion and decisive management of patients, but keeping the patient's wishes as the focus	CbD, mini-CEX	1,2,3,4
Respect diversity of status and values in patients and colleagues	MSF	3,4
Specific Learning Methods		
Take part and lead MDT discharge planning meetings		
Attend case conferences for complex discharges		
Follow discharge planning nurses in their function in discharge planning and including their assessments for CHC funding assessments		

32. Delirium

To be able to recognise, diagnose and manage a state of delirium presenting both acutely or sub-acutely in patients in hospital, in the community and in other settings

Knowledge	Assessment Methods	GMP
Diagnostic criteria for delirium	CbD, mini-CEX, SCE	1
Relationship of delirium with dementia syndromes	CbD, mini-CEX, SCE	1
Appropriate standardized measures of cognitive status	CbD, mini-CEX, SCE	1
Severity indices in delirium	CbD, mini-CEX, SCE	1
Risk factors and causes	CbD, mini-CEX, SCE	1
Main outcomes observed	CbD, mini-CEX, SCE	1,2,3
Non-pharmacological management	CbD, mini-CEX, SCE	1,2,3,4
Role of drugs when other measures fail and safe dosage	CbD, mini-CEX, SCE	1,2,3
Skills		
To recognise the principal features of delirium in acute and sub-acute illness states	CbD, mini-CEX, SCE	1,2,3

To be competent in the use of the standardized measures of assessing cognitive status in delirious states	CbD, mini-CEX, SCE	1,3
To be competent in investigation and management of the delirious patient, including the underlying physical illness and the accompanying distressed mental state	ACAT, CbD, MSF	1,2,3,4
Behaviours		
To take a positive approach to the management of delirium and to seek and deal with remediable causes as quickly as possible	ACAT, CbD, MSF	1,2,3,4
To work collaboratively with other professions to manage delirium effectively	ACAT, CbD, MSF	1,2,3,4
To approach delirium as an acute or sub-acute medical emergency and to encourage all staff to work toward resolution of the delirious state	ACAT, CbD, MSF	1,2,3,4

33. Dementia

To be able to assess and manage patients who present with dementia and also to assess and manage patients with dementia who present with other illnesses in acute and intermediate care

Knowledge	Assessment Methods	GMP
Diagnostic criteria for dementia, including in younger people with dementia, people with learning disabilities, and people from minority ethnic groups	CbD, mini-CEX, SCE	1
Differential diagnosis of dementia	CbD, mini-CEX, SCE	1
Investigation of patients presenting with dementia, including neuroimaging and neuropsychological assessment	CbD, mini-CEX, SCE	1,3
Pharmacological and non-pharmacological management of dementia	CbD, mini-CEX, SCE	1,2,3,4
Palliative care of people with dementia	CbD, mini-CEX, SCE	1,3,4
Available support for people with dementia and their carers, including post-diagnostic support and advice, personalised services, peer support, housing support, housing-related services and telecare	CbD, mini-CEX, SCE	1,2,3,4
The impact of dementia on the assessment and management of other illnesses	CbD, mini-CEX, SCE	1,3
The impact of dementia on rehabilitation, e.g. in stroke and orthogeriatrics	CbD, mini-CEX, SCE	1,3
The effect of treatment of other illnesses on dementia	CbD, mini-CEX, SCE	1,3
The effect of drug treatments for dementia on other illnesses	CbD, mini-CEX, SCE	1,2,3
Skills		
Assessment of cognitive status	CbD, mini-CEX, SCE	1
Assessment of behavioural and psychological symptoms associated with dementia	CbD, mini-CEX, SCE	1,3
Assessment of dementia in people with a learning disability	ACAT, CbD, mini-CEX, MSF	1,3
Communication of diagnosis, prognosis and information about relevant support and treatment options to people with dementia and their carers	CbD, mini-CEX, MSF, SCE	1,2,3,4
Differentiating between dementia and other diagnoses (e.g.	ACAT, CbD, mini-	1,3

depression, dysphasia etc)	CEX, MSF	
Working with colleagues to optimise management of people with cognitive impairment and other co-morbidities	CbD, mini-CEX, MSF, SCE	1,3
Behaviours		
To value the person with dementia, providing advocacy that seeks to eliminate discrimination and stigma	CbD, MSF	1,2,3,4
To work in an empathetic and ethical framework helping patients and carers to understand, accept or reject medical investigations and treatments	CbD, mini-CEX, MSF	1,3,4
To discuss diagnosis, prognosis and management empathetically with patients and relatives/carers	mini-CEX, MSF	1,3,4
To recognise the value of a personalised approach to care, including for younger people with dementia, people with learning disabilities, people from minority ethnic groups, people from isolated communities and older people in prisons	CbD, mini-CEX, MSF	1,2,3,4

34. Continence

To have the knowledge and skills required to assess and manage urinary and faecal incontinence across health care settings

To know how and when to refer for further specialist advice

Knowledge	Assessment Methods	GMP
Basic Biology of Ageing	CbD, SCE	1
Ageing effects on urogenital tract	CbD, SCE	1
Epidemiology, Risk factors and causes of urinary and faecal incontinence	CbD, SCE	1
Investigations available eg Freq/Vol chart, Urinalysis, Bladder scanning, Urodynamics(principles) Current evidence base and management options including: • pharmacological treatments • behavioural treatments • surgical treatments • catheters and devices • padding • equipment	CbD, SCE	1
Role of Continence Nurse Specialist, Urogynaecologist and Proctologist	CbD, SCE	1,3
Skills		
Establish an accurate continence history using information from patient, +/- carer, +/-nursing staff	mini-CEX	1,3
Perform physical examination including external/internal genitalia, rectal examination	mini-CEX	1,3,4
Interpret baseline investigations eg frequency/vol chart, urinalysis, post void residual volume	CbD, mini-CEX	1
Safely prescribe appropriate pharmacological treatments and counsel patients regarding potential side effects	CbD, mini-CEX	1,2,3,4

Prescribe/Refer for appropriate behavioural interventions (eg bladder retraining, pelvic floor physiotherapy).	CbD, mini-CEX	1,2,3,4
Refer appropriately to other MDT colleagues(eg continence nurse specialist, OT)	CbD, mini-CEX	1,2
Behaviours		
Empathetic approach to history taking	mini-CEX, PS	3,4
Positive, sensitive and realistic approach to management	mini-CEX	3,4
Persistence in exploring all treatment options	mini-CEX	3
Collaborative and coordinating approach with members of MDT and other specialists to improve outcomes	mini-CEX, MSF	3,4
Specific Learning Methods		
Attendance and participation (assessment of new and follow-up cases) at a dedicated continence clinic (Geriatrician-led, Uro-gynaecology/Gynaecology-led, Other). Suggest at least 8 clinic sessions.		
Attendance at one Urodynamics session (Observe)		
Working with Continence Nurse Specialist (including assessment re padding and other containment devices)		
Observation of, assisting and discussion with Occupational Therapist (devices, clothing, toilet adaptations and bathing aids)		
Attendance at a specialist faecal incontinence clinic (Surgeon/Physician/nurse-led)		
Education Courses		
Part Reflection in log-book/eportfolio		
Participation in audit and research		

35. Falls

To know how to assess and manage older patients presenting with falls (with or without fracture) in an in- or out-patient setting

Knowledge	Assessment Methods	GMP
Basic Biology of Ageing	CbD, SCE	1
Causes of and risk factors for falls	CbD, mini-CEX, SCE	1,2
Consequences and impact of falls	CbD, SCE	1,2
Drug and neurovascular causes of falls and syncope	CbD, mini-CEX, SCE	1,2
Interventions to prevent falls and minimise consequences e.g. diagnosis and management of osteoporosis, use of Lifeline	CbD, mini-CEX, SCE	1,2,3
Relevant National and International Publications, Guidelines and Audits eg. NICE, AGS/BGS/AAOS, Cochrane Review, National Audit	AA, CbD, SCE	1,2
The importance of fear of falling syndrome	CbD, mini-CEX, SCE	1
Skills		
Diagnostic skills	SCE, ACAT, mini-CEX, CbD	1
Gait assessment	SCE, mini-CEX, CbD	1
Drug and non-drug interventions	SCE, mini-CEX, CbD	1,2

Tilt testing and carotid sinus massage (including consent)	SCE, DOPs, CbD	1,2,4
Team and leadership skills	MSF	1,3
Health promotion	SCE, CbD	1,3
Behaviours		
Appreciation that causes of falls are often multi-factorial	SCE, mini-CEX, CbD	1
Seeking remediable causes of falls	mini-CEX, CbD	1,3
Appreciation that a multiple intervention and multi-disciplinary approach is often required	MSF, mini-CEX, MSF, CbD	1,3,4
Collaborative working with other professions and agencies, including orthopaedic services for fracture patients	MSF, CbD	1,3
Positive but realistic approach to falls investigation and management	MSF, mini-CEX, CbD,	1,3
Aim to maximise patients' functional levels	CbD, PS	1,3,4
Specific Learning Methods		
Involvement with management of patients admitted with falls in emergency admission wards, general medical wards, rehabilitation wards and day hospitals		
Attendance at specialist clinics – Falls, Syncope, Tilt, Osteoporosis		
Discussions with multidisciplinary team members eg. physiotherapists, occupational therapists, nurses, social workers		

36. Poor Mobility

To know how to assess the cause of immobility and declining mobility and aid its management		
Knowledge	**Assessment Methods**	**GMP**
Basic Biology of Ageing	SCE, CbD	1
Risk factors and causes of immobility	SCE, mini-CEX, CbD	1
Principles of rehabilitation	SCE, mini-CEX, CbD	1
Interventions to improve mobility	SCE, mini-CEX, CbD	1
Skills		
Physical examination	SCE, mini-CEX,	1,3,4
Gait assessment	SCE, mini-CEX	1,3,4
Team skills	mini-CEX, MSF	1,2,3
Drug and non-drug interventions	SCE, mini-CEX, CbD	1,3
Behaviours		
Taking a positive and realistic approach to the investigation and management of immobility	CbD, mini-CEX, MSF	1,2,3
Encouraging the use of available resources to prevent and reduce immobility in individual patients	CbD, mini-CEX, MSF	1,2,3
Working collaboratively with other professions (eg therapists, nurses, podiatrists, orthotists and orthopaedic surgeons, primary care) to improve mobility	mini-CEX, MSF	1,3
Specific Learning Methods		
Supervised in-patient and out-patient assessments of immobility e.g geriatric clinics, specialised		

immobility clinics, day hospitals, residential homes Attendance at specialist clinics (e.g. Parkinson's disease clinic), supervised by consultant or nurse specialist

37. Nutrition

To know how to assess the nutritional status of older people in different care settings and in conjunction with other relevant health professionals be able to devise an appropriate nutritional support strategy for patients

Knowledge	Assessment Methods	GMP
Basic physiology of the digestive system	CbD, SCE	1
The effect of ageing on the digestive system	CbD, SCE	1
Epidemiology of nutrition and malnutrition	SCE	1
Nutritional requirements of older adults	CbD, mini-CEX, SCE	1
How to calculate the body mass index (BMI)	CbD, mini-CEX	1,2
Risk factors and causes of poor nutrition	SCE, CbD, mini-CEX	1
Nutritional assessment including assessment tools such as the Malnutrition Universal Screening Tool (MUST)	SCE, CbD, mini-CEX	1,2
Investigations for patients with malabsorption	SCE, CbD, mini-CEX	1,2,3
Nutritional support including delivery routes (oral, nasogastric (including "nasal bridles"), gastrostomy, parenteral) and potential problems such as refeeding syndrome	SCE, CbD, mini-CEX	1,2,3
Withholding and Withdrawing Life-prolonging Treatments when appropriate and the Mental Capacity Act and Mental Health Act in relation to this	CbD, mini-CEX	1,3
Other useful strategies such as protected meal times and coloured trays	CbD	1,2,3
The effect of nutrition on disease processes, tissue viability, recovery from illness and surgery	SCE, CbD	1,2,3
Skills		
History taking on factors relating to and affecting nutrition	CbD, mini-CEX	1,3
Undertake a full physical and mental state examination to ensure causes which may affect nutrition are excluded	CbD, mini-CEX	1
Undertake and interpret relevant investigations	SCE, CbD, mini-CEX	1,2
Identify which patients have or are at risk of malnutrition	CbD, mini-CEX	1, 2,3
Formulate a nutritional support strategy in conjunction with other health professionals, in particular dieticians	CbD, mini-CEX	1,2,3
Know the most appropriate feeding route and when to refer to other specialists/departments	SCE, CbD, mini-CEX	1,2,3
Behaviours		
Assesses patients holistically with reference to GMC guidelines	CbD, mini-CEX	1,4
Monitors the progress of patients	CbD, mini-CEX, MSF	3,4
Works with other members of the multidisciplinary team in particular nurses and dieticians	CbD, mini-CEX, MSF	3,4
Liaises and refers appropriately with other departments such as	CbD, mini-CEX, MSF	1,2,3

gastroenterology, dietetics
Specific Learning Methods
An attachment to a dietician (particularly one with an interest in nutrition in older people)
An attachment to a gastroenterologist, geriatrician or other physician with an interest in nutrition
Experience of the indication for PEG feeding which can be gained from medicine for the elderly wards or stroke wards
Discussion with ward managers, hospital matrons or a nutrition nurse specialist about screening tools and nutritional support strategies

38. Tissue Viability

To know how to assess, diagnose and monitor common types of leg and pressure ulceration, surgical and other wounds in older patients

Knowledge	Assessment Methods	GMP
Basic biology and disease processes of ageing skin	SCE	1
Aetiology, risk factors & pathology of common causes of ulceration	SCE	1
Prevention of ulceration in particular pressure relief	SCE, CbD	1,2
Risk Scores for prevention e.g. Waterlow, Norton, Braden	SCE, CbD	1,2
Principles of wound and stump care	SCE, CbD	1
Nutrition relating to tissue viability	SCE, CbD	1,2
Dressings, topical and systemic antibiotic therapy	SCE, CbD, mini-CEX	1,2
Indications and techniques for non-surgical and surgical debridement	SCE, CbD	1,2
Compression treatment, larval and vacuum therapy	SCE, CbD, mini-CEX	1,2, 4
Indications for skin biopsy	CbD	1,2
Skills		
Physical examination, diabetic foot screening	CbD, mini-CEX	1,3
Undertake Ankle-Brachial Pressure Index measurement & Dopplers	CbD, mini-CEX	1
Diagnosis of benign or malignant lesions & reasons for non-healing	SCE, CbD, mini-CEX	1,2
Ability to diagnose the common types of skin ulceration in the elderly	CbD, mini-CEX	1, 2
Managing scenarios in lipodermatosclerosis, pressure and diabetes	CbD, mini-CEX	1, 2,3
Ability to understand indication for different dressings & other therapy	SCE, CbD, mini-CEX	1,2
Recognise unusual causes of non-healing eg malignancy, vasculitis	SCE, CbD, mini-CEX	1
Behaviours		
Assesses patients holistically, includes systemic & functional factors	PS, CbD, mini-CEX	1,4
Works with other members of the multidisciplinary team including nurses, podiatrists and other members of the wound care team	CbD, mini-CEX, MSF	3,4
Liaises and refers appropriately with other departments such as vascular surgery and diabetes	CbD, mini-CEX, MSF	3,4
Specific Learning Methods		

Observation and discussion with team - tissue viability team, consultant colleagues, podiatry, ward nurses and therapists

Attendance at specialist clinics – leg ulceration, vascular surgery, diabetes podiatry (at least three of each)

