Department of Health

NHS

The Competence and Curriculum Framework for the Medical Care Practitioner

A consultation document

The Competence and Curriculum Framework for the Medical Care Practitioner

November 2005

Policy	Estates
HR/Workforce	Performance
Management	IM & T
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Clinical	Partnership Working

Document Purpose	Consultation/Discussion
ROCR Ref:	**Gateway Ref:** 5497
Title	The Competence and Curriculum Framework for the Medical Care Practitioner.
Author	The Competence and Curriculum Framework Steering Group on behalf of the Medical Care Practitioner National Programme Board.
Publication Date	November 2005
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Circulation List	
Description	Commissioned by the National Practitioner Programme, this is the proposed Competence and Curriculum Framework for MCPs. It sets out the standards required for safe and effective practice and the underpinning education and training required to develop the new role.
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For Recipient's Use	

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The consultation process

The purpose of this document is to share with you progress that has been made on the development of a new healthcare role, and to seek your comments on the proposed Competence and Curriculum Framework. For the purpose of this consultation, the working title of Medical Care Practitioner (MCP) will be used throughout. The proposed Competence and Curriculum Framework has been developed between September 2004 and November 2005 in partnership with the Royal College of Physicians and the Royal College of General Practitioners with support from Skills for Health, those higher education institutions (HEIs) expressing an interest in providing an educational programme for the MCP role and clinical colleagues drawn from a range of backgrounds including the armed services.

The MCP role seeks to build capacity in the NHS workforce, by drawing in a new cadre of recruits from sources such as life-science graduates, rather than focusing on extending existing clinical roles for established healthcare professionals. The MCP role draws upon existing models, particularly that of the Physician Assistant role that has been well established in the USA for over 40 years and has been positively evaluated in the NHS over the last 2-3 years.

Regulation of MCPs will be sought, to ensure patient safety through an agreed national standard for training and competence. This consultation document stipulates the standards that those using the title will need to meet before entering practice. Registered MCPs will be required to adhere to a professional code of conduct and undertake continuing professional development as set down by the regulatory body. It is proposed that students will be required to pass a national exam prior to registration and at points of re-accreditation after registration as an MCP.

This document outlines the proposed Competence and Curriculum Framework that sets the standards of the education, training and assessment of MCPs to enable qualification from a UK higher education institution.

The Framework outlines the knowledge, skills and core competences expected at the point of qualification. Although it is recognised that MCPs may develop areas of special interest and expertise, they will be required to maintain this broad competence throughout their careers.

We would particularly welcome your comments with respect to:

- the Curriculum Framework for the MCP as the basis for the development of educational programmes
- entry routes to the MCP programme
- the core competences at qualification
- the core clinical skills which the MCP needs to demonstrate
- the core clinical conditions which the MCP will meet in practice and the level of competence required

- arrangements for teaching and supervision
- methods of assessment, pre and post registration and national support structures
- the title for the new role.

Specific questions on the above topics will be posed at appropriate intervals throughout the document.

Following the consultation process, comments received will be incorporated into a final document which will inform the development of educational programmes as part of whole workforce planning by health economies. The consultation document and feedback will be accessible online at:
www.wise.nhs.uk/sites/workforce/practitioners/medical/default.aspx

Links will be established from the following websites:

- 'What's New' (Department of Health) www.dh.gov.uk/news
- Consultation Register (Department of Health) www.dh.gov.uk/consultations
- The Government's central register of consultations www.ukonline.gov.uk
- The Royal College of Physicians www.rcplondon.ac.uk
- The Royal College of General Practitioners www.rcgp.org.uk
- Skills for Health www.skillsforhealth.org.uk

Hard copies can be obtained by writing to:

MCP Competence and Curriculum Framework
National Practitioner Programme (NPP)
South West London Improvement Academy
Hollyfield House
22 Hollyfield Road
Surbiton
Surrey
KT5 9AL

or by emailing:
mcpconsultation@swlia.nhs.uk

Responses to or queries regarding this consultation can be made via the postal and email addresses above. The closing date for the consultation will be 14 weeks after the public launch of the document. The document was launched on the 4th November 2005 and the closing date for responses will be 10th February 2006.

Please note:
Although this document is subject to Crown Copyright, the conditions matrix described on pages 13 & 14 is the intellectual property of Nick Ross and the University of Birmingham.

By responding to this consultation document you are consenting for information to be shared and published appropriately as part of the response to this consultation process. This consent overrides any confidentiality disclaimer that is generated by your organisation's IT system, unless you specifically include a request to the contrary in the main text of your submission to us.

If you have any concerns about the conduct of this consultation process you should contact The Department of Health Consultations Co-ordinator, Steve Wells who is Head of Freedom of Information, Records and Data Protection on steve.wells@dh.gsi.gov.uk or 020 7972 6073.

We look forward to receiving your comments.

Foreword

The Medical Care Practitioner (MCP) role provides an opportunity to improve and develop the skill mix in primary and secondary care, whilst recognising the unique skills and knowledge of other healthcare professionals. Both hospital practice and primary care have been under substantial pressure in recent years with demographic changes, technological and therapeutic advances and the need to improve access and choice for patients leading to a rising workload. The current clinical and medical workforce is struggling to meet the demand for access to healthcare services in all areas and innovative solutions have evolved. Nursing staff and other allied health professionals have developed extended roles with benefits to patient care and job satisfaction, but the capacity issue in the workforce has led to the rapid establishment of a wide range of new posts of medical support workers across the country with variable training, roles and responsibilities and in standards of clinical practice. This is unsatisfactory, both from the regulatory point of view, with the need to ensure that patient care is delivered by safe and competent practitioners, and from the need to define, certify and reward individuals who acquire knowledge and skills and allow transferability across the NHS.

The model of the Physician Assistant was developed in the USA in the mid-1960s, to meet a similar need to increase healthcare services, and is quality assured by educational courses based on national standards of training, competences and certification. This has resulted in increased capacity of high quality healthcare, which is underpinned by independent accreditation of standards of practice, in contrast to the situation in the UK. The development of new roles is often contentious, with perceived threats to the training, role and status of existing healthcare professionals, and the need to safeguard standards of patient care. We believe that there is a need for a broadly based new healthcare professional who can contribute to holistic patient centred care in both primary and secondary care settings, but that it is essential to define the role and scope of practice and the standards for education and assessment in order to ensure that practice is to a uniformly high standard. The collaboration of the Royal College of Physicians and the Royal College of General Practitioners in partnership with the National Practitioner Programme, the University of Birmingham Medical School and Skills for Health, with the support of many other clinical colleagues has resulted in the development of this Competence and Curriculum Framework. We hope that this consultation document is the first step to a new and welcome addition to healthcare teams in the NHS.

Mary Armitage
Clinical Vice-President
Royal College of Physicians

Nigel Sparrow
Vice Chairman
Royal College of General Practitioners

Development of this document

This document has been produced through the work of a Competence and Curriculum Framework Steering Group commissioned originally by the former Changing Workforce Programme and jointly chaired by Dr Mary Armitage, Clinical Vice-President, Royal College of Physicians and Dr Nigel Sparrow, Vice Chairman, Royal College of General Practitioners.

The steering group was established for the time limited task of developing a Competence and Curriculum Framework for the emerging role of MCPs. The Royal College of Physicians and the Royal College of General Practitioners were asked to build on similar work being progressed by the Royal College of Anaesthetists and the Royal College of Surgeons of England to develop Competence and Curriculum Frameworks for Anaesthetic Practitioners and Surgical Care Practitioners, respectively. They were also asked to develop competences through Skills for Health who are the Sector Skills Council for the UK Health Sector.

The content of this document has also been informed by the significant contribution of trainee MCPs, their mentor/supervisors, managers and clinicians working within pilot sites in North East London and South West London: Waltham Forest Primary Care Trust, Epsom and St. Helier University Hospitals NHS Trust, Mayday University Hospital NHS Trust, St. George's Healthcare NHS Trust in addition to US trained Physician Assistants, their managers and employers in the West Midlands.

The Higher Education Institutions (HEIs) who had expressed an interest in developing programmes for MCPs were represented on the Steering Group by the University of Birmingham.

Terms of Reference of the MCP Competence and Curriculum Framework Steering Group

1. To define the role, remit, scope and reporting structure for MCPs.

2. To develop a Competence and Curriculum Framework for MCPs which will be subject to consultation. The Framework will cover:

    - professional and educational values
    - the curriculum structure
    - entry criteria into the programme
    - assessment
    - qualification and registration issues
    - quality assurance.

3. To identify and agree detailed competences for the role.

4. To undertake other functions, as required, which will assist in the development of the Curriculum Framework and Competences.

5. To report by the end of November 2005 and earlier if possible.

6. To take advice from other interested parties as necessary.

If accepted the Competence and Curriculum Framework would become the national specification for all programmes leading to qualification as an MCP.

The steering group members were:

Mary Armitage – Clinical Vice President, Royal College of Physicians (co-chair of Steering Group)
Nigel Sparrow – Vice Chairman, Royal College of General Practitioners (co-chair of Steering Group)
Jim Parle – Professor of Primary Care, University of Birmingham
Nick Ross – Director of Learning and Teaching (Medicine), University of Birmingham
Andrew Butcher – Project Consultant, Skills for Health
Jenny Manning – Technical Consultant, Skills for Health
Alison Baker – Director of Professional Development and Quality, Royal College of General Practitioners
Declan Chard – Chair, Royal College of Physicians Trainees Committee
Sunny Kaul – Public Relations and Communications Officer, Royal College of Physicians Trainees Committee
Rachel Catanzaro – US trained Physician Assistant previously working in the West Midlands
Lynn Tyrer – US trained Physician Assistant working in the West Midlands
Kirsten Gipson – US trained Physician Assistant working in the West Midlands
Robert Standfield – Lead Workforce Designer, National Practitioner Programme
Cheryl Wright – Workforce Designer, National Practitioner Programme
Jo-Anne Welsh – Associate Workforce Designer, National Practitioner Programme

With additional advice from:

- The MCP National Programme Board
- The University of Hertfordshire, St Georges University of London, London South Bank University, University of Surrey, Wolverhampton University
- Managers and clinicians from pilot sites in North East London, South West London and Birmingham and the Black Country
- The armed services
- Competence and Curriculum Framework Reference Group.

Contents

1 Introduction

1.1 The role of the Medical Care Practitioner

In order to meet the workforce requirements set out in the NHS Plan (2001) to maintain and increase capacity in healthcare, many practitioners have been developing and extending their role in the care of their patients. This is not a recent phenomenon as, over many years, non-medical staff who have been interested in developing their skills have been encouraged and supported by the medical teams with which they work.

The development of new and extended roles has been driven by local workforce needs of the NHS in response to national policy initiatives and European legislation such as the Working Time Directive. This localised response has resulted in the development of bespoke programmes of training for small groups of practitioners to enable them to fulfil roles that are often defined by their immediate supervisors. Because of local and often fragmented definition, such roles may lack the potential for sustainability and transferability across the NHS.

In view of the many emerging new roles within the NHS, it is acknowledged that there is potential for confusion and variable standards. Partnership working with the medical Royal Colleges to develop standardised, nationally approved roles, increases transferability and standardisation to the benefit of the NHS, the healthcare practitioner and the patient.

The focus of this document reflects the intention to define standards for the education and practice of a broadly-based healthcare professional, who is able to contribute to holistic patient centred care in both primary and generalist secondary care settings.

An MCP is defined as someone who is:

> ***a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision.***

An MCP can:

- formulate and document a detailed differential diagnosis having taken a history and completed a physical examination
- develop a comprehensive patient management plan in light of the individual characteristics, background and circumstances of the patient
- perform diagnostic and therapeutic procedures and prescribe medications (subject to the necessary legislation)
- request and interpret diagnostic studies and undertake patient education, counselling and health promotion.

The MCP role provides a new way of working that will complement roles already developed in primary and secondary care and strengthen the multi-professional team. An MCP will always work under the supervision of a designated doctor. Their detailed scope of practice in a given setting is circumscribed by that of the supervising doctor. Although there may be circumstances when the supervising doctor is not physically present, they will always be readily available for consultation. Like all other regulated healthcare professionals the MCP is responsible for their own practice though the supervising doctor always maintains the ultimate responsibility for the patient.

The MCP will be employed as a member of the medical team in either primary or secondary care and will be answerable to their supervising doctor.

The MCP will always act within a predetermined level of supervision and within agreed guidelines.

Qualified MCPs may develop specialist expertise through experience and continuing professional development, but will be expected to maintain their broad clinical knowledge base.

1.2 The key points of the Competence Framework

In addition to competences and skills, this Framework describes the level of responsibility that MCPs will be expected to take for the diagnosis and management of a range of clinical conditions. This is expressed through a diagrammatic matrix which allows for clarity of purpose, enabling employing organisations to hold appropriate expectations of the MCP. Although referring to individual clinical conditions, the classification of conditions within the matrix recognises that they may often be present as part of a more complex picture of co-morbidity.

1.3 The key points of the Curriculum Framework

The Curriculum Framework recognises that the development of common standards on qualification requires:

- flexible but rigorous entry criteria to programmes
- a substantial academic programme that will allow the time required for individual professional development
- agreed minimum levels of clinical experience
- a common core knowledge base
- common core learning outcomes
- national (or international) standardised assessment.