Attachment to specific departments/teams such as

tissue viability team (including community), diabetes foot round

39. Movement Disorders

To be able to competently manage patients with movement disorders (MDs) of any stage including knowing when to ask for help

Knowledge	Assessment Methods	GMP
Incidence and prevalence of MDs (Parkinson's disease; parkinsonism; Lewy body dementia; essential tremor; multisystem atrophy, PSP etc) and their significance in the context of population demography changes and other age related diseases	SCE, CbD	1
Symptoms, signs, progress, complications, investigations, imaging, and management of MDs	SCE, mini-CEX, CbD	1
Skills		
Diagnosing the more common syndromes and diseases while understanding the similarities, differences and overlap areas and how to communicate these diagnoses to patients	SCE, mini-CEX,	1,3,4
Skills in pharmacotherapeutics in MDs	SCE, mini-CEX	1,3,4
Skills of diagnosis, management and rehabilitation of the complications and problems in the complex phases of MDs	mini-CEX,MSF	1,2,3
Skills in managing MDs from diagnosis with a shifting emphasis towards a palliative approach with disease progression	SCE, mini-CEX, CbD	1,3
Behaviours		
Taking a positive, realistic and empathetic approach to the diagnosis and management of patients with MDs	CbD, mini-CEX, MSF	1,2,3
Encouraging the use of available resources	CbD, mini-CEX, MSF	1,2,3
Working collaboratively with other professions (eg therapists, nurses, podiatrists, orthotists and orthopaedic surgeons, primary care)	mini-CEX, MSF	1,3

Specific Learning Methods

Experience working in an MD service offering or having access to all aspects of care for at least 6 months. This includes working in a MD/PD clinic and with the wider inter professional team

Experience working with MD specialist nurses in the community and primary/ secondary care interface

Experience of assessing referrals from related disciplines (eg A&E, trauma, psychiatry etc)

Experience of tertiary referral services (eg neurosurgery) – attendance at a neurosurgical assessment clinic for patients with Parkinson's disease

To learn to be able to supervise an apomorphine challenge test

Personal study including national guidelines, specialist societies' information (eg PD Society, BGS Movement Disorder Section, NICE/SIGN Guidelines) and references in reading list neurology section in this curriculum

Attendance at least one relevant College accredited MD Course

40. Community Practice Including Continuing, Respite and Intermediate Care

To have the knowledge and skills required to assess a patient's suitability for and deliver care to older people within intermediate care and community settings, working with multidisciplinary teams, primary care and local authority colleagues

Knowledge	Assessment Methods	GMP
Basic Biology of Ageing	SCE	1
Frailty	CbD, mini-CEX, SCE	1,2,3
Major Geriatric Syndromes and Illnesses	CbD, mini-CEX, SCE	1
Clinical Pharmacology, therapeutics and pharmacy for older people	CbD, mini-CEX, SCE	1,2
Rehabilitation	CbD, mini-CEX, SCE	1,3
Health promotion	SCE	1
Models of intermediate care/community geriatrics including evolving role of day hospitals and care home medicine	CbD, SCE	1,2
Understanding of the various agencies involved in community care	CbD, SCE	1
Opportunities provided by assistive technologies eg Monitoring devices, technology assisted living	CbD, SCE	1
Evidence base for intermediate care and community practice	CbD, SCE	1
Ethics and Medico-legal issues	CbD, mini-CEX, SCE	1,3,4
CPR decisions	CbD, mini-CEX	1,3,4
End of Life Care including advanced care planning	CbD, mini-CEX, SCE	1,2,3,4
Relevant National Publications including Guidelines on Continuing Health Care	CbD, mini-CEX, SCE	1
Relevant National Publications including Guidelines on Respite Care	CbD, mini-CEX, SCE	1
Understanding of Care Home Structures, Regulation and Inspection	CbD, mini-CEX, SCE	1,2
Role of Independent Sector within intermediate and long term care	CbD, mini-CEX	1,2
Skills		
Establish Diagnosis/Differential Diagnosis	CbD, mini-CEX, SCE	1,2,3
Recommend pharmacological and non-pharmacological interventions	CbD, mini-CEX, SCE	1,2,3
Provide medication review	CbD, mini-CEX, SCE	1,2,3
Provide team leadership	ACAT, MSF	1,2,3,4
Manage time effectively (personal/team)	ACAT, MSF	1,3
Manage problems safely within a non-hospital setting	CbD, mini-CEX, SCE	1,2,3
Identify opportunities to prevent ill health and disease in patients	CbD	1
Identify opportunities to promote changes in lifestyle and other actions which will positively improve health.	CbD	1
Provide palliative care when appropriate – liaising with relevant agencies	CbD, mini-CEX, SCE	1,2,3,4
Guide and support patients/staff/relatives/carers through advanced care planning – "what if scenarios"	CbD, mini-CEX, SCE	1,2,3,4

Undertake/Discuss nutritional assessments and develop approaches to feeding including appropriateness of PEG	CbD, mini-CEX, SCE	1,2,3
Skin and wound care – assessment and treatments	CbD, mini-CEX, SCE	1,3
Continence Care – assessment and treatments	CbD, mini-CEX, SCE	1,3
Participate in assessment and selection of patients requiring continuing health care	CbD, mini-CEX	1,3
Liaise effectively with GPs including joint management of cases	CbD, mini-CEX, MSF	1,2,3,4
Behaviours		
Develop an approach to care that crosses the traditional division between primary and secondary care	mini-CEX	1,2,3,4
Recognise the importance of geriatrician involvement in intermediate care	CbD, mini-CEX	1,2,3,4
Recognise the role of the geriatrician in education and management of community staff	mini-CEX, MSF	1,2,3,4
Ability to work flexibly and deal with tasks in an effective fashion	mini-CEX, MSF	1
Appreciation that small changes in disability can improve quality of life	CbD, mini-CEX	1
To work in an empathetic and ethical framework helping patients and relatives/carers to understand and accept or reject medical investigations and treatments	CbD, mini-CEX, MSF, PS	1,3,4
To recognise the value of a structured, active approach to care in care homes	CbD, mini-CEX	1
Recognition that the patient's wishes are important	CbD, mini-CEX, PS	1,2,3,4
To strike the right balance between opinion-seeking, discussion and decisive management of patients	CbD, mini-CEX	1,2,3,4
Specific Learning Methods		
Attachment to Intermediate Care and Community Schemes		
Visits to Care Homes and Continuing Care Hospitals		
Visits to Community Services		
Attendance at a Continuing Care Assessment Panel		
Short attachment to Primary Care		
Performing/Taking part in medical home visits		

41. Orthogeriatrics

To know how to assess acutely ill orthopaedic patients and how to manage these patients including rehabilitation

Knowledge	Assessment Methods	GMP
Surgical and anaesthetic issues and understanding of postoperative care and complications (including pain control and tissue viability)	ACAT, SCE, mini-CEX, CbD	1,2,3
Different models of orthogeriatric care including role of intermediate care	SCE, mini-CEX, CbD	1,3
Causes and management of falls	SCE, mini-CEX, CbD	1,2,3
Causes and management of osteoporosis and role of fracture liaison	SCE, mini-CEX, CbD	1,2,3

services		
Relevant National Publications and Guidelines including NICE and the Blue Book	SCE, CbD	1,2
Understanding of National Audits and the Hip Fracture Database	CbD, AA	1,2
Skills		
Diagnostic skills	SCE, mini-CEX, CbD	1,2, 3
Drug and non drug interventions	SCE, mini-CEX, CbD	1,2,3
Team and leadership skills	MSF, ACAT	1,3,4
Planning transfers of care	SCE, mini-CEX, CbD	1,3,4
Nutritional assessment and intervention	SCE, mini-CEX, CbD	1,2,3
Behaviours		
An approach to the management of elderly people with fracture that seeks to maximize function	SCE, mini-CEX, CbD, PS	1,3,4
Close collaboration with orthopaedic surgeons, anaesthetists and other professionals to ensure best care	MSF, mini-CEX, CbD	1,2,3,4
Specific learning methods		
Work in orthopaedic wards where hip fractures admitted for operation, orthogeriatric wards, rehabilitation facilities.		
Discussions with anaesthetists, orthopaedic surgeons, other medical specilaities eg cardiology, nurses, physiotherapists, occupational therapists, social workers, fracture liaison nurse, falls co-ordinator.		
Attend osteoporosis clinics and falls clinics		

42. Psychiatry of Old Age

To know how to assess and manage older patients presenting with the common psychiatric conditions, and to know when to seek specialist advice		
Knowledge	**Assessment Methods**	**GMP**
Major psychiatric conditions and illnesses: depression, delirium, dementia, anxiety and paranoid states	SCE, mini-CEX, CbD	1
Clinical Pharmacology, therapeutics and pharmacy for older people with psychiatric conditions	SCE, mini-CEX, CbD	1,2
Ethics and Medico-legal issues	SCE, mini-CEX, CbD	1,3,4
Organisation of old age psychiatry services	SCE, CbD	1,2,3,4
Psychiatric assessment methods and tools	SCE, mini-CEX, CbD	1
Skills		
Diagnostic skills	SCE, mini-CEX, CbD	1,2,3
Drug and non drug interventions	SCE, mini-CEX, CbD	1,2,3
Team and leadership skills	MSF, ACAT	1,2,3,4
Cognitive and mood assessment	SCE, mini-CEX, CbD	1,2,3,4
Appropriate referral to other specialists	SCE, mini-CEX, CbD	1,2,3
Assessment and documentation of mental capacity	SCE, mini-CEX, CbD	1,3
Behaviours		

To develop a positive approach to the investigation and management of psychiatric conditions in respect of older people	MSF, CbD, ACAT	1,2,3,4
To work collaboratively with other specialists, particularly old-age psychiatrists, and agencies to manage the older patient with mental ill health	MSF, mini-CEX, CbD	1,2,3,4
To take account of a patient's family, cultural and religious background bettering order to enable the management of the psychiatric health of the individual patient	MSF, mini-CEX, CbD	1,3,4

43. Palliative Care

To have the knowledge and skills required to assess and manage patients with life-limiting diseases (malignant and non-malignant) across all health care settings, in conjunction with other health care professionals

Knowledge	Assessment Methods	GMP
Symptom profiles in terminally ill and an understanding of their pathophysiology	SCE, CbD, mini-CEX	1
Pathophysiology of pain, including types of pain – nociceptive, visceral, neuropathic, incident	SCE, CbD, mini-CEX	1
Range of therapeutic options available for common symptoms ie disease modifying &symptom modifying treatments (palliative surgery, radiotherapy, chemotherapy, immunotherapy, hormone therapy, drugs, physical therapies, psychological interventions)	SCE,CbD, mini-CEX	1
Knowledge (including pharmacodynamics/pharmacokinetics) of commonly used medications for pain, including: • Range of drugs and routes of administration • Adjustment of dosage in frail elderly • Adjustment of dosage in altered metabolism, disease progression and last few days of life • Problems of polypharmacy	SCE, CbD, mini-CEX	1,2
Emergencies in palliative care eg acute pain, hypercalcaemia, haemorrhage, spinal cord compression, breathlessness	SCE, CbD, mini-CEX	1,2
Hydration and nutrition eg legal, ethical and technical aspects (including withholding and withdrawing of treatment)	SCE, CbD, mini-CEX	1,3
Management of common symptoms in non-malignant life-limiting disease eg end-stage Dementia, Heart Failure, COPD	SCE, CbD, mini-CEX	1,2
Role of palliative care team and other agencies	SCE, CbD, mini-CEX	1,2,4
Modern bereavement care	SCE, CbD, mini-CEX	1,2,4
Skills		
Undertake comprehensive assessment of physical and mental state (including patients with impaired cognition/dementia)	CbD, mini-CEX	1,3,4
Assessment of prognosis (ability to recognise when patient is dying)	CbD, mini-CEX	1,3,4
Ability to consider quality of life	CbD, mini-CEX	1,3
Ability to formulate a holistic management plan which anticipates problems, includes pharmacological and non-pharmacological treatments, special equipment and may include formal palliative	CbD, mini-CEX	1,2,3,4

instruments		
Compassionate understanding of a dying person's wishes	CbD, mini-CEX,PS	3,4
Behaviours		
Empathetic approach to patients and relatives/carers	CbD, mini-CEX, PS	3,4
Respectful of the wishes of a dying patient, their family and carers	CbD, mini-CEX, PS	3,4
Awareness of patient`s personal, cultural and religious background	CbD, mini-CEX, PS	3,4
Collaborative and coordinating approach with members of MDT, other specialists and agencies to provide best possible care	CbD, mini-CEX, PS	3,4
Specific Learning Methods		
Work directly with a consultant-led palliative care team on a full-time or part-time (eg 1 day per week over 4-5 months)		
Assess new and follow-up patients and discuss with educational supervisor		
Work within a variety of settings eg hospice, specialist palliative care unit, day hospice, general hospital, outpatients		
Attendance at specialist palliative care MDT meetings		
Small group sessions with other trainees (Geriatrics and/or Palliative Care)		
Education Courses –Palliative Care, Communication		
Reflection in log-book/eportfolio		
Participation in audit and research		

44. Perioperative Medicine for Older People

To know how to risk assess, optimise and manage the older elective and emergency surgical patient throughout the surgical pathway

Knowledge	Assessment Methods	GMP
Demographics and political landscape relevant to the older surgical patient	SCE, CbD	1, 4
National reports and policy drivers relevant to the older surgical patient	CbD	1,2,3
Models and pathways of care for older surgical patients	CbD	1,2
Risk assessment of perioperative morbidity and mortality (including use of tools e.g. Proactive Care of Older People Undergoing Surgery (PCOPUS) and investigations e.g. Cardiopulmonary exercise testing))	CbD	1,2
Modification of risk including the use of organ specific national and international guidelines (e.g. European Society Cardiology)	SCE, CbD	1,2
Use of inter-disciplinary and cross-speciality interventions to improve postoperative outcome (e.g. therapy delivered pre-habilitation)	SCE	1,2
Skills		
Clinical assessment with appropriate use of investigations and tools to preoperatively risk assess for perioperative morbidity and mortality	CbD, mini-CEX	1,3
Communication of risk with health professionals and patients/relatives	MSF, PS, CbD	1,3
Timely medical optimisation of comorbidity and geriatric syndromes	CbD	1,2
Appropriate allocation of postoperative resources (e.g. use of level 2 and 3 care)	CbD	1,2
Decision making regards rehabilitation, and timely and effective	MSF, CbD	1,2,3

discharge pertinent to the surgical patient		
Liaison with patients, anaesthetists and surgeons to ensure shared decision making	MSF, CbD	1,2,3
Application of ethical and biomedical approaches to ensure appropriate ceilings for escalation of care	CbD	1
Behaviours		
Objectively assess the risk-benefit ratio of surgery for older patients without value-laden judgement	CbD	1,2
Develop confidence in the added value of the geriatrician's role in shared decision making	MSF, TO	1,2,3
Appreciate the importance of collaboration between geriatricians, anaesthetists and surgeons in promoting high quality care	MSF	1,2,3
Specific Learning Methods		
Attend clinics where comprehensive geriatric assessment methodology is used to improve outcomes		
Participate in routine nurse led pre-assessment and high risk anaesthetic led pre-assessment of older surgical patients		
Liaison work on surgical wards		
Attend surgical ward multidisciplinary team meetings		
Attend training days and conferences (BGS National Meetings) relevant to the older surgical patient (e.g. POPS training day, AAGBI training day, Age Anaesthesia Association meetings). Literature review.		