MCPs will complete a degree level academic programme of no less than 90 weeks. It is proposed that this should be followed by a probationary period (to be determined) in an approved clinical training setting. This foundation will enable them to practice as part of the clinical team, within a range of primary and secondary healthcare settings. Length and academic level of individual programmes will vary depending on intended intake and organisational policies.

2 The Competence Framework

This chapter defines the core achievements required of the MCP student at the point of qualification, in order to be placed on the register. There are three major components to this specification.

1. The core competences which the MCP is expected to be able to demonstrate across all their clinical practice.

2. The range of procedural skills in which the MCP must have demonstrated competence.

3. The core clinical conditions and the level of responsibility which the MCP is expected to take for diagnosis and management and consequently the main body of the document includes:

    a. an explanation of the clinical conditions matrix

    b. examples of indicative conditions across the full range of systems

    c. a complete example of the specification for one system

    d. an example of specification on the basis of a disease process

    e. an example of specification of conditions on the basis of a clinical presentation.

This document sets out the competence expected at the point of qualification. The MCP is required to maintain this breadth of competence throughout their professional career. The additional expertise that they may acquire in particular fields, through experience or further training, is an addition to this general competence and not a substitute for it.

2.1 The context for the specification of competence

It is anticipated that MCP students will be drawn from a variety of backgrounds, but it is intended that a major pool of applicants will be life-science graduates, thus encouraging recruitment from this sector into the NHS. Other areas for recruitment include armed services, nursing, and allied health professions. Consequently, there is likely to be variation in knowledge levels, clinical and educational experience of different entrants, as well as variation in their life experience. Some prospective entrants may need access programmes to enable them to follow the proposed intensive university level education.

The competences reflect the requirement for a significant knowledge base and an understanding of scientific principles acquired through an appropriate academic and clinical curriculum approved by the regulatory authority. The core competences outlined in this document must be achieved by those that are undergoing MCP education and training in order to take up the professional role. In keeping with the philosophy of lifelong learning in the NHS, further skills will be acquired, assessed and accordingly, MCPs may then work in specialist areas.

MCPs will be accountable for their own practice within the boundaries of delegation but they will work under the overall supervision of a general practitioner or medical consultant.

Arrangements for supervision and the delegation of duties and responsibilities will vary according to the MCPs level of overall experience and expertise in the particular clinical field. Detailed organisation of assessment of clinical competences, skills and core conditions will be a matter for individual institutions, but must be rigorous and will include:

- a national knowledge-based examination
- objective structured clinical examination (e.g. clinical skills laboratory, simulated patients or, where appropriate, actual patients)
- direct observation of the student's application of communication, interpersonal, clinical and procedural skills in practice
- evidence provided by other healthcare practitioners regarding the performance of the student
- direct questioning by an assessor to check understanding of patient centred care, health and safety procedures, technological interventions and interpretation of results, in addition to demonstrating core knowledge
- a portfolio of evidence maintained by the student. This will include a record of progress as well as reflective accounts of critical learning encounters and will inform the assessment process and its outcome.

Summative assessment at the prescribed times will take account of the development of the trainee MCP against the specification set. In terms of providing evidence for the core clinical competences, skills and conditions, the evidence must reflect that the MCP has demonstrated the skills of working with patients in the clinical setting.*

* with the exception of cardio-pulmonary resuscitation (CPR) where competence can be demonstrated through simulation.

2.2 Specification of core competences

To specify competence, it is necessary within the following section to break down the clinical role into a series of component parts. In reality, the MCP moves freely between the application of these component competences as required by the clinical situation. It is essential to the medical model to which the MCP works that their consultations and interventions are responsive to the individual patient and their situation, rather than mechanistic – that is, they should apply their knowledge and skills in a patient centred way rather than sticking closely to predetermined protocols.

It is acknowledged that additional work is needed on the core competences specified throughout the document in order to ensure that MCPs, who are likely to have significant contact with children and young people (particularly in primary care and A&E settings), are able to demonstrate additional core competences for working with children and young people as reflected by national policy and guidance.

(Common Core of Skills and Knowledge for the Children's Workforce, Department for Education and Skills, 2005; Core Standards Document; NSF for Children, Young People and Maternity Services, Department of Health 2004; Keep Me Safe, The Royal College of General Practitioners Strategy for Child Protection, 2005.)

01 The patient relationship

a. Communicate effectively and appropriately with patients and carers even when communication is difficult

b. Demonstrate the ability to utilise the clinician-patient encounter therapeutically

c. Perform a flexible and holistic assessment in order to make an appropriate management plan

d. Facilitate patient involvement in management, planning and control of their own health and illness

e. Appropriately and sensitively identify and utilise, opportunities for patient education

02 History taking and consultation skills

a. Structure interviews so that the patient (carer's) concerns, expectations and understanding can be identified and addressed

b. Elicit a patient history appropriate to the clinical situation, which may include, presenting complaint, history of the present illness, past medical history, social history, family history, medications, allergies, review of systems, risk factors and appropriate targeted history

c. Identify relevant psychological and social factors, integrating these perspectives with the biomedical evidence to elucidate current problems

03 Examination (general)

a. Perform a physical examination (including screening examinations) appropriate to the clinical situation. This will include neurological examination, musculo-skeletal examination, Blood Pressure (BP) measurement and control, male and female uro-genital examination, breast examination, ophthalmic examination, oropharyngeal examination cardiovascular examination, respiratory examination, abdominal examination and dermatological examination

b. Perform a comprehensive mental state examination. This will include assessment of appearance and behaviour, levels of consciousness, posture and motor behaviour, thoughts and perceptions, affect, speech and language, orientation, memory and higher cognitive function

04 Interpreting evidence/determining the requirement for additional evidence

a. Interpret the findings from the consultation (history, physical examination and mental state examination), in order to determine the need for further investigation and/or the appropriate direction of patient management

b. Understand the indication for initial and follow-up investigations

c. Select, interpret and act upon appropriate investigations

d. Determine the relevance of screening tests for a given condition

05 Clinical judgment in diagnosis and management

a. Formulate a differential diagnosis based on objective and subjective data

b. Make use of clinical judgement to select the most likely diagnosis in relation to all information obtained

c. Recognise when information/data is incomplete and work safely within these limitations

d. Recognise when a clinical situation is beyond their competence and seek appropriate support

06 Therapeutics and prescribing

a. Determine appropriate therapeutic interventions from the full range of available prescription medications

b. Write accurate and legible prescriptions in out-patient and in-patient settings

c. Prescribe appropriate fluid regimes on commencing intravenous infusion

d. Use the British National Formulary (BNF) and local formularies appropriately and be familiar with the yellow card system for reporting side effects/drug interactions

e. Recognise their responsibility for gaining patient compliance for the drug regime they are prescribing

Whilst it is recognised, that the granting of independent prescribing rights is subject to separate approval/legislation (via a process of consultation with the Committee for the Safety of Medicines; Medicines and Healthcare Products Regulatory Agency under the auspices of the Department of Health) it is included here because, unlike professions for whom it is a part of the extended role, it is central to the role and practice of the MCP.

Question

Do you believe that the practitioner should have access to a prescribing formulary identical to that of their supervising physician and to be used within local agreed guidelines?

Please explain your answer.

07 Clinical planning and procedures

a. Formulate and implement a management plan in collaboration with the patient, the carers and healthcare professionals

b. Perform clinical procedures using knowledge of the indications, contraindications, complications and techniques

c. Monitor and follow up changes in patient's condition and response to treatment, recognising indicators of patient's response

08 Documentation and information management

a. Initiate and maintain accurate timely and relevant medical records

b. Contribute to multi-professional records where appropriate

09 Risk management

a. Recognise potential clinical risk situations and take appropriate action

b. Recognise risks to themselves, the team, patients and others and takes appropriate action to eliminate/minimise danger

c. Value the importance of clinical governance and participates as directed

10 Teamwork

a. Value the roles fulfilled by other members of the health and social care team and communicate with them effectively

b. Effectively manage patients at the interface of different specialties and agencies, including primary/secondary care, imaging and laboratory specialties

c. Effectively and efficiently hand over responsibility to other health and social care professionals

11 Time/resource management

a. Prioritise workload using time and resources effectively

b. Recognise the economic constraints to the NHS and seek to minimise waste

12 Maintaining good practice

a. Critically evaluate own practice to identify learning/developmental needs and identify and utilise learning opportunities

b. Use evidence, guidelines and audit (including significant event analysis) to benefit patient care and improve professional practice

13 Professional behaviour and probity

a. Consistently behave with integrity and sensitivity

b. Behave as an ambassador for the role of MPC, acting professionally and behaving considerately towards other professionals and patients

c. Recognise and work within limitations of their professional competence and scope of professional practice

d. Maintain effective relationships with colleagues from other health and social care professions

e. Inform patients and others of the nature of the clinical role

f. Contribute to the effectiveness of a clinical learning environment

g. Act as a good role model

14 Ethical and legal issues

a. Identify and address ethical and legal issues, which may impact on patient care, carer and society. Such issues will include:

- ensuring patients' rights are protected
- maintaining confidentiality
- obtaining informed consent

- providing appropriate care for vulnerable patients (including vulnerable adults, children and families in need)
- responding to complaints.

15 Equality and diversity

a. Recognise the importance of people's rights in accordance with legislation, policies and procedures

b. Act in a way that:

- acknowledges and recognises people's expressed beliefs, preferences and choices
- respects diversity
- values people as individuals.

c. Be aware of own behaviour and its effect on others

d. Identify and take action when own or others' behaviour undermines equality and diversity

16 Current developments and guiding principles in the NHS

Awareness of

a. Patient centred care

b. Systems of quality assurance, such as clinical governance, national clinical guidelines and clinical audit

c. The significance of health and safety issues in the healthcare setting

d. Risk assessment and management strategies for healthcare professionals

e. The importance of working as part of a team within a multi-professional environment

f. Broader government policy impacting on health

17 Public health

a. Address issues and demonstrate techniques involved in studying the effect of diseases on communities and individuals including:

- assessment of community needs in relation to how services are provided
- recognition of genetic, environmental and social causes of, and influences on the prevention of illness and disease
- application of the principles of promoting health and preventing disease.

2.3 Specification of core procedural skills

The following is a list of procedural skills which the MCP should be able to perform on completion of the educational programme. This section is designed to be read in conjunction with the competences (2.2) and for the sake of brevity we do not repeat the vitally important skills of routine examination, communication with the patient, seeking informed consent, ensuring safety, avoiding infection etc.

01 Cardiovascular System

a. Undertake an ECG

b. Participate in cardiopulmonary resuscitation to the level expected in Immediate Life Support Training: which medication to use and when depending upon ECG reading, oxygen with mask and bag intubation

02 Respiratory System

a. Undertake pulmonary function tests, including the administration of peak flow measurement

b. Commence and manage nebulised therapy

c. Commence and manage oxygen therapy

03 Gastrointestinal System

a. Insert a naso-gastric tube

04 Musculoskeletal System

a. Identify dislocation of the shoulder and relocate it

b. Undertake appropriate strapping and splinting for common musculoskeletal injuries

05 Eyes

a. Perform fluorosceine dye examination of the cornea

06 Ear, Nose and Throat

a. Perform anterior nasal packing

07 Female Reproductive System

a. Obtain a cervical smear, cultures for HVS etc

08 Renal and Genitourinary System

a. Undertake male and female urinary catheterisation

b. Perform a urine dipstick test

09 Skin

a. Undertake simple skin suturing

b. Undertake incision and drainage of abscesses

10 Diagnostics and Therapeutics

a. Draw up and give, intramuscular, subcutaneous, intradermal and intravenous injections and infusions

b. Take a venous blood sample, using appropriate tubes for required tests

c. Obtain an arterial blood gas (ABG) sample

d. Undertake venous cannulation

2.4 Specification of core clinical conditions

The model on the following page describes a two-dimensional categorisation: the X axis referring to competence in undertaking the diagnostic process and the Y axis referring to competence in managing the condition. This model of conditions is then used in the systems based lists on subsequent pages.

Depending on local arrangements and agreement with the supervising practitioner, experience post-qualification may draw diseases from a lower into a higher category (e.g. 2B to 1A). However it is key to the MCP role that, whatever their current field of practice they maintain competence in the breadth of clinical conditions outlined in this section.

Following the explanation of the core condition matrix, this chapter gives four examples of matrices as follows:

a. examples of indicative conditions across the full range of systems

b. a complete example of the specification for one system

c. an example of specification on the basis of a disease process

d. an example of specification of conditions on the basis of a clinical presentation.

Appendix 1 of this document includes the full list of clinical conditions set out by category of level of competence in accordance with the matrix model.

2.5 A model for categorising clinical conditions on the basis of required competence

X Axis: Is the MPC competent to take a significant role in the diagnostic process?