45. Stroke Care

To be able contribute to a comprehensive service for patients with acute stroke and chronic stroke-related disability in hospital and the community

Knowledge	Assessment Methods	GMP
Epidemiology of stroke, particularly pertinent to older people e.g. incidence, prevalence, disease burden	CbD, SCE	1
Primary and secondary prevention measures, particularly risk factor management appropriate to older people e.g. when to consider treatment of hypertension, use of statins, use of anticoagulants and anti-platelet agents, appropriate use of brain imaging, vascular imaging and cardiac investigations	CbD, SCE	1,2,3
Acute stroke and TIA management. Knowledge of ABCD2 risk stratification, knowledge of OCSP (Bamford) classification, knowledge of indicators for intravenous stroke thrombolysis, management of physiological parameters in acute stroke, initial monitoring to identify early complications such as dysphagia, indicators for specialist service (including neurosurgical) referral	CbD, ACAT, SCE, mini-CEX	1,2,3
Complications of stroke and their management. Short term e.g. DVT, pressure sores, respiratory and urinary infection, depression. Long term e.g. contractures, seizures, neuropathic pain	CbD, SCE, mini-CEX	1,2,3
Different rehabilitation models in hospital and community. Evidence for specialist stroke rehabilitation and early supported discharge	CbD, MSF, SCE	1,3

Effects on carers and patients. Knowledge of prognosis, local services and voluntary agencies, availability of pamphlets	CbD, SCE	1,3
Ethical and legal issues relating to patients with severe disability Feeding issues, mental capacity and welfare issues in cognitively impaired patients, DVLA regulations	CbD, SCE	1,3,4
Awareness of functional presentations	mini-CEX, CbD	1
Skills		
Assessment of patients with acute stroke and/or TIA		
Ability to:		
Assess a neurological referral history given in person, on the phone or in writing from a general practitioner or other health professional	mini-CEX, ACAT, CbD	1,3
Take a rapid and detailed neurological and cardiovascular history from patients, carers and bystanders	mini-CEX, ACAT	1,3
Undertake a neurological and cardiovascular examination	mini-CEX	1
Conduct a bedside assessment of cognitive function	mini-CEX	1
Identify common mechanisms underlying stroke symptoms	mini-CEX, CbD, SCE	1
Give a logical differential diagnosis of common alternative pathologies	mini-CEX, CbD, SCE	1
Distinguish between ischaemic and haemorrhagic stroke subtypes, and common differentials (including tumour and subdural) on CT. SEE G(I)M CURRICULUM FOR CLARIFICATION	mini-CEX, CbD	1
Interpret abnormal haematology, biochemistry, clotting	mini-CEX, CbD, SCE	1
Interpret 12-lead ECG, 24 hour ECG and blood pressure monitoring recordings . SEE G(I)M CURRICULUM FOR CLARIFICATION	mini-CEX, CbD	1
Communicate effectively with imaging and laboratory staff	MSF	1,3
Obtain initial consent from a patient for invasive investigations	mini-CEX, PS	1,3,4
Explain results in language which the patient and carers can understand	mini-CEX, PS	1,3,4
Refer to appropriate specialties when required	MSF	1,2,3
Screening for safe swallowing	mini-CEX	1,2,3
Assess and manage fluid balance	ACAT	1,3
Interpret and manage the changes in physiological variables, including hypoxia, abnormal cardiac rhythms, hypotension, hypertension, hypoglycaemia and hyperglycaemia	ACAT, CbD	1
Interpret neurological observation charts	mini-CEX	1
Accurately score patients using the Glasgow Coma Score	ACAT	1
Refer appropriate patients to neurosurgery	ACAT, MSF	1,3
Initiate appropriate management of complications based on relevant investigations	ACAT, CbD	1,2,3
Provide intensive monitoring to acutely unwell patients	ACAT	1,2
Manage cardiorespiratory and/or other complications of stroke	ACAT, mini-CEX, CbD	1,2

Manage dysphagia	ACAT, CbD	1,2
Assess and manage nutrition and hydration within a multidisciplinary team	MSF, CbD	1,2,3
Formulate appropriate strategies for prevention of DVT and early stroke recurrence	CbD	1,2
Rehabilitation of stroke patients, and assessment and management of patients with chronic stroke-related disability		
Ability to:		
Work with a multidisciplinary team working including, goal setting after initial assessment	MSF,	1,3,
Leadership of a multi-disciplinary team and the organisation of a stroke rehabilitation service	mini-CEX,	1,2,3
Delegate leadership to other responsible members of the team	MSF,	1,2,3
Communicate with patients and their carers about practical and emotional issues arising from living with disability	MSF, PS	1,2,3
Recognise and assess functional deterioration	CbD	1,3
Management of complications of stroke, both short-term and long-term	CbD, mini-CEX	1,3
Manage an outpatient return clinic	mini-CEX	1
Behaviours		
Foster a supportive and respectful environment where there is open and transparent communication between all team members	MSF	1,3,4
Appreciate team dynamics in different situations and over time	MSF	3
Show willingness to maintain a close working relationship with other members of the multi-disciplinary team, primary and community care	MSF	3
Encourage patients to voice their preferences and personal choices about their care	MSF, PS	1,3,4
Appreciate the impact on patients and carers of the number of professionals who may be involved in their care	MSF, PS	3,4
Recognise and explain the impact of long term conditions on the patient, family and friends	CbD, PS	3,4
Recognise and respect the role of family, friends and carers in the management of the patient with a long term condition	CbD, PS	3,4
Facilitate patients' access to the appropriate training and skills in order to develop the patient's confidence and competence to self-care	MS, PS	1,3
Ensure equipment and devices relevant to the patient's care are discussed, including availabilty	MSF,PS	1,3
Recognise the importance of prompt and accurate information sharing with Primary Care team following hospital discharge	MSF	1,2,3,4
Show willingness to seek the opinion of others when making decisions are to be made about resuscitation status, and withholding or withdrawing treatment	CbD, MSF, mini-CEX	3,4
Specific Learning Methods		
Working in acute medical care, including out of hours 'on call', assessing new patients presenting with features of acute stroke, including assessment of suitability for intravenous thombolysis (with urgent onward referral to a specialist centre if necessary)		

Where possible attendance at / short term attachment to an acute specialist stroke service that delivers intravenous thrombolysis for suitable patients with acute ischaemic stroke

Working with a multidisciplinary team in a stroke rehabilitation ward with exposure to stroke specialist nursing and Allied Health Profession services including physiotherapy, occupational therapy, dietetics, speech and language and social work services,

Attendance at specialist clinics – neurovascular, spasticity, prosthetics, orthoptics, clinical psychology

Attachment to an early supported discharge / community rehabilitation service with links to voluntary services

Behaviours: – please cross refer to additional behaviours set out in Grids for (1) Acute Illness, diagnosis and management, (2) Rehabilitation, (3) Planning transfers of Care and Discharge, (4) Chronic Disease and Disability and (5) Palliative Care

N.B. The knowledge, skills and behaviours listed above represent the competencies in stroke care required by all trainees for CCT in Geriatric Medicine ('level 1' stroke competencies). Trainees are expected to undertake the optional one year of formal additional training in advanced stroke care for the Stroke sub specialty recognition. This will need to be approved by the Stroke Medicine SSAC and will need to take place within a comprehensive stroke service.

Optional Higher Level Curriculum Grids

For trainees wishing to demonstrate additional competencies in Geriatric Medicine

46. Falls and Syncope

To provide the trainee with advanced knowledge and skills to assess and manage older patients presenting with falls (with or without injury) or syncope in any healthcare setting

Knowledge	Assessment Methods	GMP
Epidemiology of Falls	SCE, CbD,	1
Aetiology and pathophysiology of falls	SCE, CbD, mini-CEX	1
Evidence-based interventions to reduce falls risk	SCE, CbD, mini-CEX	1,2
Models of falls prevention services	SCE, CbD	1,2
Epidemiology of syncope	SCE, CbD	1
Aetiology and pathophysiology of syncope	SCE, CbD	1
Evidence-based assessment of syncope	SCE, CbD, mini-CEX	1,2
Evidence-based treatment of syncope	SCE, CbD, mini-CEX	1,2
Assessment of bone health and treat of bone disorders such as osteoporosis and vitamin D deficiency/insufficiency	SCE, mini-CEX	1
Skills		
Ability to assess gait and balance, including at least one validated balance assessment tool	SCE, CbD, mini-CEX	1,2
Ability to assess causes of vertigo and dizziness	SCE, CbD, mini-CEX	1,2
Ability to diagnose causes of falls and syncope	SCE, CbD, mini-CEX	1
Ability to perform tilt testing	DOPs, mini-CEX	1,2
Ability to perform diagnostic carotid sinus massage	DOPs, mini-CEX	1,2
Ability to interpret relevant cardiovascular tests (ECG, Holter monitor, Echo)	SCE, CbD	1,2
Ability to conduct drug and non-drug interventions	SCE, CbD, mini-CEX	1,2
Ability to assess vision as it relates to falls risk	SCE, CbD,mini-CEX	1
Ability to interpret bone density scans and use at least one validated tool	SCE, CbD, mini-CEX	1
Critically appraise a falls service to assess if it is evidence based and complies with national standards	AA	1,2
Leadership of a specialist multi-disciplinary falls team	MSF, mini-CEX	3,4
General team and leadership skills	mini-CEX, MSF	2,3,4
Ability to promote health in patients	SCE, CbD	1,3
Behaviours		
Empathetic view of compromises between patient's safety and improved mobility	mini-CEX, DOPs, MSF	1,2,3,4
Specific Learning Methods		
Experience working in a multidisciplinary falls prevention programme for at least 3 months (not necessarily all at once)		
Experience of performing tilt testing and carotid sinus massage and keeping a log of the procedures (at		

least 25 procedures each and experience of at least two vasovagal and 2 carotid sinus syndrome results).

Keeping up to date with guidelines such as NICE, British Geriatrics Society/American Geriatrics Society

Attending national / international conferences or training courses on falls/syncope

Attending osteoporosis clinics (at least 10)

47. Orthogeriatrics and Bone Health

To have advanced knowledge and skills in order to assess and manage older patients presenting with fracture, particularly hip fracture, from presentation to discharge

To have advanced knowledge and skills to assess and manage fracture risk

Knowledge	Assessment Methods	GMP
Causes and management of falls and osteoporosis	SCE, CbD	1,2
Effects and risks of injury, surgery and anaesthesia on older people	SCE, CbD, mini-CEX	1,2
Effects and risks of surgery and anaesthesia on older people	SCE, CbD, mini-CEX	1,2
Knowledge of appropriate assessment technologies to inform clinical management decisions, eg on rehabilitation, use of intermediate care, discharge planning and prognosis.	SCE, CbD, mini-CEX	2,3,4
Different models of orthogeriatric care and of evidence base of evaluations	SCE, CbD,	1,2
Drug and non-drug treatments for osteoporosis	SCE, CbD, mini-CEX	1,2
Other relevant metabolic bone disorders (osteomalacia, Paget's disease, etc.)	SCE, CbD	1
Knowledge of the causes of osteoporosis and appropriate strategies for the prevention and treatment of osteoporosis, including the evidence base for pharmacological and non-pharmacological treatments.	mini-CEX, CbD	1,2
Understanding of medical and surgical management of common metabolic bone diseases eg. osteomalacia, Paget's disease & primary hyperparathyroidism.	SCE, mini-CEX, CbD	1
Skills		
Clinical assessment of fracture patients including understanding risks of complications	mini-CEX, CbD	1,2
Leadership skills in interdisciplinary and multi-agency working	mini-CEX, CbD, MSF	3,4
Discharge planning	mini-CEX, CbD, MSF	3,4
Assess patients for fitness for surgery	SCE, mini-CEX, CbD	1,2
The appropriate use and interpretation of bone densitometry and the WHO FRAX tool	mini-CEX, CbD	1
Ability to manage osteoporosis in special groups (eg men, younger adults, steroid-treated, Down syndrome)	mini-CEX, CbD	1
Ability to assess falls risk and institute fall prevention measures including referral to appropriate services where appropriate eg. exercise classes, tilt testing	SCE, mini-CEX, CbD	1,3
Ability to critically appraise an orthogeriatric service in order to assess whether it is evidence based and follows national guidelines eg "Blue	AA	1,2

Book”		
Leadership of a multidisciplinary team	MSF, mini-CEX	3,4
Health promotion	SCE, mini-CEX, CbD	1,3
Behaviours		
Patient-empathetic view of compromises which may occur between patient’s safety and improved mobility	mini-CEX, CbD, MSF	1,2,3,4
Specific Learning Methods		
Experience of working in a variety of orthogeriatric settings including preoperative assessment and management, acute postoperative care, post-surgical rehabilitation and discharge planning.. At least 6 months fulltime equivalent (although not necessarily consecutively)		
Keeping up to date with evidence base for interventions and national/international guidelines.		
Attending national / international conferences or study courses on post-hip fracture care, osteoporosis and metabolic bone diseases and falls.		
Attending osteoporosis clinics (at least 15)		

48. Continence

To have the knowledge and skills required to assess patients with urinary and faecal incontinence

To have the knowledge, skills and behaviours required to develop a continence service for a specific patient group, in conjunction with specialist nursing, therapy and surgical colleagues

Knowledge	Assessment Methods	GMP
Anatomy and physiology of lower urinary tract and changes associated with later life.	SCE, CbD	1
Pathophysiology of lower urinary tract and bowel disease in adults	SCE,CbD	1
Relevant examination in the assessment of patients with urinary and faecal incontinence	mini-CEX	1,4
The appropriate use of investigation in diagnosis, including bladder scanning and multichannel cystometry	SCE, mini-CEX, CbD	1,2
Treatment options for patients with bladder and bowel problems and the appropriate use of each	SCE, mini-CEX, CbD	1,2
The roles of the multidisciplinary team in the management of continence problems	SCE, mini-CEX, CbD, MSF	1,3
Relevant national and international guidelines for the management of continence in older people (NICE, SIGN, International Consultation on Incontinence, UKCS)	SCE, mini-CEX, CbD	1,2
Relevant recent research in continence in older people	SCE	1
Implementation and development of integrated continence services	CbD, MSF	2,3
Skills		
Taking a continence focused history	mini-CEX	1,4
Physical, functional and cognitive examination with relevance to continence problems	mini-CEX	1,4
Ability to perform bladder scans and perform urodynamic testing to International Continence Society standard	CbD	1,2

Interpretation of the results of investigation, including multichannel cystometry and anal ultrasound and manometry	SCE, mini-CEX, CbD	1,2
Demonstrable ability to formulate management plans using relevant modalities, including lifestyle and behavioural treatments, pharmacological agents, and referral of relevant cases for surgical intervention	mini-CEX, CbD	1,2,3,4
Demonstrable ability to apply the results of research to clinical practice	SCE, CbD, mini-CEX	1,2
Demonstrable ability to have led and completed a piece of research in the field of continence care	CbD, Research Supervisor Reports	1,2,3,4
Demonstrable ability to have led and completed an audit in relation to an aspect of continence care	CbD, AA	1,2,3,4
Behaviours		
Empathetic approach to history taking and management	mini-CEX, PS	3,4
Collaborative and coordinating approach with member of MDT and other specialists to improve outcomes at both an individual patient and service level	mini-CEX, MSF Portfolio	3,4
Specific Learning Methods		
Attendance and participation (full independent assessment of new and follow-up cases) at dedicated continence clinic (Geriatrician-led, Uro-gynaecology/Gynaecology-led, Other).		
Suggest at least 16+ clinic sessions.		
Attendance at Urodynamics sessions and undertake assessments independently to nationally required standards		
Working with Continence Nurse Specialist (including assessment re padding and other containment devices) across various care settings (home/care home)		
Observation of, assisting and discussion with Occupational Therapist (devices, clothing, toilet adaptations and bathing aids)		
Attendance and participation in specialist faecal incontinence clinic		
Audit within the area of Continence Care		
Research project within the area of Continence Care		
Education Courses (National and Local eg Regional Urogynaecology Training Days)		
Reflection in log-book/eportfolio		