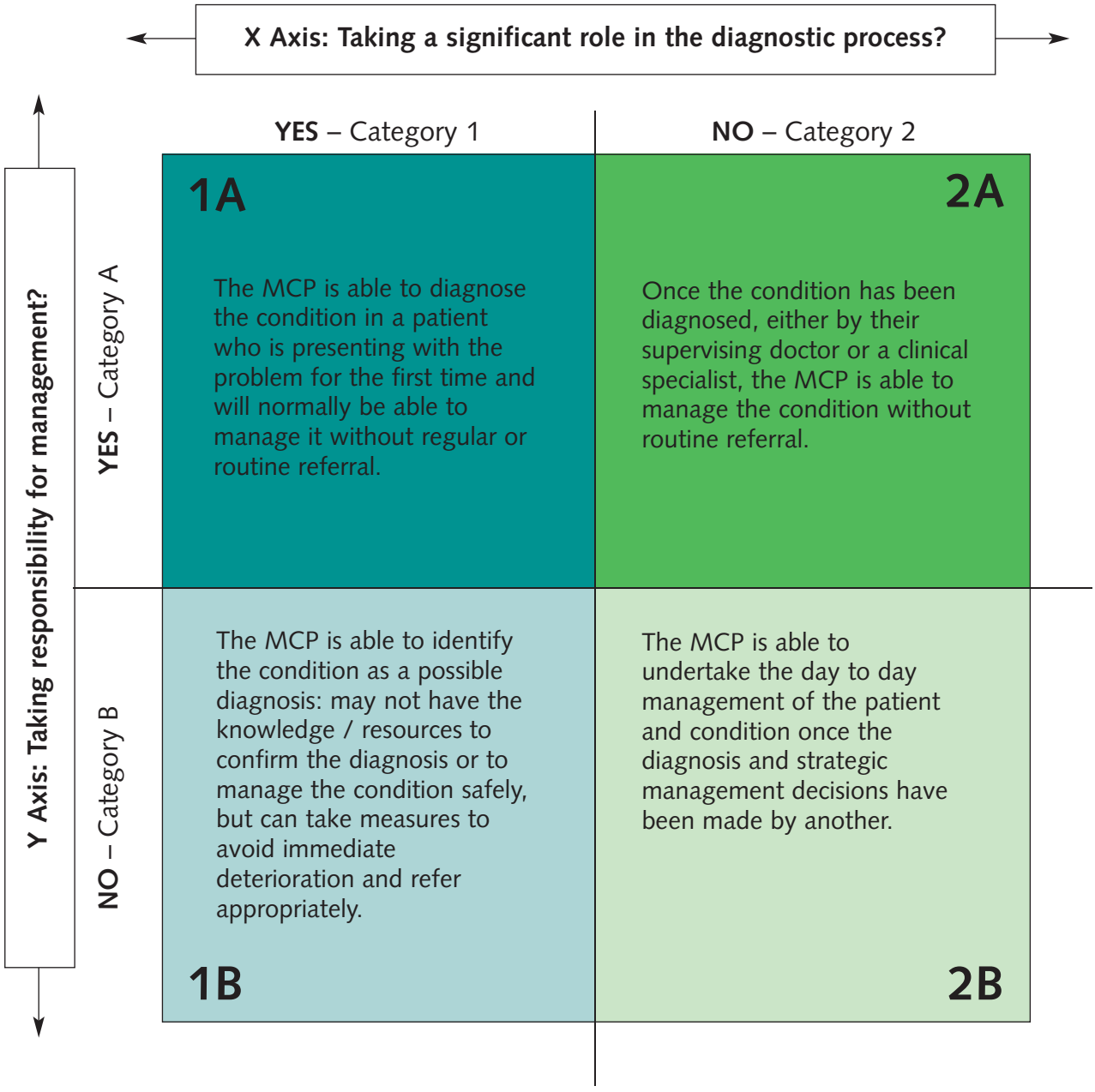
YES: Category 1 — The MCP is able to identify a condition as a possibility within differential diagnoses and to take measures to confirm or refute the diagnosis.

NO: Category 2 — The MCP is aware of the condition, but does not necessarily have the knowledge or resources to make the diagnosis.

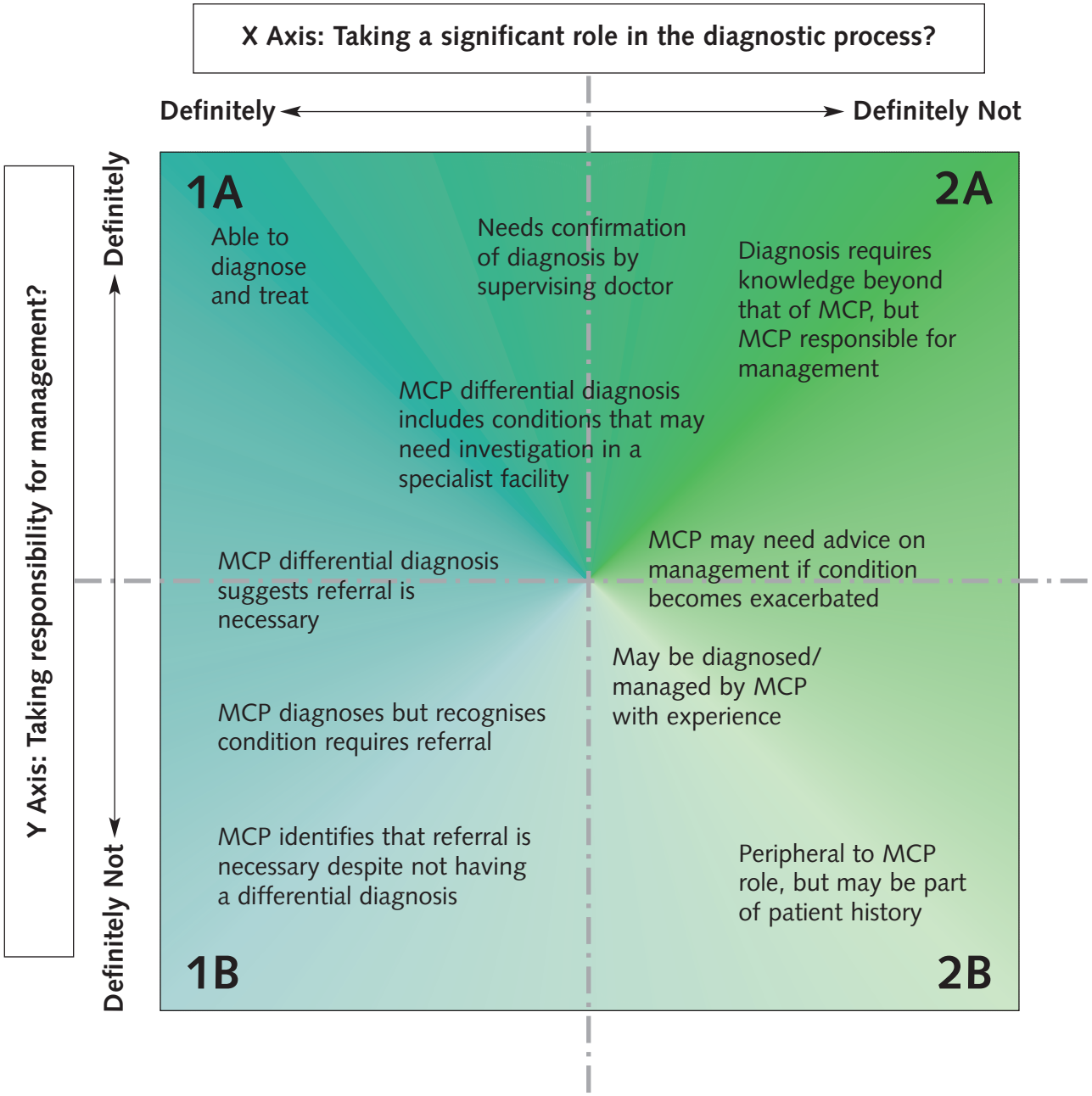
Y Axis: Is the MCP competent to take responsibility for management?

YES: Category A — The MCP is able to manage the uncomplicated condition without routine referral to others.

NO: Category B — The MCP participates in the management of the condition, but does not take a lead role in determining the management strategy.

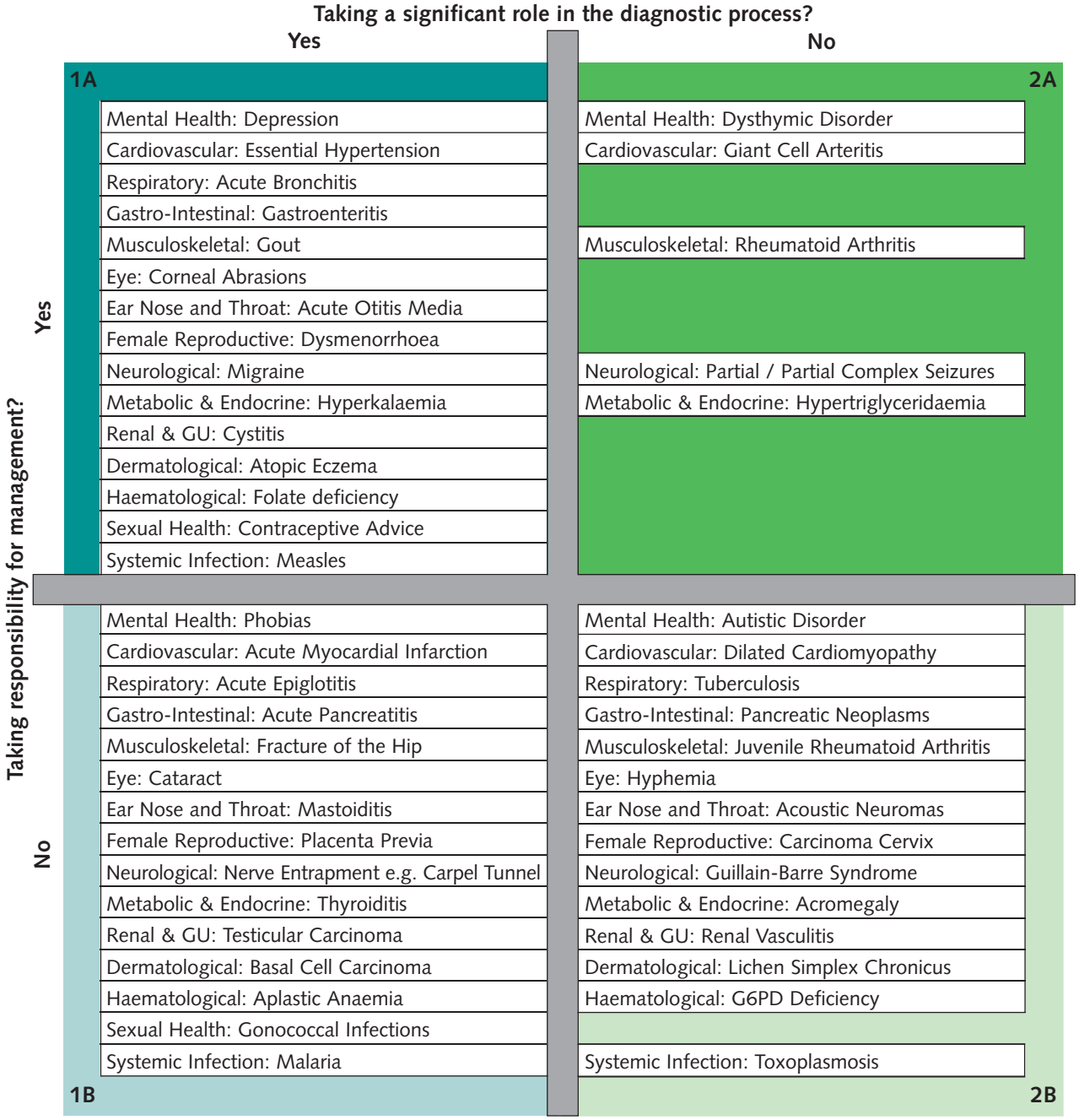


As with most models, this is something of an oversimplification of reality, relatively simple conditions may be complicated by the personal circumstances of the patient, their reaction to the disease process or some other underlying health problem. Equally, an MCP may already be familiar with a non-core condition because of prior experience. However, whilst the following diagram may be closer to the truth, we believe that the simplified model is a more appropriate basis for the development of curricula.



2.6 Examples of core conditions matrices

2.6.1 Matrix showing indicative conditions (as available) across the full range of system categories



2.6.2 Example of a complete single system matrix: The Cardiovascular System

Taking a significant role in the diagnostic process?

Taking responsibility for management?