49. Dementia and Psychogeriatric Services

Delirium, incidental cognitive impairment, chronic cognitive impairment (dementia, MCI) and cognitive decline in the presence of an intellectual disability

To be able to assess and manage patients who present acutely with cognitive impairment

To be able to assess and manage patients who present non-acutely with cognitive impairment

To be able to assess and manage patients who present with cognitive impairment incidental to other co-morbidities

To be able to assess and manage patients who present with pre-existing intellectual disability presenting with cognitive decline

Knowledge	Assessment Methods	GMP
Biological substrates involved in delirium and dementia	SCE, mini-CEX, CbD	1

Assessment tools for delirium and dementia	SCE, mini-CEX, CbD	1
Complications of delirium	SCE, mini-CEX, CbD	1
Pharmacological management of delirium and dementia	SCE, mini-CEX, CbD	1,3,4
Non-pharmacological management of delirium and dementia	SCE, mini-CEX, CbD	1,3,4
Legal issues of capacity and consent in delirium and dementia	SCE, mini-CEX, CbD	1,3,4
Differential diagnosis of cognitive decline in people with pre-existing intellectual disability	SCE, mini-CEX, CbD	1
Atypical presentations of dementing illnesses in people with pre-existing intellectual disability	SCE, mini-CEX, CbD	1
Assessment scales useful to measure cognitive status in people with pre-existing intellectual disability	SCE, mini-CEX, CbD	1
Common co-morbidities that might affect management of dementia in people with pre-existing intellectual disability	SCE, mini-CEX, CbD	1,3
Specialist services available for people with pre-existing intellectual disability	SCE, mini-CEX, CbD	1,2,3
The impact of cognitive impairment on the assessment and management of other illnesses	SCE, mini-CEX, CbD	1,3
The impact of cognitive impairment on rehabilitation, e.g. in stroke	SCE, mini-CEX, CbD	1,3
The effect of treatment of other illnesses on cognitive impairment	SCE, mini-CEX, CbD	1
The effect of drug treatments of cognitive impairment on other illnesses	SCE, mini-CEX, CbD	1
Skills		
Physical assessment of people with cognitive impairment, including in the presence of an intellectual disability	SCE, mini-CEX, CbD	1
Ordering appropriate investigations	SCE, mini-CEX, CbD	1
Appropriate prescribing of drugs	SCE, mini-CEX, CbD	1
Multi-disciplinary team working to ensure appropriate non-pharmacological management	SCE, mini-CEX, CbD	1,3,4
Assessment of cognitive status	SCE, mini-CEX, CbD	1
Assessment of behavioural and psychological symptoms associated with dementia	SCE, mini-CEX, CbD	1,3
Differentiating between cognitive impairment and other diagnoses (e.g. depression, dysphasia etc)	SCE, mini-CEX, CbD	1,3
Working with colleagues to optimise management of people with cognitive impairment and other co-morbidities	SCE, mini-CEX, CbD	1,3
Behaviours		
To value the person with cognitive impairment, providing advocacy that seeks to eliminate discrimination and stigma	MSF, CbD	1,2,3,4
To work in an empathetic and ethical framework helping patients and carers to understand and accept or reject medical investigations and treatments	MSF, mini-CEX, CbD	1,3,4
To discuss diagnosis, prognosis and management empathetically with patients and relatives/carers	MSF, mini-CEX	1,3,4
To provide leadership and advice to staff unfamiliar with caring for	MSF, CbD	1,2,3,4

people with cognitive impairment		
To recognise the value of a personalised approach to care, including for younger people with cognitive impairment, people with learning disabilities, people from minority ethnic groups, people from rural and island communities, and older people in prisons	MSF, mini-CEX, CbD	1,2,3,4
Specific Learning Methods		
Experience: minimum 6 months to include at least 1 month for assessment and management of patients with delirium in acute settings with discussion with senior medical staff, 2 months memory clinic attachment, 1 month for assessment and management of in-patients, and sessional or full-time attachment with Community Learning Disability team with experience of outpatients, day hospital and community assessments equivalent to at least 1 month whole-time equivalent. Assessment standards will be set higher than those expected for core curriculum dementia and delirium grids commensurate with the knowledge, skills and behaviours required to provide a specialist service.		

50. Intermediate Care and Community Practice

To be able to confidently diagnose and manage ill or disabled older people in intermediate care or community settings for those with a special responsibility for this type of care

Knowledge	Assessment Methods	GMP
Models of Intermediate Care/Community Geriatrics including evolving role of Day Hospital	SCE, CbD	1
Understanding of the various agencies involved in community care	CbD	1
Opportunities provided by Assistive Technologies, eg Monitoring devices, technology assisted living	SCE, CbD	1
Current evidence base for intermediate and community care	SCE, CbD	1
Evidence regarding suitability and effectiveness of different forms of supported care for older people (including retirement villages, highly sheltered housing, and care homes with or without nursing, both general and with specialist designation	CbD	1,3
Current national publications regarding intermediate care	SCE, CbD	1,2
Current national publications regarding end of life care	SCE, CbD	1,2
Regulatory bodies with responsibility for care homes	SCE, CbD	1,2
Understand the role of PCT's practice based consortia (PBC's) in commissioning community services for older people	CbD/ SCE	1,3
Understand regulation regarding medicine administration in care homes	SCE, CbD	1,2,3
Models of medical care for care home patients including knowledge of evidence base	SCE, CbD	1,2
Knowledge of pressure relieving and other specialist equipment and their uses.	CbD, SCE	1,2
Knowledge of criteria for continuing care assessments	CbD	1
Skills		
Good clinical skills	mini-CEX	1,4
Excellent risk assessment and management skills in identifying most appropriate place of care	mini-CEX, CbD	1,2
Excellent communication skills in sharing with patients and their carers decisions about place of care in the light of risk assessment	mini-CEX, CbD	1,2,3

Extended skills in medication review in those with frailty and life limiting conditions	mini-CEX, CbD	1,2
Excellent communication skills including verbal and written timely communication	mini-CEX, MSF	1, 3
Appropriate use of facilities	CbD, mini-CEX	1,2
Managing in a non-hospital setting	mini-CEX, SCE, MSF	1,3
Good time management	mini-CEX, MSF	1,3
Multidisciplinary team leadership	mini-CEX, MSF	1,3
Effective liaison with GPs including joint management of cases	mini-CEX, CbD, MSF	1
Developing community and intermediate services for older people	mini-CEX	1,2,3,4
Effective interagency working; with social services and the voluntary sector including older people's representative groups	CbD, MSF	
Excellent influencing skills in joint working with providers and commissioners of community services for older people	CbD, MSF	
Behaviours		
Develops an approach to care that crosses the traditional division between primary and secondary care	mini-CEX	3
Recognises the importance of geriatrician involvement in intermediate care	mini-CEX, CbD	1,2 ,3
Recognises the role of the geriatrician in education & management of community staff	mini-CEX, TO	1,2,3
Works in a context of mutual respect with other health and social care colleagues	MSF, mini-CEX	3
Works in a context of recognition of the older person as central to decisions about their future plan of care whether in their own home or other community setting	mini-CEX	1,3
Facilitates the sharing of relevant information with appropriate regard both to patient confidentiality and to the important role of carers	CbD	1,4
Specific learning methods		
Experience (minimum 4 months full time or equivalent part time)		
Sessional or full-time attachment with intermediate care services at home or in institutional settings both at nursing and residential levels		
Leading a MDT for at least 10 meetings, leading at least 5 complex case conferences and undertaking solo at least 10 home visits to assess older patients		
Attachment to a primary care team and consultant geriatrician with a special responsibility for community and intermediate care		
Attachment to a public health service or commissioners organising and funding care for older people including that in community settings		
Accompany a community geriatrician or GP (or both) on proactive planned visits to care homes (minimum 10 visits)		

4 Learning and Teaching

4.1 The Training Programme

The organisation and delivery of postgraduate training is the statutory responsibility of the General Medical Council (GMC) which devolves responsibility for the local organisation and delivery of training to the deaneries. Each deanery oversees a "School of Medicine" which is comprised of the regional Specialty Training Committees (STCs) in each medical specialty. Responsibility for the organisation and delivery of specialty training in Geriatric Medicine in each deanery is, therefore, the remit of the regional Geriatric Medicine STC. Each STC has a Training Programme Director who coordinates the training programme in the specialty.

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 entire curriculum is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. Ideally, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest.

Objectives by Year of Training

Trainees should achieve specific objectives each year relevant to the type of training programme being undertaken. Progress will be ascertained each year.

Year 3 post foundation training (ST3) will usually include a greater emphasis in G(I)M but if not, this will occur in ST4 or rarely ST5. Normally by the end of year ST3 trainees should have successfully completed part 2 of the MRCP (UK) diploma (trainees entering from August 2011 will require full MRCP on entry to ST3). During years ST3-5, trainees will be expected to achieve a level of competence which aims to satisfy the first five principle learning objectives. ST Years 6 and 7 will be spent consolidating this experience, but with greater emphasis on acquiring the skills and experience to achieve the remaining learning objectives which include subspecialty experience. There will be a geriatric medicine knowledge assessment (Specialty Certificate Examination (SCE)) which should be taken normally in ST years 5 or 6 though may be taken in years 4 or 5 (for single CCT trainees or those progressing well with achieved competencies) . Trainees should have passed the SCE by the time of the penultimate year assessment and it must be passed before completion of training in order to obtain the certificate of completion of training (CCT). Normally a minimum of one year, though preferably two, will be full time in geriatric medicine. Concurrent acute general takes should not detract from geriatric medicine training during this period. There should also be further training in General (Internal) Medicine during ST years 6 and/or 7 or in acute geriatric medicine for those undertaking a single CCT in Geriatric Medicine.

Academic and scholarly training should take place throughout the training programme.

Acting up as a consultant (AUC)

In the final year of training after the PYA a satisfactorily progressing trainee may undertake a post as an "Acting Up Consultant" for up to 3 months whole time equivalents (w.t.e). Each trainee should have a named supervisor during this period. Approval is given by the trainee's deanery but the JRCPTB must be notified in advance.

"Acting up" provides doctors in training coming towards the end of their training with the experience of navigating the transition from junior doctor to consultant while maintaining an element of supervision.

Although acting up often fulfills a genuine service requirement, it is not the same as being a locum consultant. Doctors in training acting up will be carrying out a consultant's tasks but with the understanding that they will have a named supervisor at the hosting hospital and that the designated supervisor will always be available for support, including out of hours or during on-call work. Doctors in training will need to follow the rules laid down by the Deanery / LETB within which they work and also follow the JRCPTB rules which can be found at www.jrcptb.org.uk/trainingandcert/Pages/Out-of-Programme.

Required Special Topic Experience

Experience in various special topics is a mandatory requirement for completion of training in geriatric medicine and the following are designated as high priority special training areas: palliative care, orthogeriatrics, old age psychiatry, specialist stroke care, intermediate care and community practice. A minimum of a full-time attachment of 4 weeks or equivalent in each of the special topics of palliative care, old age psychiatry and intermediate care with community practice and 12 weeks or equivalent in stroke and orthogeriatrics with falls over the seven years of training is recommended. Sessional experience over a longer period is also acceptable as long as training objectives are agreed and progress is reviewed accordingly. Longer periods (more than 3 months fulltime) of special topic training will count towards the out of programme experience allowance of 1 year.

Out of Programme Experience

For the satisfactorily progressing trainee, up to one year in total can be taken out of programme (and counted towards the CCT required experience) for research, overseas experience, stroke care, primary care (GP), high level specialist area training (community and intermediate care, dementia and psychogeriatric services, continence, movement disorders, orthogeriatrics and falls) or in other specialties related to geriatric medicine e.g. neurology, rehabilitation, rheumatology, oncology, diabetes, renal medicine and palliative care. Alternatively a trainee could take a year out of programme to acquire a Masters in Business Administration or in Education. All such training must be prospectively approved by the trainee's deanery and by the SAC using the approved JRCPTB application form (research or clinical training forms). On approval by the SAC, the JRCPTB will advise the trainee and the deanery of the decision. The deanery will make an application to the GMC for approval of the out of programme research. **All applications for out of programme experience must be prospectively approved.**

Evidence will need to be provided from the supervisor of training during the attachment of satisfactory progress and achievement of the required objectives e.g. relevant publications in peer reviewed journals after a period out of programme in research.

Out of programme experience will normally take place from year ST4 onwards.

More than 1 year can be taken out of programme (normally a maximum of 3 years) but only 1 year will count towards a CCT in geriatric medicine.

4.2 Teaching and Learning Methods

Teaching and learning methods are recommended by the SAC from its experience of training in Geriatric Medicine and used locally by supervisors under the direction of the educational supervisors and programme directors.

The majority of learning is from clinical practice with opportunities created by trainees, programme directors and the specialty training committees for training in the main places of work but also practice outside the principal place of work. There will be learning with peers both in everyday practice and as part of formal teaching. Teaching will be from clinical supervisors during clinical attachments, from peers in the same specialty and other specialties and as formal teaching in lectures and small groups.

Learning will also take place by undertaking audit, research, teaching, presenting and writing and observing management and taking part in clinical governance activities e.g. risk management, handling complaints, writing guidelines and pathways etc. In particular all trainees should take part in clinical audit and will need to complete a full audit cycle for at least one topic.

Most competencies will be acquired over a sustained period of experience.

Trainees will rotate to different work places often on an annual basis.

Off-the job education and rotations to various work places will be arranged to enable delivery of the totality of the curriculum.

The key will be regular work-based assessment by educational supervisors who will be able to assess, with the trainee, their on-going progress and whether parts of the curriculum are not being delivered within their present work place. The practice of educational supervisors is described below under supervision and feedback

Work-based Experiential Learning

The majority of learning will be work-based experiential on an inpatient, day patient, outpatient and at home basis. Trainees will learn from practice (work-based training) on acute, rehabilitation and post-take ward rounds, multidisciplinary meetings, in outpatients, day hospitals, care homes and patients' own homes. Where appropriate they will take day to day responsibility for patients completing appropriate medical notes. In these settings they will undertake activities both independently and directly supervised and observed by senior staff; trainees will have opportunities for concentrated practice in skills and practical procedures during their hospital placements; they will learn from peers and be supervised when not yet fully competent in skills by senior staff. This will be regularly backed up by feedback from senior staff including consultants and monitored by clinical, educational and research supervisors. Experience will be graded to the level of training and proportionate to the level of expertise. Supervision will always be given where the trainee has not yet acquired a sufficient level of competence.

Learning with Peers

Peer learning is also important with discussion amongst colleagues at all levels in the clinical placements and at regional meetings.

Formal Learning

Approximately 4 hours per week of education in a lecture or seminar setting will be delivered for all hospital placements. A minimum of 4 hours each week of the

timetable and preferably 6-8 hours will be allocated for continuing professional development, research and audit. Activities could include case presentations, grand rounds, journal clubs, presentation of audit and research, lectures and small group teaching.