1A — Yes / Yes

Hypertension
Essential
Isolated systolic
Iatrogenic
Hypotension
Orthostatis/postural
Hypovolaemic shock
Vascular Diseases
Phlebitis/thrombophlebitis

2A — No / Yes

Vascular Diseases
Giant cell arteritis
Ischemic Heart Disease
Angina pectoris
• *Stable*

1B — Yes / No

Hypertension
Secondary
Malignant/accelerated
Hypotension
Cardiogenic shock
Conduction Disorders
Bundle branch block
Premature beats
Atrioventricular block
Paroxysmal supraventricular tachycardia
Ventricular tachycardia
Ventricular fibrillation/flutter
Atrial fibrillation/flutter
Vascular Diseases
Chronic/acute arterial occlusion
Varicose veins
Venous thrombosis
Peripheral vascular disease
Acute rheumatic fever
Aortic aneurysm/dissection
Arterial embolism/thrombosis
Valvular Disease
Aortic stenosis/regurgitation
Mitral stenosis/regurgitation
Tricuspid stenosis/insufficiency
Pulmonary stenosis/insufficiency
Cardiac failure
Ischaemic
Valvular
Hypertensive
Ischaemic Heart Disease
Acute myocardial infarction
Angina pectoris
• Unstable
• Prinzmetal's/variant
Other Forms of Heart Disease
Acute and subacute bacterial endocarditis
Acute pericarditis
Cardiac tamponade
Pericardial effusion

2B — No / No

Cardiomyopathy
Dilated
Hypertrophic
Restrictive
Congenital Heart Disease
Atrial septal defect
Ventricular septal defect
Coarctation of aorta
Patent ductus arteriosus
Tetralogy of Fallot
Valvular Disease
Mitral valve prolapse

2.6.3 Example of core conditions related to a particular disease process: Infection

2.6.4 Example of a condition matrix for a clinical presentation: Chest Pain

Question

What are your views on the proposed standard of proficiency as set out in the preceding sections, which focus on competence, procedural skills and core clinical conditions, in terms of the level at which the practitioner will practice upon registration?

Please explain your answer.

3 The Curriculum Framework

3.1 Introduction to the Curriculum Framework

For a new profession (in some ways even more so than for one that is already well established and understood in the public mind) it is vital that all entrants to the professional register meet a transparent and agreed standard. The purpose of this Curriculum Framework is to make that standard explicit and to set out the criteria which any initial training programme for MCPs must meet, in order to ensure that that standard can be achieved.

To fulfil this purpose, it is clearly important that the document should identify the outcome of any such programme: the competences to be demonstrated by graduates and the clinical problems that they should be able to address. In the case of a programme leading to professional registration, it is also appropriate that a Curriculum Framework includes certain specifications of structure and content and the nature of the educational process and experience.

However, it is not the purpose of this Framework to create homogeneity by placing unnecessary constraints on individual HEIs running MCP programmes. It is recognised that different institutions have their own constraints and opportunities and may well be tailoring programmes to specific catchment groups. Variation in programmes is, in any case, to be welcomed, as an enrichment of the professional educational resource and the opportunity to develop and share areas of good practice.

The competences set out within this document are therefore a minimum, to which an individual institution may choose to add in determining the outcomes for their own graduates. The length of the programme and the hours of clinical experience (both general and in terms of particular fields) are equally set as minima. Educational process is discussed in terms of the philosophical underpinning and the effect of process on the equipping of the professional for fulfilling their role, rather than in terms of a specification of particular learning and teaching strategies.

However tightly the specification of minimum standards might be worded, they are still open to differential interpretation by individual institutions, teachers and students. This document therefore also proposes a role for a national assessment of competence as a determinant of registration, without wishing to contest the right of individual higher education institutions to determine the academic award for their own students.

3.2 Principles of learning and teaching

The primary responsibility for the achievement of the required learning rests with the student. It is the responsibility of curriculum developers, programme organisers and teachers to provide educational structures and experiences through which the student can fulfil their responsibilities. This includes teaching, but also the facilitation of individual and group work and the encouragement of autonomous learning.

The clinical environment provides many of the most important learning experiences for healthcare professionals. Unlike other learning environments, the education of the student is not the primary purpose of such environments and the student must learn how to make best use of the opportunities available without imposing upon patients or disrupting the provision of service.

The inter-relation of theory and practice is fundamental to the development of professional competence. Students must learn to:

- seek out and recognise clinical applicability whilst they are undertaking theoretical learning
- apply the theory they have learnt in the 'classroom' when they are in the practice setting
- reflect on practice to identify learning needs
- theorise during practice (i.e. how to, during a particular practical incident, formulate new ways of thinking and doing, which go beyond what the text book can offer)
- theorise practice itself (i.e. how to recognise, in a particular piece of practice, the principles, assumptions, beliefs and theories, which actually shaped that practice).

Learning in professional practice is a collaborative activity in which members of one profession or of a number of professions may enhance their ability to achieve common learning needs by working together or may share their knowledge and skills to enable others to achieve their learning needs. This behaviour should be encouraged and rewarded through the educational process.

Professional practice involves living with uncertainty and decision making in situations where there is no single right answer and where professional judgement must be used to determine the appropriate response. Learning and teaching in the MCP programme needs to prepare students for this reality and to equip them to make and live with such decisions.

Learning is moulded and driven by assessment and it is vital that both formative and summative assessment are designed in such a way that this direction coincides with the outcomes stated in the curriculum.

3.3 Learning partnerships

The establishment of effective learning partnerships between the student MCP and their clinical supervisors is vital to the professional learning process. To be effective, such individual partnerships must be framed by a partnership between the HEI and the service provider which mutually values the role that both play in shaping and enabling learning.

The learning partnership between the student MCP and their clinical supervisor moves beyond the traditional approach of apprenticeship. Learning is to be co-directed and questioning to be encouraged, so that both parties engage more thoughtfully in the processes of teaching and learning. This in turn should provide the basis for more motivated and better directed education.

For the partnership to work effectively, the clinical supervisor must have an understanding of the educational principles and values underpinning the programme and, in addition to a detailed understanding of student learning needs in the educational experience they facilitate, and in addition, should have an understanding of how that experience fits in to the totality of the course.

Training in clinical decision making is more complex than training in technical or factual matters. Where circumstances permit, the clinical supervisor should facilitate students in making a professional judgment rather than simply offering their own. Where the supervisor does offer their own professional judgment, they must be prepared for the student to question how that judgement was made. Students in turn must recognise that there is much professional knowledge that is tacit and may be difficult for the supervisor to elucidate.

Both supervisor and student should make efforts to be adaptable to the normal learning or teaching style of the other.

The partnership should be guided by educational principle and must not be a collusion of ease. It is important for the student to be thrown back on their own resources and to learn independently (whether from patients or library/internet resources) even where this may be more time consuming and where it involves a loss of control of the learning agenda by the clinical supervisor.

Where the clinical supervisor is involved in processes of formative and summative assessment, they must recognise both the different and the common intentions of the two processes.

Consequently, this Curriculum Framework supports the belief that the following principles are essential in shaping the education of the MCP:

- observation in clinical settings is directed so that student MCPs learn to see, analyse and interpret all that occurs
- action (rather than just observation) in the practical setting is essential to foster learning
- ongoing dialogue in the clinical setting between educator, clinical supervisor and student MCP, is a vital part of the learning process
- Clinical supervisors help student MCPs to investigate examples of professional judgment in both medical and educational practice
- problem-solving by the student MCP in a range of different practical activities, using critical thinking, creativity and improvisation
- Clinical supervisors enable student MCPs to develop their use of the processes of deliberation and reflection, encouraging self-knowledge and self-appraisal.

3.4 The aims and outcomes of the MCP programme

As mentioned previously, this Curriculum Framework aims to identify the core criteria which any MCP programme should enable students to meet. The statements included in this section may therefore not constitute the complete criteria against which students on any particular programme are judged.

In this section, the broad aims of MCP programmes are specified. The more detailed learning requirement from programmes, in terms of competences and skills and core conditions, is that included on pages 5 to 18 and Appendix 1of this document.

The programme aims to produce graduates who have the knowledge, skills and professional behaviours to function as MCPs (and to have their qualification nationally and internationally recognised) and the personal and intellectual attributes necessary for life-long professional development. Such graduates will be:

- safe practitioners under medical supervision in a wide variety of clinical settings, with patients from diverse social and ethnic backgrounds
- expert communicators who are empathic in a manner appropriate to a healthcare profession
- aware of health inequalities and the challenges of working in a multicultural environment
- aware of the limits of their competence and determined to act within those limits
- trained in the context of multi-professional working in a team environment
- adept in the use of C&IT (Communication and Information Technology) skills for healthcare
- capable and motivated lifelong learners continually engaged in active professional development
- understanding of the need to maintain and promote health, as well as to cure or palliate disease and aware of their obligations to the wider community as well as to individuals
- trained to integrate theoretical and clinical learning.

3.5 The structure of MCP programmes

The structure of the MCP programme will be highly dependent on the institution running it and the nature of the catchment group for which the course is primarily intended. For this Framework it is therefore only possible to state the structural specification which all courses must meet.

3.5.1 Overall length of the programme

This will be equivalent in length to a three year degree programme: i.e. the minimum length of the programme will be 90 weeks. This is believed to be the minimum length of time required in order to enable the development of the knowledge base and the competences/skills identified above, but equally the minimum time in which effective professional socialisation can be achieved. Ninety weeks is equivalent to the six semesters of the standard honours degree programme. Some programmes may choose to follow the standard pattern for a three year programme. Other programmes are likely to compress the six semesters into two calendar years.

3.5.2 Clinical experience in the programme

Ninety weeks should constitute a minimum of 3,150 hours of nominal study time. Of this time, a minimum of 1,600 should be designated as clinical learning. Up to 200 hours of the designated clinical learning time may consist of learning in skills centres but a minimum of 1,400 hours will be spent in practice in the clinical area, in substantive attachments to a unit or to a doctor. This includes time spent with the doctor in hospital or general practice, on ward rounds, in clinics, etc. as well as time spent in tutorials. It also includes independent learning in the clinical area that is facilitated by the doctor, or time spent with other healthcare professionals.

It is intended that the MCP, on qualification will be able to undertake first contact medical care in General Practice or A&E units and to provide 'out of hours cover' in hospital and primary care/community settings. For this to be achieved, it is important that students have a breadth of clinical placement. Whilst recognising that many of the competences can be demonstrated and many of the core conditions encountered in any, or at least many clinical areas, it is felt appropriate to set certain minima for experience in different fields. The minimum core placements are as follows:

Community Medicine	**280 hours**
General Hospital Medicine	**350 hours**
A&E	**160 hours**
Mental Health	**70 hours**
Obstetrics & Gynaecology	**70 hours**
Paediatrics (acute setting)	**70 hours**

Within this framework of clinical attachment, students must have the opportunity to have experience relevant to a broad range of core areas identified in National Service Frameworks.

This adds up to 1000 hours, leaving a minimum of 400 hours to be designated by individual institutions. Although not a requirement, institutions will be encouraged to use these 400 hours to extend the time spent in core placements, reflecting local educational opportunity, rather than simply to broaden the training circuit. In addition, institutions will be encouraged to maintain flexibility in their programmes which would allow individual students to spend further periods of time in a clinical area where they were experiencing some difficulty in achieving the learning, or alternatively, in which they had a particular interest.

3.5.3 Progression

Progression through the programme is largely a matter for regulation by individual HEIs, but all institutions must ensure that they have in place a rigorous and formally constituted process to ensure that student progress is dependent on the demonstration of appropriate clinical skills and the development and maintenance of appropriate professional behaviour (fitness to practice) as well as on what might be considered the standard basis of academic performance.

Since acceptance for registration is dependent on factors in addition to academic performance, it is proposed that the award of the academic qualification at the end of the programme should not confer automatic registration and that registration will be dependent on the award of an appropriate academic qualification and a statement from the institution of the candidate's fitness to practice, in terms of professional behaviour and clinical competence.

Following registration it is also proposed that there should be a short period of 'probationary practice' during which levels of supervision are such that supervisors are able to sign off practitioners as able to apply their knowledge and skills appropriately in clinical practice. This proposal is aimed at ensuring clinical practice is provided in a manner that is safe and productive. One could argue that this should be assessed during the educational programme but we anticipate that assessment of practice in the "real world" adds value in that the exposure to these pressures and circumstances of clinical practice can be assessed more fully.

Questions

Would you agree that there should be a period of 'probationary practice' post academic qualification and prior to formal registration as an MCP?

If you agree that there should be this period, how long should it be and what should be the outcomes?

During this period would you agree that the practitioner should have their own caseload?

During this period would you agree that the MCP should be able to refer on to other practitioners including hospital consultants, therapists and other specialist medical services?

Please explain your answers.

3.6 Criteria for entry to the programme

3.6.1 Major entry groups

It is envisaged that, during the early implementation of MCP programmes produced on the basis of this Framework, there will be two main catchment groups from which students will be drawn – life-science graduates and existing health professionals. Universities may tailor the programmes they offer to one group of candidates or the other and select accordingly. In their selection processes for this programme, we would encourage universities to recognise and value life experience as well as proven academic ability.

Whichever catchment a university is drawing on, the institution has a duty to ensure that the students it recruits to the programme are 'of good character' as well as academically capable of completing the course and undertaking the clinical role. As specified by the General Medical Council (GMC), with regard to undergraduate medical training:

> *"Universities have a duty to make sure that no member of the public is harmed as a result of taking part in the training of their medical students. Medical students cannot complete the undergraduate curriculum without coming into close, and sometimes intimate, contact with members of the public who may be vulnerable or distressed. The vocational part of their training, which prepares them for clinical practice when they become registered doctors, is such that they may not be directly observed or supervised during all contact with the public, whether in hospitals, in general practice or in the community."*

The means by which the character and capability of candidates is assessed is a matter for individual institutions or groups of institutions. However, in determining admission processes, institutions must be cognisant of developing practice in other healthcare professions* and the need to take opportunities to widen participation in both higher education and the NHS. However, account needs to be taken of the eventual acceptability of candidates to the regulatory body (e.g. candidates previously removed from a professional register; with a criminal record etc).