In addition the equivalent of 4 hours per month for at least 10 months of the year should be delivered on a regional basis for delivery of taught components of the curriculum.

Formal teaching is needed for topics such as teaching skills, research methodology, information technology skills, appraisal techniques and other clinical governance methodology. Trainees are expected to attend courses to cover such topics. The final part of any management course usually will be undertaken in the last year of the training programme.

It is expected that trainees will attend national and regional study days including at least one national meeting of the British Geriatrics Society each year. Where appropriate other national and international meetings may provide appropriate experience.

Personal Self-Directed Study

Personal study (self-directed learning) including the reading of relevant professional journals and textbooks and use of CDs, DVDs, searching the worldwide web (Appendix 1) and use of other library resources as detailed in the attached reading list (shared with the British Geriatrics Society) (Appendix 2) is also important.

Trainees are expected to complete evidence of reflective practice through case reports and other experiences in their e-portfolio. Other self-directed work will be planning, data collection, analysis and presentation of audit and research work such that the training record will contain evidence of academic pursuits.

Trainees will take part in and lead bedside teaching and will teach undergraduates, postgraduates and non-medical staff in small groups and formal lectures making personal presentations using a variety of audiovisual methods. They will be expected to present at journal clubs, and make case presentations at grand rounds or similar settings. They will be expected to undertake personal audit and research and make presentations of their findings at clinical meetings.

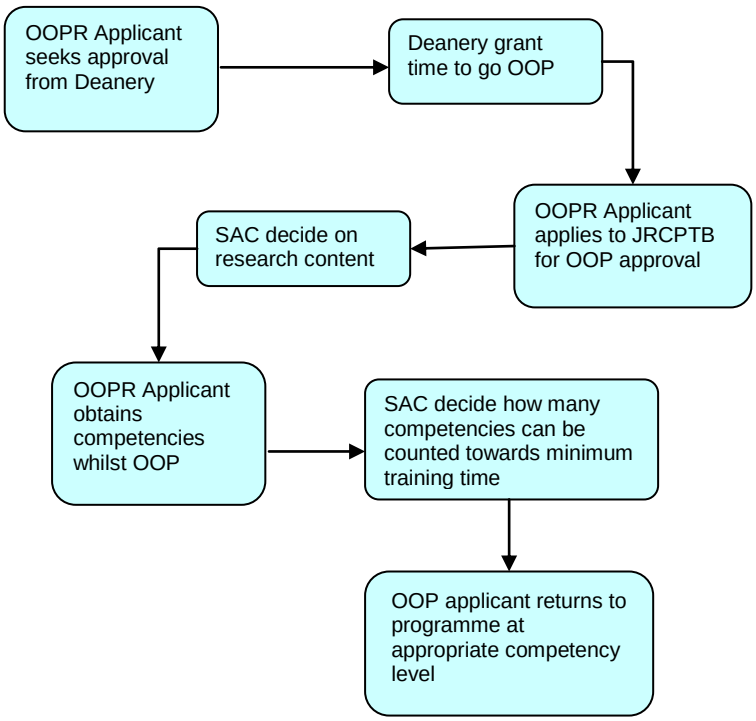
4.3 Research

Trainees who wish to acquire research competencies, in addition to those specified in their specialty curriculum, may undertake a research project as an ideal way of obtaining those competencies. For those in specialty training, one option to be considered is that of taking time out of programme to complete a specified project or research degree. Applications to research bodies, the deanery (via an OOPR form) and the JRCPTB (via a Research Application Form) are necessary steps, which are the responsibility of the trainee. The JRCPTB Research Application Form can be accessed via the JRCPTB website. It requires an estimate of the competencies that will be achieved and, once completed, it should be returned to JRCPTB together with a job description and an up to date CV. The JRCPTB will submit applications to the relevant SACs for review of the research content including an indicative assessment of the amount of clinical credit (competence acquisition) which might be achieved. This is likely to be influenced by the nature of the research (eg entirely laboratory-based or strong clinical commitment), as well as duration (eg 12 month Masters, 2-

year MD, 3-Year PhD). On approval by the SAC, the JRCPTB will advise the trainee and the deanery of the decision. The deanery will make an application to the GMC for approval of the out of programme research. **All applications for out of programme research must be prospectively approved by the trainee's deanery, the SAC and GMC.**

Upon completion of the research period the competencies achieved will be agreed by the OOP Supervisor, Educational Supervisor and communicated to the SAC, accessing the facilities available on the JRCPTB ePortfolio. The competencies achieved will determine the trainee's position on return to programme; for example if an ST3 trainee obtains all ST4 competencies then 12 months will be recognised towards the minimum training time and the trainee will return to the programme at ST5. This would be corroborated by the subsequent ARCP.

This process is shown in the diagram below:



Funding will need to be identified for the duration of the research period. Trainees need not count research experience or its clinical component towards a CCT programme but must decide whether or not they wish it to be counted on application to the deanery and the JRCPTB.

A maximum period of 3 years out of programme is allowed and the SACs will recognise up to 12 months towards the minimum training times.

4.4 Academic Training

All trainees should be able to appraise research literature and use the evidence base to guide their practice. They should be able to demonstrate expertise in the assurance of the quality of health services. All trainees should be competent to teach and train others to a professional standard Suitable indicators of achievement of these objectives includes the award of a higher degree (e.g. MSc), the completion of closed loop audits, participation in teacher training courses or the award of teaching diplomas / certificates, and the publication of one or more peer reviewed articles and the presentation of one or more abstracts to learned societies. A minimum of 4 hours

per week and preferably 6-8 hours per week as specified above should be dedicated to this work including continuing professional development throughout the programme. It is likely that achievement of these objectives is likely to be possible only during the final years of the training programme. This underscores the importance of the academic mentor and also requires that the ARCP process is used to monitor progress.

For those trainees undertaking training for a future academic career there are a number of options. Some trainees will undertake an academic fellowship which may mix academic and clinical training or have separate periods of academic and clinical training. Others will take time out of programme to undertake a higher degree of which one year will count as out of programme experience if prospectively approved by the SAC in Geriatric Medicine, the deanery and GMC. The competencies expected of other trainees will still need to be achieved by the academic trainee and confirmation by the appropriate assessments. Greater flexibility in how these competencies are achieved will be supported wherever possible by the SAC in Geriatric Medicine. Trainees may need to spend a greater proportion of their training time in teaching or academic institutions. Most deaneries should organise a separate academic ARCP with assessment of achievement of academic competencies by clinical and other academics.

For those contemplating an academic career path, there are now well-defined posts at all levels in the Integrated Academic Training Pathway (IATP) involving the National Institute for Health Research (NIHR) and the Academy of Medical Sciences (AMS). For full details see http://www.nccrcd.nhs.uk/intetacatrain and http://www.academicmedicine.ac.uk/uploads/A-pocket-guide.pdf. Academic trainees may wish to focus on education or research and are united by the target of a consultant-level post in a university and/or teaching hospital, typically starting as a senior lecturer and aiming to progress to readership and professor. A postgraduate degree will usually be essential (see “out of programme experience”) and academic mentorship is advised (see section 6.1). Academic competencies have been defined by the JRCPTB in association with AMS and the Colleges and modes of assessment have been incorporated in the latest edition of the Gold Guide (section 7, see http://www.jrcptb.org.uk/forms/Documents/GoldGuide2009.pdf).

Academic integrated pathways to CCT are a) considered fulltime CCTs as the default position and b) are run through in nature. The academic programmes are CCT programmes and the indicative time academic trainees to achieve the CCT is the same as the time set for non-academic trainees. If a trainee fails to achieve all the required competencies within the notional time period for the programme, this would be considered at the ARCP, and recommendations to allow completion of clinical training would be made (assuming other progress to be satisfactory). An academic trainee working in an entirely laboratory-based project would be likely to require additional clinical training, whereas a trainee whose project is strongly clinically oriented may complete within the “normal” time (see the guidelines for monitoring training and progress) http://www.academicmedicine.ac.uk/careersacademicmedicine.aspx. Extension of a CCT date will be in proportion depending upon the nature of the research and will ensure full capture of the specialty outcomes set down by the Royal College and approved by GMC.

All applications for research must be prospectively approved by the SAC and the regulator, see www.jrcptb.org.uk for details of the process.

5 Assessment

5.1 The Assessment System

The purpose of the assessment system is to:

- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, measure 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;
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- ensure trainees are acquiring competencies within the domains of Good Medical Practice*;*
- assess trainees' actual performance in the workplace;
- ensure that trainees possess the essential underlying knowledge required for their specialty;
- inform the Annual Review of Competence Progression (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.

The integrated assessment system comprises workplace-based assessments and knowledge – base assessments. Individual assessment methods are described in more detail below.

Workplace-based assessments will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide trainees with formative feedback. They are not individually summative but overall outcomes from a number of such assessments provide evidence for summative decision making. 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.

The assessments recommended have been chosen by the SAC from its wide experience of use of these methods, their relevance to the nature of the clinical work involved in the specialty and the relevant generic competencies that need to be acquired.

5.2 Assessment Blueprint

An assessment blueprint is contained within the syllabus (section 3.4). It has been developed in a way which maps the assessment methods on to the curriculum in a systematic way. The blueprint ensures that there is appropriate sampling across the curriculum. The "Assessment Methods" shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed and that where they are assessed not every method will be used.

There are decision support aids and an assessment plan (section 5.5) to indicate the way these assessment tools should be used. The relevant documents are available in addition to this curriculum.

5.3 Assessment Methods

The following assessment methods are used in the integrated assessment system:

Examinations and Certificates

- The Specialty Certificate Examination in Geriatric Medicine (SCE)
- Advanced Life Support Certificate (ALS)

The Federation of Royal Colleges of Physicians of the UK, in association with the British Geriatrics Society, has developed a Specialty Certificate Examination. The aim of this national assessment is to assess a trainee's knowledge and understanding of the clinical sciences relevant to specialist medical practice and of common or important disorders to a level appropriate for a newly appointed consultant. The Specialty Certificate Examination is a prerequisite for attainment of the CCT.

Information about the SCE, including guidance for candidates, is available on the MRCP(UK) website www.mrcpuk.org

Workplace-based Assessments (WPBAs)

- Multi-Source Feedback (MSF)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Case-Based Discussion (CbD)
- Patient Survey (PS)
- Acute Care Assessment Tool (ACAT)
- Audit Assessment (AA)
- Teaching Observation (TO)

The SAC is also working on an assessment tool of leading multidisciplinary team meetings which is in the process of being piloted

These methods are described briefly below. More information about these methods including guidance for trainees and assessors is available in the ePortfolio and on the JRCPTB website www.jrcptb.org.uk. Workplace-based assessments should be recorded in the trainee's ePortfolio. The workplace-based assessment methods include feedback opportunities as an integral part of the assessment process, this is explained in the guidance notes provided for the techniques.

Multisource 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 objective systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administration staff, and other allied professionals. The trainee will not see the individual responses by raters, feedback is given to the trainee by the Educational Supervisor.

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.

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 include discussion about a written record (such as written case notes, out-patient letter, discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

Acute Care Assessment Tool (ACAT)
The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice during a period of work on the Acute Medical Take or similar work in an alternative acute care setting. Any senior doctor who has been responsible for the supervision of a trainee during their acute medical work can be the assessor for an ACAT

Patient Survey (PS)
Patient Survey address issues, including behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

Audit Assessment (AA)
The Audit Assessment Tool is designed to assess a trainee's competence in completing an audit. The Audit Assessment can be based on review of audit documentation OR on a presentation of the audit at a meeting. If possible the trainee should be assessed on the same audit by more than one assessor.

Teaching Observation (TO)
The Teaching Observation form is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation 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).

There will be immediate feedback by the assessors to the trainees at the time of the above assessments. This will relate to the specific knowledge, skills and behaviours tested by the assessment. General progress judged by the summation of all the assessments will be given back to the trainee at regular reviews with their educational supervisor and through the supervisors report and other assessments following the ARCP in training organised by the programme director.

Other Evidence

Supervisors' Reports (Educational (ESR) and Research (RSR))
Some aspects of behaviour and attitudes can only be assessed by supervisors who repeatedly observe the trainee in their clinical practice and are not amenable to a workplace-based assessment or a knowledge based assessment. These reports though not one of the formal assessments listed in our grids provide a summation of the experience of the educational supervisor of the work of the trainee taking into account all the evidence from work-place based and other formal assessments. These reports are acquired annually by the deaneries as part of the ARCP process (see below) the information being used alongside the ePortfolio to evaluate trainee progress.

Previous Assessments Prior to Commencement of the Specialty Curriculum
Many assessments will have taken place prior to entry to the specialty training programme during Undergraduate, Foundation and Core Medical Training. These will particularly relate to practical skills and generic performance that are still relevant during the specialty training programme (e.g. infection control). Though there may not be formal assessment of this knowledge, skills and attitudes during the specialty training programme if problems are observed during clinical training specific workplace-based assessments or supervisor reports will be used to report on performance in these areas even though these specific assessments are not listed in the ARCP decision grids.

5.4 Decisions on Progress (ARCP)

The Annual Review of Competence Progression (ARCP) is the formal method by which a trainee's progression through her/his training programme is monitored and recorded. ARCP is not an assessment – it is the review of evidence of training and assessment. The ARCP process is described in "A Reference Guide for Postgraduate Specialty Training in the UK" (the "Gold Guide" – available from www.mmc.nhs.uk). Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's ePortfolio.

5.5 ARCP Decision Aid for Geriatric Medicine

The table that follows includes a column for each training year which documents the targets that have to be achieved for a Satisfactory ARCP outcome at the end of the training year.

An educational supervisor report covering the whole training year is required before the ARCP. Great emphasis is placed on the educational supervisor confirming that satisfactory progress in the curriculum is being made compared to the level expected of a trainee at that stage of their training. This report should bring to the attention of the panel events that are causing concern e.g. patient safety issues, professional behaviour issues, poor performance in work-place based assessments, poor MSF report, issues reported by other clinicians. It is expected that serious events would trigger a deanery review even if an ARCP was not due.
It is recognised that there is a hierarchy of competencies within the curriculum. It is expected that the breadth and depth of evidence presented for the core Geriatric Medicine topics will be greater than that for the common competencies which should be sampled to a lesser extent.

Workplace assessment evidence of performance will be required for each of the former group but not for the common competencies. There should however be evidence of engagement with those sections of the curriculum with WPBA or other evidence (as described below) presented for the majority of the common competencies.

The e portfolio curriculum record should be used to present evidence in an organised way to enable the educational supervisor and the ARCP panel to determine whether satisfactory progress with training is being made to proceed to the next phase of training. Evidence that may be linked to the competencies listed on the e portfolio curriculum record include work place assessments of performance, reflections on clinical cases or events or personal performance, reflection on teaching attended or other learning events undertaken e.g. e learning modules, reflection on significant publications, audit or quality improvement project reports (structured abstracts recommended) and / or assessments, feedback on teaching delivered and examination pass communications.

Summaries of clinical activity and teaching attendance should be recorded in the logbook facility in the e portfolio.It is recognised that the experience gained in each training year varies as well the order in which it is gained. The targets for each training year make some allowance for that. The decision aid is a guide and some discretion can be used before the final CCT when the educational supervisor indicates to the ARCP panel that overall progress is satisfactory.