* For example developments aimed at assessing the intellectual capacity of candidates as opposed to their achievement (e.g. the GAMSAT test in Australian medical schools) and/or admission processes which allow institutions to broaden the basis of selection beyond the traditional mix of paper qualification and interview, to include team-working, debating current issues, problem-solving, interpersonal skills etc. (e.g. the Stepping Stone Module developed by the Professional Development Unit at Leicester Medical School).

3.6.2 Other entry routes

Some of those interested in training as an MCP may not have the professional experience or appropriate education to allow direct entry to MCP programmes. As the MCP role becomes better known, this may include mature students looking for a change in career and school leavers selecting an MCP career. It may also include medical technicians/assistants in the armed services looking for professional development within the forces or a means of ensuring a career path when they return to civilian life. In this context, HEIs offering MCP programmes may wish to look at graduates from degrees or other preparatory programmes, or to consider providing access routes into MCP programmes.

3.6.3 Transitional arrangements

A number of trainees on pilot MCP programmes may find that their training does not equip them to achieve the breadth of competence set out in this document and, in future, required for registration as an MCP. Such trainees are an important resource and institutions offering MCP programmes set up under this Curriculum Framework will seek to provide tailored fast-track courses to meet the needs of these individuals, through the accreditation of prior learning/experiential learning (APL/APEL).

3.6.4 APL/APEL for other groups

Whilst current MCP trainees seeking to top up their existing learning are the urgent group to consider in terms of APL/APEL, there may well be a continuing flow of highly experienced personnel from other health professions who would wish to receive a shortened training. In this context, it is important to identify that the MCP role differs in important respects from those that such candidates have previously undertaken. There are issues of socialisation into the MCP profession that can only be achieved through an accepted quantum of experience as an MCP trainee. In addition, it should be noted that experience in a given clinical area (for example as a nurse working in A&E) may not necessarily mean that there is no need to undertake experience in that field as part of MCP training. Having said this, there are clearly circumstances where APL/APEL would be appropriate, but any other health professional, whatever their experience, should undertake a minimum of 1000 hours of clinical experience as part of MCP training. The clinical fields in which this 1000 hours is spent would depend on prior learning and experience.

Questions

Would you agree that arrangements need to be put in place to assimilate practitioners who meet the competences of the MCP into the regulatory process?

Who should be responsible for this?

Do you think that the above proposals regarding the APEL process provide sufficient protection for public safety whilst not being too restrictive?

Please explain your answers.

4 Assessment

4.1 Definition of competence

In common usage, the word 'competent' often implies 'only just good enough': i.e. 'not incompetent, but not very good either'. When the term competence is used in this document, it refers to a specified level of capability or proficiency in relation to an activity (see definition below). Whilst the achievement of such competences may define the borderline between the student passing and failing, they do not define the borderline between competent and incompetent and are generally set at a high level of performance.

In this Framework competence is defined within a professional context as the broad ability with which a professional person is able to practise to the required standards in a predetermined range of clinical fields and across a range of situations. This broad definition includes attributes that can be applied, clinical performance (Stuart 2003), and the use of professional judgement (Carr 1993).

Competences therefore are the elements performed to the predetermined standard, which combine to create professional competence in a defined role (Stuart 2003).

4.2 Roles of assessment

Assessment fulfils a number of roles in an educational programme leading to a professional qualification. These can be primarily divided into summative and formative roles.

Summative assessment relates to the setting of standards and of assessments to judge whether they have been met, and thus protect the public and, in this case, the health service, by ensuring that all those qualifying from a course have achieved the required competences and knowledge, and the skills and professional behaviours that underpin them. Equally, it protects the educational institution by ensuring that there is no devaluation of the degrees or other qualifications that they offer.

Formative assessment is a 'no stakes' process, in as much as failure does not bar progress or affect grades or classification, but it is no less important for that. Its main purpose is to provide feedback and enable students to identify their learning needs, so that they can focus their future efforts effectively.

Formative assessment will be a largely continuous, rather than event based process, with a portfolio playing a key role. The portfolio will include a log of experience and a reflective diary. This would form the basis for discussion with personal tutors and mentors so that students can receive appropriate guidance and feedback. It must be structured in such a way that it encourages students to recognise weaknesses as well as demonstrate strengths and to determine their learning needs accordingly.

The two types of assessment (formative and summative) both have a role in shaping learning. Whilst formative assessment may enable a student to prioritise learning in response to their current performance profile it is summative assessment that sets the learning agenda in the first place. All candidates look at what they are going to be tested on and what form the test will take, as a major determinant of what they are going to learn. Assessment drives learning and, if the problems associated with a hidden curriculum at variance to the published curriculum are to be avoided, there is a need to ensure that the syllabus is in concordance with the programme, in other words the pattern of assessment is what would be expected from the pattern and purpose of the curriculum. In the case of MCP programmes, it is vital that assessment should drive students towards education, intellectual development and the application of knowledge and professional judgement, rather than training, the simple accumulation of knowledge and the unquestioning use of protocols.

In setting standards to be tested, it is vital that knowledge, skill and professional behaviour, although they may be used together in the clinical environment, are seen as constituting separate domains for the purposes of assessment, that there can be no compensation between them and that a satisfactory standard must be demonstrated in each. It is as inappropriate for a student who has 'a good way with patients' to be allowed to graduate despite a lack of knowledge, as it is for academic brilliance to be allowed to compensate for a lack of probity in a student.

The nature of the assessment process appropriate to one domain may be entirely different from that for another. Students need to demonstrate that they can perform a particular skill. Skills development takes longer for some students than for others and it may be perfectly appropriate for them to go several times around the learning and testing cycle until they have achieved the standard required. It may be perfectly appropriate for students to demonstrate in an examination that they can apply knowledge and professional judgement in a given scenario, but in terms of professional behaviour, they need to demonstrate that they habitually act in an appropriate way towards patients rather than that they can behave appropriately in an examination situation.

4.3 National assessment and accreditation

It is proposed that there should be a national assessment (theoretical and clinical) taken by all MCP students, to assess their core knowledge, skills and attitudes. Individual institutions may incorporate this into their overall assessment package as a component of a graduating examination, or may choose to use it as a separate and additional hurdle, relating to registration rather than academic qualification. In either case, the individual institution is left free to set further assessments on the basis of any additional elements and the academic level of the programme. Such a national assessment is the only way to ensure a common standard is met by all entrants to the MCP profession, since, because the profession is new, the published standard may be open to different interpretations by different institutions.

It is proposed that qualification from the MCP programme should be followed by a probationary period in an approved training environment during which time they will be supervised more closely and their 'competence in action' will be assessed on a continuing basis. Registration will be dependent on this assessment and MCPs who do not demonstrate the required competence in action will be offered an additional period of provisional registration and training. Ultimately entry onto the full register must depend on satisfactory performance.

In addition to any requirement by the regulator for intermittent re-application for registration on the basis of Continuing Professional Development (CPD), it is proposed that all MCPs should be required to take a national examination on a six yearly basis. The re-accreditation examination will be closely related to that for initial accreditation, requiring candidates to demonstrate that they have maintained competence across the whole range of potential clinical settings, rather than simply developed expertise in the single setting in which they have been working. It is this maintenance of general competence that maintains career flexibility and transferability for the MCP and offers a major advantage to doctors and others working with MCPs. In the context of secondary care, the breadth of competence is a useful counterbalance to the increasing specialism of the doctor and ensures that concurrent problems that are relevant, but outside the specialism (e.g. mental health problems in the surgical patient, cancer in the client at the alcohol dependency unit) are not missed by the team.

4.4 Criteria for assessment and standard setting

Although the standards which qualifying MCPs are expected to achieve are set out in some detail in the competences, skills and core conditions, such specifications are still open to interpretation and a common standard for all registrants can only really be achieved through a common assessment process. As a minimum, it is proposed that a national paper or computer based examination should be used for the assessment of knowledge and there will be a national assessment of clinical competence. In addition, comprehensive national criteria should be set for the content of and expectation in locally held assessment of competence/decision making/professional behaviour etc.

Whilst a common standard is, in itself, very important, it is equally important that the standard set is correct, that the assessment is reliable (i.e. that it is maintained from one diet of assessment to another) that it is rigorous (i.e. that candidates cannot pass by chance) that it is valid (i.e. it tests what it purports to test) and is congruent with the stated aims of all the curricula developed under this Framework.

This requires a rigorous and formalised process of standard setting (e.g. modified Angoff or borderline method) for individual examination papers, so that any variation in the pass/fail standard between sittings is smoothed out. It is equally important that reliability is ensured in assessments of practical competence/problem solving etc. The most common method for undertaking standard setting in this context is the borderline group method.

Recognising that this is a new profession and that maintenance of patient safety is paramount, the establishment of a National Examination Board is recommended. It is envisaged that this National Examination Board would be responsible to a future MCP professional body and to the appropriate regulating/registering body. Such a Board would need to be constituted as the sole provider of assessment for the register. It would need to have the support of all HEIs running courses leading to registration, both in terms of valuing its role in standard setting and the standards set and in terms of practical support: the provision of questions and assessment 'stations', involvement in the standard setting process, involvement in assessing, moderating and external examining.

Questions

What are your views on the proposal for a single national assessment for the profession?

The assessment of professional examinations through either an examination board or a professional body is the usual route prior to regulation. However on becoming part of a statutory register there is a requirement for qualifications to be independently assessed and quality assured and therefore requires professional body examinations to be embedded within the HEI sector. Should the regulator be the sole assessor of educational programmes?

The steering group members who have written this document have the combined expertise to validate educational programmes for the role in the interim period.

What are your views?

4.5 Maintaining professional competence

As with any profession, the MCP will need to undertake CPD to maintain and update their professional competence and to fit it to the professional roles they are required to undertake. However, it is one of the strengths of the role that the practitioner will be expected to maintain a generalist capability, whatever field they happen to be working in at a given time. For the MCP working in a specialist field, or taking special interest in particular aspects of a generalist role, the purpose of CPD is twofold and must involve both a generalist and specialist component.

CPD taken as a whole is likely to be assessed through a portfolio approach, through which the MCP can demonstrate that they have undertaken sufficient learning to support their practice. There will be a requirement for a certain quantity of learning to have been undertaken during any period of professional practice, but the focus of that learning will normally be determined by the MCP, with or without input from their supervising doctor.

Whatever the profession, CPD must be highly individualised and the determination of content and therefore outcome is largely a matter for each professional. Whilst the MCP remains free to choose the content of their CPD, they have to be aware that there will be formal periodic assessment of their generalist capability and the outcome of the generalist component of the CPD must support them in achieving the required standard.

4.6 Periodic assessment and the maintenance of registration

On a six yearly cycle, each MCP will have to demonstrate that they have maintained the generalist capability central to the role. For this purpose a national examination will be set, which will focus on knowledge, but may also involve assessment of core skills. The assessment is about knowledge applied in practice and the level expected of the MCP that will be required of the qualifying MCP after the probationary period of practice referred to in Section 3.5.3. Since the assessment is intimately involved with the maintenance of the professional register, it is expected that the registering body, or an expert panel designated by the registering body will:

- remind MCPs of the date by which they must have passed the periodic assessment in order to maintain unbroken practice
- construct the assessment and set standards
- administer the assessment and manage the processes of marking and moderation
- inform MCPs of the outcome of the assessment and arrangements for any reassessment required.

Question

Periodic re-registration through the passing of a re-accreditation examination is a relatively new process for healthcare professions. Do you forsee any issues with the introduction of this process?

4.7 Funding

Uncertainty remains with regard to the likely costs of provision of periodic assessment of CPD. Should the profession grow then the professional body should participate in the maintenance of their professional standards. However, the public needs to be re-assured that the standards cannot be compromised through a conflict of interest and therefore we would propose that an independent body be responsible for this aspect of future development.

Questions

What are your views on compulsory periodic re-assessment?

Do you have any suggestions regarding how this periodic re-assessment will be funded whilst remaining independent?

5 The Core Syllabus

Any division of curriculum content into separate subjects may suggest barriers which are not really there. Whether focusing on the domain level of knowledge, skills and professional behaviours, or the discipline level of anatomy, ethics and immunology etc. the whole purpose of the curriculum is to provide graduates with an integrated platform from which to undertake the professional role.

Whilst the following sections of this Framework necessarily separate out the various strands of professional learning, for the purpose of specifying the core elements which must be included in the whole, any curriculum must explicitly facilitate students in reintegrating these areas of study into a meaningful whole.

5.1 Core theoretical knowledge

As with the specification of clinical experience, it is not intended that there should be a national specification to identify the whole theoretical input that might be included in any given programme, but only those aspects which all MCP students should cover.

Equally, the detailed structure and provision of such a programme of theoretical knowledge to students is not specified. The information is presented on the basis of standard academic subject areas (itself an unlikely structure for an MCP programme) so that individual institutions have free rein to offer courses structured on a systems-based approach, problem based learning etc. For each academic discipline, the information is structured as shown in the list below.

The list of theoretical (i.e non-clinical) knowledge subject areas to be covered in the core syllabus is as follows. The list is alphabetical and does not suggest chronological order or the subject's priority or the amount of time it should have within the programme. In addition, there are a number of threads which should run throughout the programme including diversity in society and the appropriate professional response, competence as a user of and participant in research and the basis of inter-professional working.

Anatomy
Biochemistry
Communication
Development, growth and reproduction
Ethics and law
Health education
Healthcare policy
Histology

Immunology and microbiology
Pathology
Pharmacology & Therapeutics
Physiology
Psychology
Public Health & Epidemiology
Sociology
Teaching and assessing

Questions

This list is not exhaustive, but do you think that there is a core theoretical knowledge area that is missing?

What is your opinion of the weighting that should be given to each core theoretical knowledge area i.e. what are the priority theoretical knowledge areas?

6 Validation, accreditation, and evaluation of the programme

Validation, accreditation and evaluation are central elements of the quality assurance process in professional education. Although the processes are interlinked in their aims, each is carried out separately by the body/group with the legitimate authority to do so.

6.1 Validation and accreditation of the programme

Validation refers to the approval process applied by each university to the programmes they run. It will normally require the submission of detailed plans for the programme and for individual modules. The intention is for the university to assure itself that there is a market for the programme, that it is supported by effective management structures and resources, that it is fit for purpose in terms of the level and content of the education it purports to offer and that the processes of assessment are sufficiently rigorous to differentiate appropriately between those who have or have not achieved the required standard.

Accreditation refers to the equivalent approval process as carried out by the competent professional/regulating body (e.g. GMC for medicine). The purpose of accreditation is for the body to assure itself that all programmes conferring professional registration on those qualifying will enable the appropriately selected and duly diligent student to achieve nationally agreed minimum standards in relation to knowledge, skills and attitudes. In the case of MCPs it is expected that the professional body will carry out this function under the umbrella of the appropriate regulating/registering body. Until the MCP title is registered and a formal professional body is established, it is proposed that this function will be performed by a panel drawn from the Curriculum Framework and Competence Steering Group, the MCP National Programme Board and the participating HEIs.

Where appropriate, validation and accreditation can be carried out through a single joint process, enabling negotiation on any issues dividing the validating and accrediting bodies.

Question

Do you think it is appropriate that until the regulatory body is established that the accreditation function be carried out by a panel drawn from the Curriculum Framework and Competence Steering Group, the MCP National Programme Board and participating HEIs?

If not, what alternatives would you suggest?

6.2 Evaluation of the programme

Universities will have their own regulations regarding the evaluation of programmes which they validate. These regulations usually relate to the formal, cyclical processes of review, although review, in its turn, will require the submission of evidence from evaluation of the programme by individual students and their teachers/supervisors.

Evaluation will take account of as wide a range of audiences as possible. It should cover all aspects of the programme and reports should be sought both orally and in writing. The evaluation should be focused on the intentions of the programme, as expressed by aims and learning outcomes, and the utility of teaching and available learning opportunities for enabling outcomes to be achieved.

The university led processes of cyclical review should not usually be replicated by the professional body, which will have access to all relevant university reports. However, such processes may, on occasion, be supplemented by the professional body, to explore different perspectives or areas.

7 Regulation and accountability

7.1 Professional title

It is acknowledged that the title for this profession needs both to reflect the proposed role and to avoid confusion between this and other healthcare professions. Existing protected titles limit the options for new titles. 'Medical Care Practitioner' creates some problems on this basis since it is too close to the protected title 'Medical Practitioner' which can only be used by a registered doctor. A number of titles have been suggested to the Steering Group:

Associate Medical Practitioner
Medical Care Associate
Medical Care Professional
Medical Care Officer

Legal advice will need to be sought on the viability of the final preferred title.

Question

The issue of the eventual title of the role has been contentious. Ultimately the title should be one that the public are able to recognise as a descriptor of the role. The title is not a beauty contest and neither should it be a descriptor of 'rank' in a team. Do you have a suggestion that meets the needs of the patient and one that the profession will be happy to adopt?

7.2 Regulation and registration*

It is expected that new legislation in 2006 will enable MCPs to be registered as a profession. A separate regulatory framework is necessary because the proposed role is inherently and sufficiently different from that of existing professions and their primary regulated roles (as opposed to extended practice).

Statutory regulation has four functions.

1. Set standards of proficiency (competence), ethics and conduct for practitioners of a profession.

2. Set standards for education and training which will produce competent, safe and effective practitioners in that profession.

3. Keep a register of those who meet the standards and are fit to practise.

4. Have a mechanism for dealing with those registrants who stop meeting the standards and need to be removed or restricted from practice, by investigating complaints and taking any necessary action to restrict their practice.

As registered professionals, MCPs will be accountable for their own practice and subject to the requirements of the regulator.

From a legal perspective, only one regulatory body can undertake statutory regulation for a distinct profession. From an individual's perspective, practitioners can be registered with two bodies if qualified for two regulated professions and wish to practise in both (e.g. a registered nurse can change career and become a registered MCP). However, only registration with the appropriate regulator will confer entitlement to practise as a specific regulated professional, so for instance, a registered nurse cannot work as a MCP without undergoing a new registration process which will demonstrate competence to work in that role.

** This section is subject to further consideration from a legislative and regulatory perspective. This section expresses one of a number of views and all of the concurrent positions will be considered as part of the consultation process and the Department of Health regulatory review.*

7.3 Accountability and supervision

It is envisaged that supervising doctors will be accountable overall for the work of the MCP, in a similar manner to their responsibilities for trainee doctors, non-consultant career grade doctors, staff and associate specialist grade doctors. Individual MCPs will still be accountable for their own practice, within the boundaries of supervision and defined scope of practice. Supervising clinicians must accept overall responsibility for any duties that are undertaken by an MCP in training or a qualified MCP. On this basis, doctors should determine the scope of duties and responsibilities of the MCP on the basis of known competence within the relevant area of practice.

MCPs work under the supervision of doctors throughout their professional lives. Whilst this may appear to contrast with autonomous practice in nursing and other health professions, it should be remembered that all health professions, including doctors remain professionally and managerially accountable to others throughout their working lives despite being independent clinically autonomous practitioners. The particular position of the MCP relates to the fact that they are working in association with and under the supervision of the doctor as an integral part of the medical team. Those who come from other professions, but wish to undertake the MCP role, must recognise and respect this relationship.

8 The proposed timeframe

Notwithstanding the response from the publication of the Competence and Curriculum Framework it is evident that a number of employers view the role as necessary to deliver care in the primary and secondary care settings. This is shown through the employment of US trained Physician Assistants in a number of areas in England, Wales and Scotland. As mentioned earlier, these ad-hoc arrangements, whilst successfully addressing local need, have resulted in the growth of non-regulated professional groups with no assimilation, equivalency or incorporation into the UK regulatory framework.

The results of the public consultation will shape the development of the processes required to ensure public safety of the role, and its equivalencies. A number of HEIs have developed, or are developing, MCP type courses as local employers are seeking to replicate the US type Physician Assistant to service their local health economy.

Consequently, there will be a requirement for employers to have established a framework for employment of this type of post in a regulated manner by 2007.

Questions

Do you anticipate that the proposed timeframe is adequate?

Have you any further comments regarding the process, the document and the role?

9 Glossary of terms

Clinical supervisor	An accredited physician with responsibility for an identified trainee MCP within their medical team.
Co-morbidity	Co-existence of more than one disease in an individual patient.
Competence	For the purpose of this document, a competence is defined as a definitive statement of demonstrated performance and the application of skills, knowledge and understanding to perform a required skill or activity to a specific, predetermined standard expected in employment.
Competences	A range of specific skills, which may be taught and tested in a very didactic way. It does not require professional judgment.
Continuing Professional Development (CPD)	A process of life-long learning for all individuals and teams which enables professionals to expand and fulfil their potential and which also meets the needs of patients and delivery of the health and healthcare priorities of the NHS. CPD should be purposeful, patient centred and educationally effective.
Core knowledge	The content of medical practice that is common to all and skills specialties (and often to other medical disciplines).
Curriculum Framework	The main educational policy document providing the background, development entry routes, definitions, structure of education and training, and assessment strategy for trainees on the programme.
Differential diagnosis	Distinguishing between two or more diseases and conditions with similar symptoms by systematically comparing and contrasting their clinical findings, including physical signs and symptoms, as well as the results of laboratory tests and other appropriate diagnostic procedures.
Medical Model	The medical model is a perspective which is predominantly concerned with the diagnosis and treatment of disease which is based on pathology and disease processes, but places this within the context of the individual patient and their social context.

Patient-centred care	Care which explores a) the patient's main reason for the visit, concerns and need for information b)seeks an integrated understanding of the patients' world – that is their whole person, emotional needs and life issues c) finds common ground on what the problem is and mutually agrees on management d) enhances prevention and health promotion e) enhances the continued relationship between the patient and health professional.
Professional judgement	The application of relevant knowledge and experience within the context provided by clinical standards (that reflect the collective judgement of the profession) and rules of professional conduct in reaching decisions where a choice must be made between alternative possible courses of action.

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Appendix 1: Core Clinical Conditions

In this appendix the conditions are set out by category to bring together the whole range of conditions for which practitioners are expected to demonstrate a given level of capability. Within each category, individual conditions/disorders are set out by 'body system/clinical field', and then 'broad disorder type'.

Whichever category they occur in, the 'body system/clinical field' and the 'broad disorder type' will always have the same number: e.g. Mental Health will always be 1 and Eating Disorders will always be 1.3. Because each broad disorder type does not appear in each category, the numbering may not be continuous: e.g. 1.2 (Anxiety Disorders) does not appear in category 1A.

Individual conditions, disorders are numbered sequentially through the categories: e.g. Mood Disorder 1.2.3 (bipolar) occurs in category 1B and 1.2.4 (dysthymic disorder) occurs in category 1B.

Conditions in category 1A

Definition: The MCP is able to diagnose the condition in a patient who is presenting with the problem for the first time and will normally be able to manage it without regular or routine referral.

The numbering below relates to
Body System/Clinical Field
Broad disorder type
Individual condition/disorder

1			**Mental Health**
1	**1**		**Mood Disorders**
1	1	1	Depressive
1	1	2	Affective
1	**3**		**Eating Disorders**
1	3	1	Obesity
1	**4**		**Substance Use Disorders**
1	4	1	Tobacco use/dependence
1	4	2	Alcohol abuse/dependence
1	**5**		**Other Behaviour/Emotional Disorders**
1	5	1	Acute reaction to stress
1	5	2	Uncomplicated bereavement

Conditions in category 1A			
2			**Cardiovascular**
2	**1**		**Hypertension**
2	1	1	Essential
2	1	2	Isolated systolic
2	1	3	Iatrogenic
2	**3**		**Hypotension**
2	3	1	Orthostatic/postural
2	3	2	Hypovolaemic shock
2	**4**		**Vascular Diseases**
2	4	1	Phlebitis/thrombophlebitis
2	**10**		**Other Cardiovascular Problems**
2	10	1	Hypothermia
3			**Respiratory**
3	**1**		**Infectious Respiratory Disorders**
3	1	1	Acute bronchitis
3	1	2	Influenza
3	1	3	Croup
3	1	4	Respiratory syncytial virus infection
3	1	5	Bacterial pneumonia
3	1	6	Viral pneumonia
3	**7**		**Near Drowning**
4			**Gastro-Intestinal**
4	**1**		**Oesophagus**
4	1	1	Oesophagitis
4	**2**		**Stomach**
4	2	1	Gastro-oesophageal reflux disease
4	2	2	Gastritis
4	2	3	Peptic ulcer disease
4	**3**		**Small Intestine/Colon**
4	3	1	Constipation/Faecal impaction
4	3	2	Irritable bowel syndrome
4	3	3	Infectious diarrhoea
4	**4**		**Rectum**
4	4	1	Haemorrhoids
4	**9**		**Other Gastro-Intestinal Conditions**
4	9	1	Dyspepsia
4	9	2	Gastroenteritis
4	9	3	Acute poisoning

Conditions in category 1A			
5			**Musculoskeletal**
5	**1**		**Disorders of the Shoulder**
5	1	1	Sprain/strain
5	**2**		**Disorders of the Forearm/Wrist/Hand**
5	2	1	Sprains/strains
5	2	2	Tenosynovitis: *Epicondylitis*
5	**3**		**Disorders of Back/Spine**
5	3	1	Back strain/sprain
5	3	2	Back/neck pain
5	3	3	Injury (differential diagnosis – musc./neuro.)
5	**5**		**Disorders of the Knee**
5	5	1	Osgood-Schlatter disease
5	5	2	Sprains/strains
5	**6**		**Disorders of the Ankle/Foot**
5	6	1	Sprains/strains
5	**10**		**Other Musculoskeletal Problems**
5	10	1	Osteoarthritis
5	10	2	Osteoporosis
6			**Eye**
6	**1**		**Eye disorders**
6	1	1	Blepharitis
6	1	2	Conjunctivitis
6	1	3	Corneal abrasion
6	1	4	Keratitis
6	1	5	Foreign body
6	1	6	Pterygium
6	1	7	Chalazion
6	1	8	Orbital cellulitis
6	1	9	Dacryoadenitis
7			**Ear, Nose and Throat**
7	**1**		**Ear Disorders**
7	1	1	Acute otitis media
7	1	2	Cerumen impaction
7	1	3	Labyrinthitis
7	1	4	Otitis externa
7	1	5	Vertigo
7	1	6	Chronic otitis media
7	**2**		**Nose/Sinus Disorders**
7	2	1	Acute sinusitis
7	2	2	Allergic rhinitis
7	2	3	Epistaxis