Geriatric Medicine ARCP Decision Aid- standards for recognising satisfactory progress							
Curriculum domain		**ST3**	**ST4**	**ST5**	**ST6**	**CCT**	**Comments**
Educational Supervisor report	Overall report	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	Satisfactory with no concerns	To cover whole training year since last ARCP
SCE in Geriatric Medicine					SCE attempted	SCE passed	
ALS		Valid	Valid	Valid	Valid	Valid	
Workplace Based Assessments (WPBAs)	WPBAs should be performed proportionately throughout each training year and performed by a number of different assessors It is expected that a range of assessments will be used and structured feedback given to aid the trainees personal development.						
	mini - CEX	6	6	6	6	6	
	CbD	6	6	6	6	6	
	ACAT	1	1	1	1	1	
	MSF		1		1		Replies should be received within a 3 month time window from a minimum of 12 raters including 3 consultants and a mixture of other staff for a valid MSF. If significant concerns are raised then arrangements should be made for a repeat MSF(s)
	Patient Survey				1		
	Audit assessment	1	1	1	1 Intermediate care or continuing care	1 At least one closed loop audit to be completed	Feedback should be primarily about the audit

					audit to be completed before PYA	before CCT	
	Teaching Observation				1 before PYA		
Common Competencies		Group sign off by educational supervisor that satisfactory progress is being made	Group sign off by educational supervisor that satisfactory progress is being made	Group sign off by educational supervisor that satisfactory progress is being made	Group sign off by educational supervisor that satisfactory progress is being made	Satisfactory performance at curriculum level 3 or 4, signed off by educational supervisor	The ARCP panel will expect to see evidence of engagement with this section of the curriculum
Core Geriatric Medicine	27 to 31	Group sign off by educational supervisor that satisfactory progress is being made	Group sign off by educational supervisor that satisfactory progress is being made	Each presentation individually signed off with supporting evidence of performance			It is expected that mini-CEXs and CbDs will be mainly used to assess workplace performance of these competences
	32 to 39		Group sign off by educational supervisor that satisfactory progress is being made	Group sign off by educational supervisor that satisfactory progress is being made	Each presentation individually signed off with supporting evidence of performance		
	40 to 45			Group sign off by educational supervisor that satisfactory progress is being made	Group sign off by educational supervisor that satisfactory progress is being made	Each presentation individually signed off with supporting evidence of performance	
Optional Higher level competencies						Optional	**Advanced Stroke training should be recorded on the Stroke curriculum**

							record on the e portfolio during the additional year of training
Teaching	Overall teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	Satisfactory record of teaching attendance	
	Courses		Research Methodology course attended	Effective teaching skills course attended		Management course attended	

SUMMARY OF ALL ASSESSMENTS FOR REGISTRARS IN GERIATRIC MEDICINE

The assessment plan is an outline of the minimum number of assessments needed for satisfactory completion of the programme in order to verify reasonable coverage of the Geriatric Medicine curriculum.

At least 75% of the assessments listed below must be completed by the PYA (roughly 20% per annum) and 100% by the time of the final ARCP in ST7 before an outcome 6 is awarded to indicate that training has been completed and a CCT recommended.

SCE can be first taken from ST4 onwards and must be passed by the time of completion of training. Trainees should have an up to date ALS throughout the programme. Certificates of course attendance are not really assessments but confirm attendance at appropriate training. Workplace assessments may be used to produce evidence of assessments for competencies in the Geriatric Medicine and another curriculum e.g. G(I)M or Stroke curricula. Trainees are advised not to claim that more than 6 competencies in any single assessment.

The workplace assessments in each year should be undertaken by at least two different assessors.

The following table is a summary of all the assessments/certificates that are expected over the course of the training programme:

Name of Assessment	Minimum Number of Assessments	Suggested Year of Completion
MRCP (UK)		Before end of CMT
SCE	1	ST Year 7 to achieve CCT (can be attempted as early as ST4)
ALS	Updated regularly so that trainees always have a current ALS	ST Years 3-7
ACAT	4: Complete 1 in Year 3 and 1 in Year 7 plus two others	ST Years 3-7
CbD	26: 4 Acute(Diagnosis, Management, Prescribing) , 2 Rehab, 2 Continuing Care (at least 1 non-NHS), 1 EBM, 1 Ethics/Law, 1 Health Promotion, 1 Complaint, 1 Intermediate Care, 1 Transfer of Care Problem, 1 Falls, 1 Delirium, 1 Psychiatry of Old Age, 1 Continence, 1 Palliative Care, 1 Depression/Dementia, 1 Neurovascular Investigation, 1 Acute Stroke, 1 Rehab Stroke, 1 Orthogeriatric Acute, 1 Orthogeriatric Rehab, 1 Tissue Viability/Homeostasis	ST Years 3-7
mini-CEX	25: 4 Acute (1 Wd Rd), 2 Rehab (1 Wd Rd) , 1 Pre-op Orthogeriatric Assessment, 1 Orthogeriatric post op, 2 Chronic Disease (Clinic e.g. diabetes, arthritis etc), 1 MDT Chair (Discharge), 1 Continence, 1 Falls, 1 Movement Disorder, 1 Palliative Care/Break Bad News, 1 Delirium/Depression, 1 Old Age Psychiatry(Home Visit/Ward Referral), 1 Osteoporosis/Metabolic Bone Disease, 1 Comprehensive Geriatric Assessment, 1 Intermediate Care/Home Visit, 1 Continuing Care, 1 Day Hospital, 3 Stroke - (Acute (WR), Rehab (WR) & Neurovascular Investigation (TIA clinic))	ST Years 3-7
MSF	2 MSFs	MSFs Usually by the end of ST4 & ST6
Patient Survey	1 Patient Survey	By the end of ST 6
Publication	Preferably at least 1	By PYA
Research Presentation	Preferably at least 1 with satisfactory Research section in the Academic competencies section of the e portfolio	By PYA
Teaching Observation	At least 2	By PYA
Audit	At least 1 cycle and 3 Audits in total (1 Acute focus, 1 rehab focus, 1 Intermediate or Community Care focus) with satisfactory Clinical Governance section in the Academic competencies section of the e portfolio	By PYA
Research Methods Course Cert	At least 1	By PYA
Teaching Course Cert	At least 1	By Outcome 6 Mtg
Management Course Cert	At least 1	By Outcome 6 Mtg
ARCP	1 per year including research year or out of programme year if taken	Year 3-7

5.6 Penultimate Year Assessment (PYA)

Approximately 18 months prior to the estimated date of completion of training the ARCP takes the form of a penultimate year assessment (PYA) where recommendations on objectives to be achieved during the rest of the training programme will be made depending on progress in meeting the curriculum requirements. It may be necessary to extend training if all necessary competencies cannot be achieved in the time allocated. An external representative of the SAC will also attend the panel. It is preferable for the trainee to attend this panel meeting to meet the external SAC representative.

5.7 Complaints and Appeals

The MRCP(UK) office has complaints procedures and appeals regulations documented in its website which apply to all examinations run by the Royal Colleges of Physicians including the Specialist Certificate Examination.

All WPBA method outcomes must be used to provide feedback to the trainee on the effectiveness of the education and training where consent from all interested parties has been given. If a trainee has a complaint about the outcome from a specific assessment this is their first opportunity to raise it.

Appeals against decisions concerning in-year assessments will be handled at deanery level and deaneries are responsible for setting up and reviewing suitable processes. If a formal complaint about assessment is to be pursued this should be referred in the first instance to the chair of the Specialty Training Committee who is accountable to the regional deanery. Continuing concerns should be referred to the Associate Dean.

6 Supervision and Feedback

Trainees must work with a level of clinical supervision commensurate with their level of clinical experience and competence. This is the responsibility of the relevant clinical supervisor after discussion with the trainee's Educational Supervisor and the designated clinical governance lead. In keeping with the principles of Good Medical Practice, trainees should know that they must limit their clinical practice to within their level of clinical competence and seek help and support without hesitation.

Trainees will be supervised throughout their training by appropriately trained clinical and Educational Supervisors. Educational and Clinical Supervisors must meet their specified trainee formally at the beginning, mid-point and end of each placement and in addition provide informal feedback on trainee's performance during each placement. At the initial meeting a learning agreement should be signed by supervisor and trainee to indicate what training and supervision will be provided and what training or experience the trainee will be expected to achieve.

It is extremely important that trainees' progress is mapped against the curriculum to ensure that trainees' experience and training reflect curriculum content and objectives. It is the responsibility of educational and clinical supervisors in conjunction with the trainee to ensure that training is structured in such a way that these curriculum objectives are met.

At or soon after appointment the regional deanery Specialty Training Committee should assign an appropriately qualified Educational Supervisor to each trainee. Ideally the Educational Supervisor (ES) should be the first consultant the trainee

works for or alternatively another consultant from within that department. The trainee and Educational Supervisor must be informed of this arrangement ideally in writing (either by letter or email) and both parties must be clear of their roles and responsibilities and also those of trainee clinical supervisors (CS) and methods of communication between ESs, CSs and trainee.

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 personally discuss all cases if required. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

The role of the educational supervisor and the responsibilities of the trainee to ensure successful achievement of the curriculum are described below.

Educational Supervision

Trainees must have a designated educational supervisor for all elements of their training. The educational supervisor need not be the consultant trainer with whom the trainee works directly. Each educational supervisor's name should appear on the specialist register and should have been appointed by the deanery specialty training committee (STC).

The educational supervisor is responsible for the implementation and coordination of a structured training programme agreed with the other geriatricians and Trust management. S/he should also be in regular contact with the regional specialty adviser, programme director and STC.

An individual trainee may have one or several educational supervisors throughout the course of a training programme, but these arrangements need to be clear to all parties. Trainees should also be mentored either by the programme director or other similar appointment made by the STC.

The educational supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. The educational supervisor should be part of the clinical specialty team. Thus if the clinical directorate (clinical director) have any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the Educational Supervisor. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Requirements to be an Educational Supervisor

All educational supervisors must satisfy the following minimum standards and requirements to undertake this role:

- Educational Supervisors will normally have completed specialist training in Geriatric Medicine and, if not, must be approved by the deanery STC in Geriatric Medicine as having the appropriate knowledge and experience.
- They must comply with regional deanery requirements to undertake this role: ideally these should include training in equality and diversity (either as an e-

module or face-to-face), assessment and appraisal and be familiar with the tools-of-the trade assessment methods. Educational supervisors should provide evidence of having received this training and ensure it is updated every 5 years.

- Deaneries must have structures and processes in place to support and develop Educational supervisors
- Educational supervisors must be supported in their role by a postgraduate medical education team and have a suitable job plan with an appropriate workload and time to supervise trainees.

The Academic Supervisor (Mentor)

The academic supervisor will encourage the trainee to develop an academic portfolio including research, quality assurance, teaching and training skills. The mentor will not in most cases directly teach any or all of these skills, but will facilitate the trainee in acquiring these from locally available resources and oversee their plans. Academic supervisors should meet their trainees at least twice a year and more often if they are directly supervising their research. The academic supervisor should provide a report on their academic progress annually to the ARCP panel.

Trainees in Geriatric Medicine are expected to have an understanding of research methodology and show evidence of having participated in original research during their training. Their involvement in research may be facilitated by being assigned an Academic supervisor (or Mentor). The academic supervisor may be an academic geriatrician or an academic from another specialty, they may be employed by either the NHS or University.

The mentor will encourage the trainees to develop an academic portfolio including research, quality assurance, teaching and presentation skills. The mentor will not in most cases directly teach any or all of these skills, but will facilitate the trainees utilising locally available resources, and oversee their plans. Academic supervisors should meet their trainees at least twice a year and more often if they are providing direct supervision of research or other training. The academic supervisor should provide a report on a trainee's academic progress to the ARCP panel.

Trainees in Difficulty

The educational supervisor and programme director are responsible for identifying trainees in difficulty either through of lack of progress in training or because of personal issues such as illness, emotional strain etc. The programme director is responsible for establishing a system whereby each trainee's progress is monitored regularly and satisfactorily and that trainees know who to contact should they experience difficulty. The programme director will use the expertise within the deanery for managing these trainees and ensuring they have appropriate support.

Trainee's Responsibilities

The person ultimately responsible for an individual's training in geriatric medicine is the trainee him/herself. Although support and supervision will be available, the trainee should feel that they own their training programme. The trainee has an important responsibility to maintain a comprehensive personalised training record as detailed below.

The responsibilities of the trainee include:

- Awareness of the requirements for training as detailed in this curriculum and use of learning opportunities available within and outside their particular training rotation.
- Awareness of who their educational supervisor for each part of their training and their role as outlined above. Making arrangements to meet with their educational supervisor regularly and at least 3 monthly for appraisal and assessment and to complete an educational/learning plan.
- Awareness of who their academic supervisor is and make arrangements to meet them at least twice a year.
- Attend deanery ,Trust and unit induction programmes as arranged
- To maintain an up-to-date training record including a portfolio or reflective case reports and programmes of regional and national meetings attended, details of teaching, audit and research presentations, copies of abstracts and articles or details of book chapters they have written or contributed to, supervision reports and other certificates or documentation pertaining to their training. The trainee should provide all the necessary documentation for their annual ARCP which they may need to attend.
- To take advantage of the opportunities available to them in order to enhance their training.
- To attend local and regional training meetings, and at least one national or international geriatrics meeting each year.
- To join the British Geriatrics Society.
- To know whom to contact if problems arise: typically their educational supervisor followed by their regional speciality adviser, programme director or other mentor as arranged by the deanery.
- To be aware of their regional trainee representative.

Supervision and Practice and Safety of Patient and Doctor

Patient safety is of paramount importance and it is essential to ensure that a trainee does not undertake duties which are inappropriate to their degree of expertise and competence or without the relevant degree of supervision from a more senior clinician.

- Trainees must make the needs of patients their primary concern
- Trainees must be appropriately supervised according to their experience and competence
- Those supervising the clinical care provided by trainees must be:
    - clearly identified
    - competent to do so
    - accessible and approachable by day and by night: with time for these responsibilities identified in their job plan
- Trainees must be expected to obtain consent only for procedures which they are competent to perform
- Shift and on-call patterns must be designed to minimise the effects of sleep deprivation
- Trainees must have well-organised handover arrangements which ensure continuity of patient care between shifts.

Each deanery, Trust and department will provide induction including the provision of appropriate written or electronic information so that trainees are aware of the policy within the work-place, safety issues and support systems. Programme directors and mentors of trainees will check with trainees whether they have been exposed to situations of unsafe clinical practice.

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.

GMC recommend that each educational and clinical supervisor should have 0.25 PA per trainee per week allocated for supervision work.

6.2 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 trainee's ePortfolio

Induction Appraisal

The trainee and educational supervisor should have an appraisal meeting at the beginning of each training year to review the trainee's progress to date, agree learning objectives for the year ahead and identify the learning opportunities presented by their next year's placement(s). 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.

If the trainee's next year of training will be in a hospital which is different to that where their educational supervisor is based then the trainee should also have an initial pre-placement with their prospective clinical supervisor to ensure their training requirements and objectives are met. This meeting may be facilitated by communication (verbal or written (letter or email)) between their educational supervisor and prospective clinical supervisor about their training requirements and developmental needs.