Conditions in category 1A			
7			**Ear, Nose and Throat** *(continued)*
7	2	4	Chronic sinusitis
7	2	5	Nasal polyps
7	**3**		**Mouth/Throat Disorders**
7	3	1	Acute pharyngitis
7	3	2	Acute tonsillitis
7	3	3	Aphthous ulcers
7	3	4	Laryngitis
7	3	5	Oral candidiasis
7	3	6	Oral herpes simplex
7	3	7	Parotitis
8			**Female Reproductive**
8	**1**		**Uterus**
8	1	1	Dysfunctional uterine bleeding
8	**2**		**Cervix**
8	2	1	Cervicitis
8	**3**		**Vagina/Vulva**
8	3	1	Vaginitis
8	**5**		**Menstrual Disorders**
8	5	1	Dysmenorrhoea
8	5	2	Premenstrual syndrome
8	**6**		**Uncomplicated Pregnancy**
8	6	1	Prenatal diagnosis/care
8	**8**		**Menopausal Problems**
9			**Neurological**
9	**1**		**Diseases of Peripheral Nerves**
9	1	1	Bell's palsy
9	**2**		**Movement Disorders**
9	2	1	Essential tremor
9	**3**		**Headaches**
9	3	1	Migraine
9	3	2	Tension headache
9	3	3	Cluster headache
9	**8**		**Other Neurological Conditions**
9	8	1	Shingles
9	8	2	Syncope
9	8	3	cardiac-arrhythmias and valvular, carotid sinus
9	8	4	hypersensitivity, vaso-vagal

Conditions in category 1A			
10			**Endocrine & Metabolic**
10	**1**		**Diseases of the Thyroid & Parathyroid**
10	1	1	Hypothyroidism
10	**2**		**Diabetes Mellitus**
10	2	1	Type 2 Diabetes Mellitus
10	2	2	Hypoglycaemia
10	**3**		**Lipid Disorders**
10	3	1	Hypercholesterolaemia
10	**6**		**Electrolyte and Acid-Base Disorders**
10	6	1	Hypo/Hypernatraemia
10	6	2	Hypo/Hyperkalaemia
10	6	3	Hypo/Hypercalcaemia
10	6	4	Volume depletion
11			**Renal & Genito-Urinary**
11	**1**		**Benign Conditions of the GU Tract**
11	1	1	Benign prostatic hyperplasia
11	**3**		**GU Infectious/Inflammatory Conditions**
11	3	1	Cystitis
11	3	2	Balanitis
11	3	3	Prostatitis
11	3	4	Epididymitis
11	3	5	Orchitis
11	**5**		**Other Renal/GU Problems**
11	5	1	Haematuria
11	5	2	Ureteric trauma
11	5	3	Renal trauma
12			**Skin**
12	**1**		**Eczematous Eruptions**
12	1	1	Atopic
12	1	2	Contact
12	1	3	Nappy
12	1	4	Peri-oral
12	1	5	Seborrhoeic
12	1	6	Nummular
12	1	7	Venous stasis
12	**2**		**Papulosquamous Diseases**
12	2	1	Tinea versicolor
12	2	2	Tinea corporis/pedis
12	2	3	Drug eruptions
12	2	4	Pityriasis rosea

Conditions in category 1A			
12			**Skin** *(continued)*
12	2	5	Psoriasis
12	**3**		**Acneiform Lesions**
12	3	1	Acne vulgaris
12	3	2	Rosacea
12	3	3	Folliculitis
12	**4**		**Hair and Nails**
12	4	1	Androgenic alopecia
12	4	2	Onycomycosis
12	4	3	Paronychia
12	**5**		**Viral Diseases**
12	5	1	Exanthems
12	5	2	Herpes simplex
12	5	3	Molluscum contagiosum
12	5	4	Verrucae
12	5	5	Varicella-zoster virus infections
12	**6**		**Bacterial Infections**
12	6	1	Cellulitis/vasculitis
12	6	2	Impetigo
12	**7**		**Insects/Parasites**
12	7	1	Lice
12	7	2	Scabies
12	**8**		**Bites**
12	8	1	Insect
12	8	2	Animal
12	8	3	Human
12	**9**		**Skin Trauma**
12	9	1	Simple and complex laceration
12	9	2	Burns
12	9	3	Needlestick injuries
12	**13**		**Other Dermatological Conditions**
12	13	1	Urticaria
12	13	2	Vitiligo
12	13	3	Hydradenitis suppurativa
12	13	4	Melasma
12	13	5	Lipomas/epithelial inclusion cysts
12	13	6	Decubitus ulcers/leg ulcers

Conditions in category 1A			
13			**Haematological**
13	**1**		**Anaemias**
13	1	1	Vitamin B12 deficiency
13	1	2	Folate deficiency
13	1	3	Iron deficiency
13	**2**		**Coagulation Disorders**
13	2	1	Nutritional anaemias
14			**Sexual Health**
14	**1**		**Contraception**
14	1	1	Contraceptive Advice
14	1	2	Treatment
14	**3**		**Sexual Dysfunction**
14	3	1	Male sexual dysfunction
14	**4**		**Safe Sex Advice**
15			**Infections**
15	**1**		**Fungal Disease**
15	1	1	Candidiasis
15	**2**		**Bacterial/Mycobacterial Disease**
15	2	1	Salmonellosis
15	2	2	Shigellosis
15	**3**		**Parasitic Disease**
15	3	1	Threadworms
15	3	2	Hookworms
15	**4**		**Viral Disease**
15	4	1	Epstein-Barr virus infections
15	4	2	Herpes simplex
15	4	3	Influenza
15	4	4	Mumps
15	4	5	Roseola
15	4	6	Rubella
15	4	7	Measles
15	4	8	Varicella-zoster virus infections
15	4	9	Erythema infectiosum

Conditions in category 1B

Definition: The MCP is able to identify the condition as a possible diagnosis: may not have the knowledge/resources to confirm the diagnosis or to manage the condition safely, but can take measures to avoid immediate deterioration and refer appropriately.

1			**Mental Health**
1	**1**		**Mood Disorders**
1	1	3	Bipolar
1	**2**		**Anxiety Disorders**
1	2	1	Generalized anxiety disorder
1	2	2	Phobias
1	2	3	Panic disorder
1	2	4	Posttraumatic stress disorder
1	**3**		**Eating Disorders**
1	3	2	Anorexia nervosa
1	3	3	Bulimia nervosa
1	**4**		**Substance Use Disorders**
1	4	3	Drug abuse/dependence
1	**5**		**Other Behaviour/Emotional Disorders**
1	5	3	Child/elder abuse
1	5	4	Domestic violence
1	5	5	Deliberate self-harm
1	5	6	Attention-deficit disorder
1	**6**		**Psychoses**
1	6	1	Schizophrenia
1	**7**		**Personality Disorders**
1	7	1	Antisocial
1	7	2	Obsessive-compulsive
1	7	3	Paranoid
2			**Cardiovascular**
2	**1**		**Hypertension**
2	1	4	Secondary
2	1	5	Malignant/accelerated
2	**2**		**Conduction Disorders**
2	2	1	Bundle branch block
2	2	2	Premature beats
2	2	3	Atrial fibrillation/flutter
2	2	4	Atrioventricular block
2	2	5	Paroxysmal supraventricular tachycardia
2	2	6	Ventricular tachycardia
2	2	7	Ventricular fibrillation/flutter

Conditions in category 1B			
2			**Cardiovascular** *(continued)*
2	**3**		**Hypotension**
2	3	3	Cardiogenic shock
2	**4**		**Vascular Diseases**
2	4	1	Chronic/acute arterial occlusion
2	4	2	Peripheral vascular disease
2	4	3	Varicose veins
2	4	4	Acute rheumatic fever
2	4	5	Venous thrombosis
2	4	6	Aortic aneurysm/dissection
2	4	7	Arterial embolism/thrombosis
2	**5**		**Cardiac Failure**
2	5	1	Ischaemic
2	5	2	Valvular
2	5	3	Hypertensive
2	**6**		**Ischaemic Heart Disease**
2	6	1	Acute myocardial infarction
2	6	2	Angina pectoris: *Unstable*
2	6	3	Angina pectoris: *Prinzmetal's/variant*
2	**9**		**Valvular Disease**
2	9	1	Aortic stenosis/regurgitation
2	9	2	Mitral stenosis/regurgitation
2	9	3	Tricuspid stenosis/insufficiency
2	9	4	Pulmonary stenosis/insufficiency
2	**10**		**Other Cardiovascular Problems**
2	10	2	Acute and subacute bacterial endocarditis
2	10	3	Acute pericarditis
2	10	4	Cardiac tamponade
2	10	5	Pericardial effusion
3			**Respiratory**
3	**1**		**Infectious Respiratory Disorders**
3	1	7	Acute bronchiolitis
3	1	8	Acute epiglottitis
3	1	9	Pertussis
3	1	10	Empyema
3	**2**		**Obstructive Pulmonary Disease**
3	2	1	Sleep apnoea
3	**4**		**Pulmonary Circulation**
3	4	1	Pulmonary embolism
3	4	2	Cor pulmonale

Conditions in category 1B			
3			**Respiratory** *(continued)*
3	**5**		**Pleural Diseases**
3	5	1	Pleural effusion
3	5	2	Pneumothorax: *Primary*
3	5	3	Pneumothorax: *Traumatic*
3	5	4	Pneumothorax: *Tension*
3	5	5	Pleurisy
3	**6**		**Neoplastic Pulmonary Disease**
3	6	1	Bronchogenic carcinoma
3	6	2	Metastatic tumours
4			**Gastro-Intestinal**
4	**1**		**Oesophagus**
4	1	2	Mallory-Weiss tear
4	1	3	Neoplasms
4	1	4	Strictures
4	1	5	Varices
4	**2**		**Stomach**
4	2	4	Gastric neoplasms
4	**3**		**Small Intestine/Colon**
4	3	4	Diverticular disease
4	3	5	Appendicitis
4	3	6	Intussusception
4	3	7	Ischaemic bowel disease
4	3	8	Obstruction
4	3	9	Toxic megacolon
4	**4**		**Rectum**
4	4	2	Anal fissure
4	4	3	Anorectal abscess/fistula
4	4	4	Pilonidal disease
4	4	5	Polyps
4	4	6	Rectal neoplasms
4	**5**		**Gallbladder**
4	5	1	Chronic cholecystitis
4	5	2	Cholelithiasis
4	5	3	Acute cholecystitis
4	**6**		**Liver**
4	6	1	Acute/chronic hepatitis
4	6	2	Cirrhosis
4	**7**		**Pancreas**
4	7	1	Acute pancreatitis

Conditions in category 1B			
4			**Gastro-Intestinal** *(continued)*
4	**8**		**Hernia**
4	8	1	Hiatus
4	8	2	Incisional
4	8	3	Inguinal
4	8	4	Umbilical
4	8	5	Ventral
4	**9**		**Other Gastro-Intestinal Conditions**
4	9	4	Peritonitis
4	9	5	Gastro-intestinal perforation
4	9	6	Gastro-intestinal haemorrhage
5			**Musculoskeletal**
5	**1**		**Disorders of the Shoulder**
5	1	2	Fractures/dislocations
5	1	3	Adhesive capsulitis
5	**2**		**Disorders of the Forearm/Wrist/Hand**
5	2	3	Fractures/dislocations: *Colles'*
5	2	4	Fractures/dislocations: *Humeral*
5	2	5	Fractures/dislocations: *Pulled elbow*
5	2	6	Fractures/dislocations: *Scaphoid*
5	2	7	Tenosynovitis: *Carpal tunnel syndrome*
5	2	8	Tenosynovitis: *de Quervain's tenosynovitis*
5	2	9	Tenosynovitis: *Elbow tendonitis*
5	**3**		**Disorders of Back/Spine**
5	3	4	Kyphosis/scoliosis
5	3	5	Herniated disk pulposis
5	3	6	Back/Neck fractures
5	**4**		**Disorders of the Hip**
5	4	1	Fractures/dislocations
5	4	2	Slipped upper femoral epiphysis
5	**5**		**Disorders of the Knee**
5	5	3	Bursitis
5	5	4	Fractures/dislocations
5	5	5	Meniscal injuries
5	5	6	Chondromalacia
5	**6**		**Disorders of the Ankle/Foot**
5	6	2	Fractures/dislocations
5	**8**		**Musculoskeletal Infectious Diseases**
5	8	1	Septic arthritis
5	8	2	Acute osteomyelitis
5	8	3	Chronic osteomyelitis