Mid-point Review

This meeting between trainee and educational supervisor is mandatory (except 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

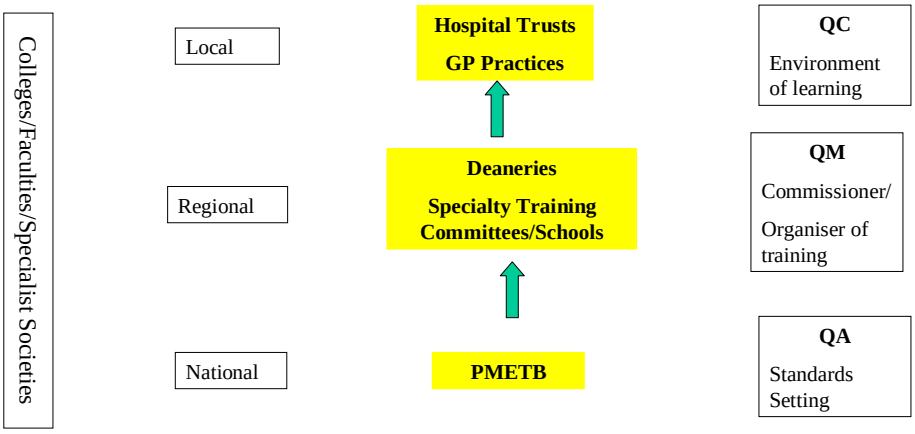
Trainees should review the PDP and curriculum progress with both their educational and clinical supervisors (if the same individuals are not undertaking these roles) using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should 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

7 Managing Curriculum Implementation

Deaneries are responsible for the quality management of training, GMC will in turn quality assure the training provided by deaneries and educational providers (hospitals, Trusts, community units) are responsible for local quality control managed by the deaneries. The Colleges have an important role in quality management which they will deliver in partnership with deaneries. The College's principal role in the process is to quality review deanery processes which will take place within the SACs on a regular basis.

The SAC in Geriatric Medicine has very broad representation with representatives of deanery specialty training committees from all four UK nations.
SAC meetings are scheduled to be immediately followed on the same day as meetings of the British Geriatrics Society Education and Training Committee whose membership includes representation from all specialty training committees in the UK. This enables close communication between the SAC, BGS and specialty training committees about all aspects of training within the specialty and ensures that any changes relating to training are immediately cascaded to colleagues in all deaneries.

The Organisation and Quality Assurance of PG Training



Deaneries are responsible for ensuring all those involved in the assessment and supervision of training have appropriate training by ensuring they provide training on equality and diversity, appraisal and assessment and "tools of the trade" locally. Each deanery should keep a register of trainers who have received training (and had refresher training) and this process should be monitored by the SAC to ensure consistent standards are provided throughout the UK.

The SAC directly with its links to deanery training representatives and indirectly via its links with them through the BGS Education and Training Committee will ensure aspects relating to the curriculum communicated and implemented. Feedback from trainee representatives as well as from training committee representatives supplemented by surveys undertaken by both committees will ensure and confirm the curriculum is implemented in a consistent way throughout the UK.

The BGS has an active Trainee Committee, and trainees are represented on the SAC and BGS Education and Training Committee ensuring trainees have a strong voice in the development, implementation and delivery of the curriculum.

The SAC in Geriatric Medicine and the British Geriatrics Education and Training Committee will play a central role in monitoring that local deaneries are providing

adequate training for trainers and supervisors and ensuring that the curriculum is implemented in a consistent manner throughout the UK.

7.1 Intended Use of Curriculum by Trainers and Trainees

This curriculum and ePortfolio are web-based documents which are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) website www.jrcptb.org.uk.

The educational supervisors and trainers can access the up-to-date curriculum from the JRCPTB website and will be expected to use this as the basis of their discussion with trainees. 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 a portfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Through their structure and representation the SAC and BGS Education and Training Committees supplemented by the undertaking of questionnaire surveys will ensure that trainees and trainers experience training which reflects the curriculum. They will also ensure that this is provided consistently by each deanery and that all trainees have access to appropriate training within their programme which meets the requirements of the curriculum. In addition the national GMC trainer and trainer surveys will help inform this process.

Further information on the quality of training will be provided by GMC's Quality Assurance deanery visits and deanery quality assessments of training. The SAC will also provide specialist input to the QA visiting process if, where and when required.

7.2 Recording Progress

On enrolling with JRCPTB trainees will be given access to the ePortfolio (electronic Training Record) for Geriatric Medicine. The ePortfolio 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 ePortfolio 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 ePortfolio 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.

Trainees should ensure their ePortfolio is kept up to date, is accurate and includes evidence about the training received (generic, specialty and special topic), courses and training days, audit, research, presentations (local, regional and national), assessments, supervisors' reports, certificates of attendance as well as other information which may have a bearing on training and progress.

It is particularly important that trainees who pursue additional training (for example in stroke) or take time out-of-programme to undertake research are able to demonstrate that curricular objectives have been met.

8 Curriculum Review and Updating

The history of the specialty of Geriatric Medicine is one of continued change, evolution and development. Originally a specialty focusing on the rehabilitation and continuing care of older people over the succeeding years it has become increasingly more acute in nature, with geriatricians becoming more involved with the acute management of older people and others developing sub-speciality interests in orthogeriatrics, falls, stroke, movement disorders, continence and community work to name but few.

It is therefore of vital importance that the curriculum in Geriatric Medicine is continually reviewed and updated to ensure that it accurately reflects the training needs of future specialists dealing with the needs of older people and providing appropriate service requirements within the NHS. In recent years the SAC have made considerable modifications to the curriculum in particular incorporating training grids for dementia, tissue viability, nutrition and homeostasis.

The review of the curriculum in Geriatric Medicine will be informed by a number of processes. The SAC and its strong links with the BGS Education and Training Committee ensure not only broad geographical representation by colleagues but also encompasses a membership with wide and varied sub-specialty interests. This enables the SAC to be continually updated and alerted to any changes within the specialty including service provision.

In addition the SAC will utilise information obtained from specialty leads, specialty deans and the National Health Service to review and if necessary modify the specialty's curriculum.

The views of trainee representatives on the SAC and BGS ETC and the results of GMC's trainee survey will ensure that trainees are involved in the curriculum review and rewrite process (trainees have made a significant direct contribution to the writing of the 2010 curriculum).

Interaction with the NHS will be of particular importance to ensure the curriculum accurately reflects the training needs of future specialists in Geriatric Medicine in a modern NHS. It will be important to ascertain the NHS's view on the balance between physicians' generalist and specialist skills, the development of generic competencies and looking to the future, the need for additional specialist competencies and curricula.

The curriculum is a living document which will be reviewed, updated and amended by the SAC as necessary (subject to GMC approval) to accurately reflect training needs, the changing face of the specialty and service provision.

The SAC will undertake a full review of the curriculum every 3 years which will include trainee and lay representation and submit any significant changes to the curriculum to GMC for consideration and approval.

9 Equality and Diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation, such as the:

- Race Relations (Amendment) Act 2000
- Disability Discrimination Act 1995
- Human Rights Act 1998
- Employment Equality (Age) Regulation 2006
- Special Educational Needs and Disabilities Act 2001
- Data Protection Acts 1984 and 1998

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. Accordingly, it warmly welcomes contributors and applicants from as diverse a population as possible, and actively seeks to recruit people to all its activities regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation.

Deanery quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC.

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 must ensure that educational supervisors have had equality and diversity training (at least as an e learning module) every 3 years
- Deaneries must ensure that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e module) every 3 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.
- monitoring of College Examinations;
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly disadvantage trainees because of gender, ethnicity, sexual orientation or disability (other than that which would make it impossible to practise safely as a physician). All efforts shall be made to ensure the participation of people with a disability in training.

In order to meet its obligations under the relevant equal opportunities legislation, such as the Race Relations (Amendment) Act 2000, the MRCP(UK) Central Office, the Colleges' Examinations Departments and the panel of Examiners have adopted an Examination Race Equality Action Plan. This ensures that all staff involved in examination delivery will have received appropriate briefing on the implications of race equality in the treatment of candidates.

All Examiner nominees are required to sign up to the following statement in the Examiner application form "I have read and accept the conditions with regard to the UK Race Relations Act 1976, as amended by the Race Relations (Amendment) Act

2000, and the Disabilities Discrimination Acts of 1995 and 2005 as documented above."

In order to meet its obligations under the relevant equal opportunities legislation such as the Disability Discrimination Acts 1995 and 2005, the MRCP(UK) Management Board is formulating an Equality Discrimination Plan to deal with issues of disability. This will complement procedures on the consideration of special needs which have been in existence since 1999 and were last updated by the MRCP(UK) Management Board in January 2005. MRCP(UK) has introduced standard operating procedures to deal with the common problems e.g. Dyslexia/Learning disability; Mobility difficulties; Chronic progressive condition; Blind/Partially sighted; Upper limb or back problem; Repetitive Strain Injury (RSI); Chronic recurrent condition (e.g. asthma, epilepsy); Deaf/Hearing loss; Mental Health difficulty; Autism Spectrum Disorder (including Asperger Syndrome); and others as appropriate. The Academic Committee would be responsible for policy and regulations in respect of decisions on accommodations to be offered to candidates with disabilities.

The Regulations introduced to update the Disability Discrimination Acts and to ensure that they are in line with EU Directives have been considered by the MRCP(UK) Management Board. External advice was sought in the preparation of the updated Equality Discrimination Plan, which has now been published.

10 Appendices

10.1 Appendix 1 – Useful Websites

(adapted from a list provided by the education and training committee of the British Geriatrics Society)

Useful Internet addresses relevant to geriatric medicine

http://www.mmc.nhs.uk MMC
http://www.JRCPTB.org.uk/ JRCPTB
http://www.bgs.org.uk/ BGS
http://www.bgs.org./links.htm BGS links site
http://www.gmc-uk.org/ GMC
http://www.bma.org.uk/ BMA
http://www.eugms.org EUGMS
http://www.britishgerontology.org British Society of Gerontology
http://www.eam.ch European Academy for Medicine of Ageing (courses for academic trainees)
http://www.kingsfund.org.uk King's Fund (useful for bibliographies)
http://www.bgs.org.uk/Publications/Compendium/compend_index.htm BGS compendium
http://ageing.oupjournals.org/ Age and Ageing
http://www.ace.org.uk/ Age Concern
http://www.merck.com/mrkshared/mmg/home.jsp Merck manual
http://www.kcl.ac.uk/kis/schools/life_sciences/health/gerontology/ Age Concern Gerontology
http://www.soc.surrey.ac.uk/bsg/welcome.html British Society of Gerontology
http://www.americangeriatrics.org/ AGS
http://www.asgm.org.au/ AUSGS
http://www.blackwell-synergy.com/loi/jgs/ JAGS
http://www.cochrane.co.uk/ Cochrane database
http://www.nejm.org. New England Journal
http://www.thelancet.com Lancet
http://www.statistics.gov.uk Useful for population statistics
http://www.interrai.org useful for assessment tools

10.2 Appendix 2 – Recommended Reading List

(Based on a list provided by the education and training committee of the British Geriatrics Society – to check for updates to this list trainees and trainers can check the BGS website- www.bgs.org.uk)

This list of reference books, journals and other forms of educational material is not meant to be exhaustive and all inclusive but merely a guide to some of the publications relevant to Geriatric Medicine which consultants, GPs, registrars and other trainees might find useful.

1. Journals

Age and Ageing

Age and Society

Gerontology

International Journal of Geriatric Psychiatry

Journal of American Geriatrics Society

Journal of Geriatric Psychiatry and Neurology

Journal of Gerontology

Reviews in Clinical Gerontology

CME Journal – Geriatric Medicine

2. Textbooks

General Introduction Undergraduates and Others

ABC of Geriatric Medicine. Cooper N, Forest K, Mulley G. 2009 ISBN 1405169424

Lecture Notes on Geriatric Medicine. Coni, Webster et al 6th Ed 2003 ISBN 1405101628

Essentials of Clinical Geriatrics. Kane et al 6th Ed 2009 ISBN 007198222

Physiological basis of Aging and Geriatrics. Timiras 3rd Ed 2002 ISBN 0849309484

2.1 General Textbooks

Acute Emergencies and Critical Care of the Geriatric Patient.Yoshikawa MM, Norman DC 2000 ISBN 0824703455

Assessing Older Persons Measures, Meaning and Practical Application. Ed Kane RL, Kane RA. 2004. ISBN -0195174356

Brocklehurst's Textbook of Geriatric Medicine and Gerontology. Fillit HM et al, 7th Ed 2000 ISBN 01416062319

Elderly Medicine: A Training Guide. Rai and Mulley 2007 ISBN 02043103025

Essential Geriatrics. Woodford 2007 ISBN 1846191701X

Measurement Scales used in Elderly Care. Gupta A. 2008. ISBN 1846192668

Merck Manual of Geriatrics. Merck 3rd Ed 2000 ISBN 0911910883

Older People at Home Practical Issues. Burns, Mulley, Penn 1998 ISBN 0727912585

Oxford Handbook of Geriatric Medicine, Bowker LK, Price JD, Smith SC. 2006. ISBN 0198530293

Oxford Textbook of Geriatric Medicine. Grimley Evans, Williams, Beattie, Michel, Wilcock 3rd Ed 2000 ISBN 0198528094

Principles and Practice of Geriatric Medicine. Pathy MSJ, Sinclair AJ,Morley JE 2005 ISBN-13: 9780470090572

Hazzards Geriatric Medicine and Gerontology. Hazzard WR, et al. 6th Ed 2009 ISBN 0071488723

Quick Cognitive Screening for Clinicians, Ed Schulman K, Feinstei A. 2006 ISBN 0415409470

Rapid Review of Medicine in Old Age. Vassallo M, Allen SC. 2007 ISBN 1840760907

The Specialist Registrar and New Consultant Handbook. Gatrell J, White AD. 3rd Ed 2006 ISBN 1846190479

2.2 Books in Specialist Areas

Cancer and Palliative Care

Cancer in the Elderly. Hunter, Johnson, Muss 2000 ISBN 0824702786

Comprehensive Geriatric Oncology. Balducci, Ershler, Layman 2004 2nd Ed ISBN 1841842966

Symptom Management in Advanced Cancer. Twycross, Wilcock 3rd Ed 2001 ISBN 1857755103

Cardiology

A Practical Guide to Heart Failure in Older People. 2009 Ward C, Witham M ISBN 0470695173

Cardiovascular Disease in the Elderly. Gerstenblith 2005 1588292827

NICE Clinical Guideline 5 Management of chronic heart failure in adults in primary and second care 2003

NICE Clinical Guideline 36 Atrial fibrillation 2006

Continence

Bowel Care in Older People Research and Practice. Eds Potter J, Norton C, Cottendedn A. London Clinical Effectiveness and Evaluation Unit Royal College of Physicians 2002. ISBN 1860161677

Consensus Guidelines on Urinary Incontinence. European Association of Urology (EEU) 2006 www. uroweb.org

Incontinence. Lucas, Emery and Beynon 1999 ISBN 0632050039

National Audit of Continence Care for Older People Report. Clinical Effectiveness and Evaluation Unit Royal College of Physicians. http://continenceaudit2006.rcplondon.ac.uk

NICE guideline 40. Urinary Incontinence: the management of urinary incontinence in women. 2006 www.nice.org.uk/cg40

Nursing for Continence. Norton 2nd Ed 1996 ISBN 0906584426

Urinary Catheters: Use and Complications Review. Weerasuriya N, Saunders F, Snape CME Journal Geriatric Medicine 2007 Vol 9 No 3 RILA

Urinary Incontinence. Wagg A, Malone-Lee JG. 2000. ISBN 13 978-1900151160

Urinary Incontinence (Part of Fast Facts Series) Shah and Leah 2nd Ed 2001 ISBN 1899541640

Continuing Care

Care of the Long Stay Elderly Patient. Denham 3rd Ed 1996 ISBN 0412606704

Dermatology

Diagnosis of Aging Skin Diseases. Normal RA. 2008. ISBN-13 978-1846286773

NICE clinical guideline 7. Pressure relieving devices 2003

NICE clinical guideline 29. Pressure Ulcer management 2005

Skin Diseases in Old Age. Marks 2nd Ed 1999 ISBN 1853172278

Diabetes and Endocrinology

Diabetes in Old Age (Practical Diabetes). Sinclair AJ 3rd Ed 2009 ISBN 0470065624

Endocrinology of Aging. Morley, van den Berg 1999 ISBN 0896037568

Elder Abuse

Crime, Abuse and the Elderly. Brogden and Nihar 2000 ISBN 1903240026

Elder abuse: concepts, theories and interventions. Bennett and Kingston 1993 ISBN 041245310

Elder Abuse: critical issues in policy and practice. Eds Slater, Eastman 1999 ISBN 0862422485

Elder Abuse in Perspective. Biggs, Phillipson and Kingston 1995. ISBN 0335191460

The Mistreatment of Elderly People. Eds Decalmer, Glendenning 2nd ed 1997. ISBN 0761952624

Falls and Syncope

Falls in Older people-Prevention and management. Tideiksaar 3rd Ed 2002 ISBN 1878812858

Falls in Older People. Lord, et al. 2nd Ed 2007 ISBN 0521680999

NICE clinical guideline CG 21. Falls. 2004

Reducing Falls in an Acute General Hospital . Barnett 2002 In Shaw T and Sanders K eds Foundation of Nursing Studies Dissemination Series Vol 1 No 1

Syncope in the Older Patient. Kenny RA, 1998 ISBN 0412568101

Syncope: Mechanisms and Management. Grubb BP 2nd Ed 2005 ISBN 1405122072

The Evaluation and Treatment of Syncope; A handbook of clinical practice Benditt, Blanc, Brignole, Sutton 2nd Ed 2006 ISBN 1405140305

The Cochrane Collaboration: Interventions for preventing falls in older people living in the community (Review) Gillespie LD, Robertson MC, Gillespie WJ, Lamb SE, Gates S, Cumming RG, Rowe BH. The Cochrane Library 2009, Issue 2

Gastroenterology

Geriatric Nutrition. The Health Professional's Handbook. Chernoff 2006 3rd Ed ISBN 0763731811

Infection

Infectious Disease in the Aging. A Clinical Handbook. Yoshikawa MM, Norman DC 2009 2nd Ed. ISBN 1603275339

Infections in Elderly Patients. MacLennan 1994 ISBN 0340559330

Infections in the Elderly Michael J. Denham 1986 ISBN 13: 9780852008003

Intermediate Care, Community Geriatric Medicine and Day Hospital

Integrating Care for Older People. New care for old –a systems approach. Foote and Stanners 2002 ISBN 184310010X

Management

New Completely Revised Understanding Organisations. Handy 2005 ISBN 10: 0713997796

Medical Ethics and Law

Assessment of Mental Capacity Guidance for Doctors and Lawyers. BMA & The Law Society 2nd Ed 2004 ISBN 072796718

BMA Guidance: The Mental Capacity Act 2005 - Guidance for health professionals http://www.bma.org.uk/ethics/consent_and_capacity/mencapact05.jsp

Biomedical Ethics. Glannon W. 2004 ISBN 0195144317

Ethical Issues in Dementia Care; Making Difficult Decisions. Eds Hughes J, Baldwin C 2006. ISBN 1843103575

Ethical Patient Care: A Casebook for Geriatric Health Teams. Mezey MD, Cassel CK, Hyer K, Howe JL, Fulmer TT 2002 ISBN 0801867703

Ethics of caring for older people. BMA 2009 ISBN 9781405176279

Health Care Law. Montgomery 2nd Ed 2003 ISBN 0198765746

Introduction to Medical Law. Marquand 2001 ISBN 0750642394

Law and Medical Ethics. Mason et al 7th Ed 2005 ISBN 9780199282395

Lecture notes on Medical Law and Ethics. Howard P, Bogle J. 2004 ISBN 1405118687

Medical Ethics and the Elderly a Practical Guide. Rai 2nd Ed 2004 ISBN 9057024039

Medical Ethics Today. The BMA's handbook of Ethics and Law. 2nd Ed 2004 ISBN 0727917447 (2007 updates available in pdf format at www.bma.org.uk)

Witholding and Withdrawing Life-prolonging Medical Treatment. Guidance for decision making. BMA books 3rd ed 2007 ISBN-13 978-1405159579

Neurology

Delirium in Old Age. McDonald A, Lindesay J, Rockwood K. 2002 ISBN-13: 978-0192632753

NICE clinical guideline 35. Parkinson's disease: diagnosis and management in primary and secondary care. 2006

Non-motor symptoms of Parkinson's Disease Chaudhuri K Ray, Tolosa E, Schapira A, and Poewe W. 2009 ISBN 9780199237234

Parkinsonism and Related Disorders. Eds Wolters Van Laar and Berendse 2007 ISBN-13: 978-9086591503

Parkinson's Disease and Parkinsonism in the Elderly. Meara, Koller 2000 ISBN- 13: 978-0521628846

Parkinson's Disease In Practice. Clarke 2nd edition 2007**.** ISBN-13: 9781853157455

Parkinson's Disease in the Older Patient. Playfer, Hindle 2nd edition 2008 ISBN-13:978 1846191145

Queen Square Neurological Rehabilitation Series: Neurological rehabilitation of Parkinson's Disease. Playford D 2003 ISBN 1841842974

Orthogeriatrics/Osteoporosis

Geriatric Orthopaedics: Rehabilitative Management of Common Problems Goldstein TS 2nd Ed 1999 ISBN 0834210762

NICE technology appraisal TA161. Osteoporosis – secondary prevention including strontium ranelate 2008

NICE Technology Appraisal TA160 Osteoporosis – primary prevention 2008

National Osteoporosis Guidelines Group (NOGG) (includes FRAX risk assessment tool) http://www.shef.ac.uk/NOGG/

Prevention and Management of Hip Fracture in Older People
SIGN Publication No. 56 ISBN 1899893 72 5 Published January 2002
http://www.sign.ac.uk/guidelines/fulltext/56/index.html

BOA/BGS Blue Book on the Care of Patients with Fragility Fractures. PDF available from National Hip Fracture Database – http://www/nhfd.co.uk/

Osteoporosis - Oxford Rheumatology Library – Author G Kline (paperback)
www.osteoporosis.ca/local/files/health_professionals/pdfs/OSTEO_Winter06_Web.pdf

2009 Cochrane review on falls
www.nelm.nhs.uk/en/NeLM-Area/Evidence/Disease-Focused-Reviews/Cochrane-Review-Antibiotics

Osteoporosis (Oxford Rheumatology Library) (Paperback)
by Gavin Clunie (Editor), Richard Keen (Editor) Oxford University Press 2007
ISBN 13: 9780199234172

Pain

The assessment of pain in older people – British Pain Society and British Geriatrics Society 2007.
http://www.bgs.org.uk/Publications/Publication%20Downloads/Sep2007PainAssessment.pdf

Pain in Older People. Eds Crome P, Lally F, Main CJ. 2007. ISBN-13: 978-0199212613

Pharmacology

Drug Therapy in Old Age. George, Woodhouse, Denham, McLennan 1998 ISBN 0471941492

Psychiatry of Old Age

Diagnosis and Management of Dementia. Wilcock, Bucks, Rockwood 1999. ISBN 0192628224

Everything You need to Know about Old Age Psychiatry. Howard 1999 ISBN 1871816386

Practical Management of Dementia: A Multi-Professional Approach. Curran C, Wattis JP. 2004. ISBN 13: 978-1857759310

Practical Psychiatry of Old Age. Curran C, Wattis JP. 2001**.** ISBN 13: 9781857757965

Principles and Practice of Geriatric Psychiatry. Copeland, Abou-Saleh, Blazer DG 2002 ISBN 0471981974

Psychiatry in the Elderly. Jacoby, Oppenheimer ed 2002 ISBN 0198515634

The Oxford Textbook of Old Age Psychiatry (2008) Editors: Jacoby R, Oppenheimer C, Dening T, and Thomas A. Oxford ISBN: 978-0199298105

Radiology

Textbook on Diagnostic Imaging in the Elderly. Impallomeni et al 2000 ISBN 1899066888

Rehabilitation

Rehabilitation of the Older Person – A Handbook for the Interdisciplinary Team. Squires, Hastings 3rd Ed 2002 ISBN 0748754709

Research, Audit and Statistics

Clinical Governance a Guide to Implementation for Healthcare Professionals. McSherry and Pearce 2007 2nd Ed ISBN 140513920X

Evidence Based Practice- a critical appraisal. Trinder and Reynolds 2000 ISBN 0632050586

How to Read a Paper – The basis of evidence based medicine. Greenhalgh 2006 3rd Ed ISBN 1405139765

Principles of Best practice in Clinical Audit. National Institute for Clinical Effectiveness (NICE) 2002 ISBN 1857759761

Statistics at Square One. Campbell and Swinscow 11th Ed 2009 ISBN 1405191007

Respiratory

Respiratory Diseases in the Elderly Patient. Connolly M 1998 ISBN 0412568306

Stroke

National Clinical Guideline for Stroke. 2nd edition. RCP 2004 ISBN 9781860162084

NICE clinical guideline 68 Stroke July 2008

Stroke Practical Management. Warlow C et al 3rd Ed 2008 ISBN 140512766X

Stroke Care. A Practical Manual. Harwood RH, Huwez F, Good D. 2005. ISBN 0198529736

Stroke Pathophysiology, Diagnosis and Management. Barnett HM, Mohr, Stein, Yatsu, 4th Ed 2004 ISBN 0443066000

Stroke Syndromes. Bogousslavsky, Caplan 2nd Ed 2001 ISBN 0521771420

Stroke (The Facts). Lindley RI. 2008. ISBN 0199212724

Handbook of Botulinum Toxin Treatment (2nd edition) A P Moore and M Naumann – Blackwell Publishing 2003. ISBN 0632059577

Surgery and Anaesthesia

Surgical Care for the Elderly. Adkins, Scott 2nd Ed 1997 ISBN 0781714508

The Principles and Practice of Geriatric Surgery. Rosenthal, Zenilman, Katlic 2001 ISBN 0387983937

3. E Learning and CD Roms

Bladder problems in Adults. CD Rom Interactive Training Programme. Kiss of Life Multimedia Ltd

Depression and Dementia in Older People. CD Rom Interactive Training Programme. Kiss of Life Multimedia Ltd.

Falls and Bone Health. CD Rom Interactive Training Programme. Kiss of Life Multimedia Ltd

“Off His Legs” CD Rom Interactive Training Programme. Kiss of Life Multimedia Ltd

Doctors.Net at www.doctors.net.uk has an E Learning CME section with over 100 learning topics (all subjects and specialties) and is free to register.

The Merck Manual online at www.merck.com has information on older people and ageing which may be useful.

The National Institute of Clinical Excellence www.nice.org.uk has produced a number of useful guidelines applicable to older people.

The Modernising Medical Careers website www.mmc.nhs.uk has information on the rapidly changing situation of medical career pathways.

The Scottish Intercollegiate Guidelines Network (SIGN) www.sign.ac.uk is a valuable source of guidelines and information in a number of clinical areas.

4. Reports in Specialist Areas

A new ambition for old age: Next steps in implementing the National Service Framework for Older People http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4133941

Adding Life to Years – Annual Report 2002-3. NHS Scotland 2003 ISBN 0755908236

Adding Life to Years – Report of the Expert Group on Healthcare of Older People. NHS Scotland 2003 ISBN 0755908236

Audit commission. The coming of age: improving care services for older people. London : Audit Commission 1997.

Clinical Standards Advisory Group. Community health care for older people. A committee report. J Clark ed. London : Stationery Office 1998.

Department of Health. National Service Framework for Older People. London . DOH,2001 www.doh.gov.uk/nsf/oldrerpeople.htm

Department of Health. Shaping the Future NHS: Long Term Planning for Hospitals and Related Services. Consultation on the Findings of the National Beds Enquiry. 2000 www.doh.gov.uk/nationalbeds.htm/

Effective practice in rehabilitation: the evidence of systematic reviews. Sinclair, Dickinson London : Kings Fund Publishing 1998.

Federation of the Royal Colleges of Physicians. Medical Aspects of Intermediate Care: Report of a Working Party. 2002

The health and care of older people in care homes: A comprehensive Interdisciplinary Approach. Royal College of Physicians (London), Royal College of Nursing and British Geriatrics Society. 2000 ISBN 1860161375

Osteoporosis: Clinical guidelines update. Working party Report. Royal College of Physicians and Bone and Tooth Society of Great Britain . 2004

Principles of Pain Control in Palliative Care for Adults. A Working Party Report. Royal College of Physicians 2000

Royal College of Physicians. Management of the older medical patient. The interface between general (internal) medicine and geriatric medicine. 2000 ISBN 1860161308

Royal College of Physicians. National Clinical Guidelines for Stroke. Clinical Effectiveness and Evaluation Unit. 2nd ed 2004 ISBN 186016120

Royal Commission on the funding of long term care with respect to old age: long term care – rights and responsibilities. London: Stationery Office, 1999

Specialist Equipment Services for Disabled People- The need for change. Royal College of Physicians and Institute of Physics and Engineering in Medicine. 2004

The Health and Well-being of Older People in Scotland – insights from national data. NHS Scotland, Information and Statistics Division 2001 ISBN 1841340006

Topic Working Group. Report to the NHS R&D Strategic Review. Ageing and age-associated disease and disability. London . NHS Executive,1999
www.doh.gov.uk/research/documents/rd3/ageing_final_report.pdf

Appendix 3 - Glossary

AA	Audit Assessment
ACAT	Acute Care Assessment Tool
ACCST	Acute Care Common Stem Training
ADL	Activities of Daily Living
ARCP	Annual Review of Competence Progression
BGS	British Geriatrics Society
CBD	Case Based Discussion
CCT	Certificate of Completion of Training
CD	Compact Disc
CESR	Certificate of Eligibility for Specialist Registration
CGA	Comprehensive Geriatric Assessment
CMT	Core Medicine Training
CPN	Community Psychiatric Nurse
CQS	Care Quality Commission
CS	Clinical Supervisor
DGH	District General Hospital
DOPS	Directly Observed Procedural Skills
DVD	Digital Video Disc
EBM	Evidenced Based Medicine
ES	Educational Supervisor
ESR	Educational Supervisor Report
G(I)M	General (Internal) Medicine
GMC	General Medical Council
IADL	Instrumental Activities of Daily Living
IMCA	Independent Medical Capacity Advocate
ITU	Intensive Therapy Unit
JRCPTB	Joint Royal Colleges Physicians Training Board
MD/DM	Doctorate of Medicine
mini-CEX	Mini-clinical skills Examination
MRCP	Member of the Royal College of Physicians Diploma
MSc	Master of Science
MSF	Multi-Source Feedback
NHS	National Health Service
NICE	National Institute of Health and Clinical Excellence
PEG	Per-Endoscopic Gastrostomy
PG	Postgraduate
PhD	Doctorate of Philosophy
PS	Patient Survey
PYA	Penultimate Year Assessment
QC	Quality Control
QM	Quality Management
RCP	Royal College of Physicians
RS	Research Supervisor
RSR	Research Supervisor Report
SAC	Speciality Advisory Committee
SCE	Specialty Certificate Examination
STC	Specialty Training Committee
TO	Teaching Observation