Conditions in category 1B			
5			**Musculoskeletal** *(continued)*
5	**10**		**Other Muculoskeletal Problems**
5	10	3	Metabolic bone disease
5	10	4	Paget's Disease
5	10	5	Renal bone disease
5	10	6	Vascular-sickle cell
6			**Eye**
6	**1**		**Eye disorders**
6	1	10	Strabismus
6	1	11	Cataract
6	1	12	Congenital cataract
6	1	13	Macular degeneration
6	1	14	Ectropion
6	1	15	Entropion
6	1	16	Glaucoma
6	1	17	Diabetic retinopathy
6	1	18	Hypertensive retinopathy
6	1	19	Retinal detachment
6	1	20	Retinal vascular occlusion
6	1	21	Retinoblastoma
6	1	22	Raised intra-cranial pressure
6	1	23	Optic neuritis
6	1	24	Optic atrophy
6	1	25	Blow-out fracture
6	1	26	Thyroid Eye Disease
6	1	27	Horner's
6	1	28	Third nerve palsy
6	1	29	Holme's Adie
7			**Ear, Nose and Throat**
7	**1**		**Ear Disorders**
7	1	7	Mastoiditis
7	1	8	Meniere's disease
7	1	9	Barotrauma
7	1	10	Hearing impairment
7	1	11	Tympanic membrane perforation
7	**3**		**Mouth/Throat Disorders**
7	3	8	Quinsy
7	3	9	Epiglottitis
7	3	10	Oral leukoplakia
7	3	11	Sialadenitis
7	3	12	Peritonsillar abscess
7	3	13	Dental abscess

Conditions in category 1B

8			**Female Reproductive**
8	**1**		**Uterus**
8	1	2	Endometritis
8	1	3	Prolapse
8	**2**		**Cervix**
8	2	2	Dysplasia
8	2	3	Cysts
8	**3**		**Vagina/Vulva**
8	3	2	Neoplasm
8	3	3	Cystocoele
8	3	4	Rectocoele
8	3	5	Bartholin's Cyst
8	**4**		**Breast**
8	4	1	Abscess
8	4	2	Fibroadenoma
8	4	3	Fibrocystic disease
8	4	4	Mastitis
8	4	5	Breast Cancer
8	**5**		**Menstrual Disorders**
8	5	3	Amenorrhoea
8	5	4	Polycystic ovarian syndrome
8	**6**		**Uncomplicated Pregnancy**
8	6	1	Normal labour/delivery
8	6	2	Emergency childbirth
8	**7**		**Complicated Pregnancy**
8	7	1	Pregnancy-induced hypertension
8	7	2	Ectopic pregnancy
8	7	3	Gestational diabetes
8	7	4	Abortion
8	7	5	Abruptio placenta
8	7	6	Placenta previa
8	7	7	Postpartum haemorrhage
8	7	8	Premature rupture of membranes
8	7	9	Rh incompatibility
8	7	10	Multiple gestation
8	7	11	Dystocia

Conditions in category 1B			
9			**Neurological**
9	**1**		**Diseases of Peripheral Nerves**
9	1	2	Diabetic peripheral neuropathy
9	**2**		**Movement Disorders**
9	2	2	Parkinson's disease
9	**4**		**Seizure Disorders**
9	4	1	Status epilepticus
9	4	2	Primary general
9	**5**		**Dementias**
9	5	1	Alzheimer's disease
9	**6**		**Vascular Diseases**
9	2	3	Stroke
9	2	4	Transient Ischaemic Attack
9	2	5	Raised Intracranial Pressure
9	6	1	Temporal Arteritis
9	**7**		**Infectious/inflammatory disorders**
9	7	1	Encephalitis
9	7	2	Meningitis
9	7	3	HIV
9	7	4	Tuberculosis
9	7	5	Syphilis
9	**8**		**Other Neurological Conditions**
9	8	6	Spinal cord lesions
9	8	7	Subarachnoid haemorrhage
9	8	8	Multiple Sclerosis
9	8	9	Venous sinus thrombosis
9	8	10	Cavernous sinus thrombosis
9	8	11	Neoplasm – primary and secondary
9	8	12	Encephalopathy – acute and chronic
9	8	13	Peripheral nerve lesions – wrist or foot drop
9	8	14	Nerve Entrapment: e.g. carpal tunnel
10			**Endocrine & Metabolic**
10	**1**		**Diseases of the Thyroid & Parathyroid**
10	1	2	Hyperthyroidism: *Graves' disease*
10	1	3	Hyperthyroidism: *Hashimoto's thyroiditis*
10	1	4	Hyperthyroidism: *Thyroid storm*
10	1	5	Thyroiditis
10	1	6	Hyperparathyroidism
10	1	7	Hypoparathyroidism
10	1	8	Thyroid Neoplastic disease

Conditions in category 1B			
10			**Endocrine & Metabolic** *(continued)*
10	**2**		**Diabetes Mellitus**
10	2	3	Type 1 Diabetes Mellitus
10	**4**		**Diseases of the Adrenal Glands**
10	4	1	Corticoadrenal insufficiency
10	**6**		**Electrolyte & Acid-Base Disorders**
10	6	5	Hypomagnesaemia
10	6	6	Metabolic alkalosis/acidosis
10	6	7	Respiratory alkalosis/acidosis
10	6	8	Volume excess
10	**7**		**Other metabolic and endocrine**
10	7	1	Gynaecomastia
10	7	2	Galactorrhoea
11			**Renal & Genito-Urinary**
11	**2**		**Renal Diseases**
11	2	1	Acute/chronic renal failure
11	2	2	Glomerulonephritis
11	2	3	Nephrotic syndrome
11	**3**		**GU Infectious/Inflammatory Conditions**
11	3	6	Pyelonephritis
11	**4**		**Renal/GU Neoplastic Diseases**
11	4	1	Bladder carcinoma
11	4	2	Prostate carcinoma
11	4	3	Renal cell carcinoma
11	4	4	Testicular carcinoma
11	4	5	Wilms tumour
11	**5**		**Other GU Tract Problems**
11	5	4	Incontinence
11	5	5	Cryptorchidism
11	5	6	Hydrocoele/varicocoele
11	5	7	Nephro/urolithiasis
11	5	8	Paraphimosis/phimosis
11	5	9	Testicular torsion
12			**Skin**
12	**1**		**Eczematous Eruptions**
12	1	8	Actinic keratosis
12	**2**		**Papulosquamous Diseases**
12	2	6	Dermatophyte infections
12	2	7	Lichen planus
12	**5**		**Viral Diseases**
12	5	6	Condyloma acuminatum

Conditions in category 1B			
12			**Skin** *(continued)*
12	**6**		**Bacterial Infections**
12	6	3	Erysipelas
12	**10**		**Vesicular Bullae**
12	10	1	Bullous pemphigoid
12	**11**		**Desquamation**
12	11	1	Stevens-Johnson syndrome
12	11	2	Erythema multiforme
12	11	3	Toxic epidermal necrolysis
12	**12**		**Dermal Neoplasia**
12	12	1	Basal cell carcinoma
12	12	2	Melanoma
12	12	3	Squamous cell carcinoma
12	**13**		**Other Dermatological Conditions**
12	13	7	Acanthosis nigricans
13			**Haematological**
13	**1**		**Anaemias**
13	1	4	Aplastic anaemia
13	1	5	Sickle cell anaemia
13	**2**		**Coagulation Disorders**
13	2	2	Idiopathic thrombocytopenic purpura
13	2	3	Thrombotic thrombocytopenic purpura
13	2	4	Von Willebrand's disease
13	2	5	Factor VIII disorders
13	2	6	Factor IX disorders
13	2	7	Factor XI disorders
13	2	8	Thrombocytopenia
13	2	9	Thalassaemia
13	**3**		**Haematological Malignancies**
13	3	1	Acute/chronic lymphocytic leukaemia
13	3	2	Acute/chronic myelogenous leukaemia
13	3	3	Lymphoma
13	3	4	Multiple myeloma
13	3	5	Polycythaemia
13	3	6	Leucopaenia

Conditions in category 1B			
14			**Sexual Health**
14	**2**		**Infertility**
14	2	1	Infertility advice
14	**3**		**Sexual Dysfunction**
14	3	2	Female sexual dysfunction
14	**5**		**Sexual assault**
14	**6**		**Bacterial Disease**
14	6	1	Chlamydia
14	6	2	Gonococcal infections
14	**7**		**Spirochetal Disease**
14	7	1	Syphilis
14	**8**		**Viral Disease**
14	8	1	Human papillomavirus infections
14	8	2	HIV infection
15			**Infections**
15	**1**		**Fungal Disease**
15	1	2	Cryptococcosis
15	1	3	Histoplasmosis
15	1	4	Pneumocystis
15	**3**		**Parasitic Disease**
15	3	3	Amoebiasis
15	3	4	Malaria

Conditions in category 2A

Definition: Once the condition has been diagnosed, either by their supervising doctor or a clinical specialist, the MCP is able to manage the condition without routine referral.

1			**Mental Health**
1	**1**		**Mood Disorders**
1	1	4	Dysthymic disorder
2			**Cardiovascular**
2	**4**		**Vascular Diseases**
2	4	8	Giant cell arteritis
2	**6**		**Ischaemic Heart Disease**
2	6	4	Angina pectoris: *Stable*
5			**Musculoskeletal**
5	**1**		**Disorders of the Shoulder**
5	1	4	Rotator cuff disorders
5	1	5	Subluxation
5	**7**		**Rheumatological Conditions**
5	7	1	Pseudogout
5	7	2	Rheumatoid arthritis
5	**10**		**Other Musculoskeletal conditions**
5	10	5	Vitamin D deficiency
5	10	6	Iatrogenic
9			**Neurological**
9	**4**		**Seizure Disorders**
9	4	3	Partial or partial complex seizures
9	**7**		**Infectious/inflammatory disorders**
9	7	6	Lyme
10			**Endocrine & Metabolic**
10	**3**		**Lipid Disorders**
10	3	2	Hypertriglyceridaemia
10	**4**		**Diseases of the Adrenal Glands**
10	4	2	Cushing's syndrome

Conditions in category 2B

The MCP is able to undertake the day to day management of the patient and condition once the diagnosis and strategic management decisions have been made by another.

1			**Mental Health**
1	**6**		**Psychoses**
1	6	2	Delusional disorder
1	6	3	Schizoaffective disorder
1	**7**		**Personality Disorders**
1	7	4	Avoidant
1	7	5	Borderline
1	7	6	Histrionic
1	7	7	Narcissistic
1	7	8	Schizoid
1	7	9	Schizotypal
1	**8**		**Other mental health disorders**
1	8	1	Autistic disorder
1	8	2	Somatoform disorders
2			**Cardiovascular**
2	**7**		**Cardiomyopathy**
2	7	1	Dilated
2	7	2	Hypertrophic
2	7	3	Restrictive
2	**8**		**Congenital Heart Disease**
2	8	1	Atrial septal defect
2	8	2	Ventricular septal defect
2	8	3	Coarctation of aorta
2	8	4	Patent ductus arteriosus
2	8	5	Tetralogy of Fallot
2	**9**		**Valvular Disease**
2	9	5	Mitral valve prolapse
3			**Respiratory**
3	**1**		**Infectious Respiratory Disorders**
3	1	11	Fungal pneumonias
3	1	12	HIV related pneumonias
3	1	13	Tuberculosis
3	**2**		**Obstructive Pulmonary Disease**
3	2	2	Bronchiectasis
3	2	3	Cystic fibrosis
3	**3**		**Restrictive Pulmonary Disease**
3	3	1	Idiopathic pulmonary fibrosis
3	3	2	Pneumoconiosis
3	3	3	Sarcoidosis

Conditions in category 2B			
3			**Respiratory** *(continued)*
3	**4**		**Pulmonary Circulation**
3	4	3	Pulmonary hypertension
3	**6**		**Neoplastic Pulmonary Disease**
3	6	3	Carcinoid tumours
3	6	4	Pulmonary nodules
3	6	5	Vasculitis
3	**8**		**Acute and chronic ventilatory failure**
4			**Gastro-Intestinal**
4	**1**		**Oesophagus**
4	1	6	Motor disorders
4	**2**		**Stomach**
4	2	6	Pyloric stenosis
4	**3**		**Small Intestine/Colon**
4	3	10	Inflammatory bowel disease
4	**6**		**Liver**
4	6	3	Hepatic neoplasms
4	**7**		**Pancreas**
4	7	2	Chronic pancreatitis
4	7	3	Pancreatic neoplasms
4	**9**		**Other GI Disorders**
4	9	7	Intra-abdominal abscess
5			**Musculoskeletal**
5	**2**		**Disorders of the Forearm/Wrist/Hand**
5	2	10	Fractures/dislocations
5	2	11	*Boxer's*
5	**3**		**Disorders of Back/Spine**
5	3	7	Spinal stenosis
5	3	8	Cauda equina
5	3	9	Ankylosing spondylitis
5	**7**		**Rheumatological Conditions**
5	7	3	Reiter's syndrome
5	7	4	Polyarteritis nodosa
5	7	5	Polymyositis
5	7	6	Scleroderma
5	7	7	Sjogren's syndrome
5	7	8	Juvenile rheumatoid arthritis
5	7	9	Systemic lupus erythematosus
5	**9**		**Musculoskeletal Neoplastic Disease**
5	9	1	Back/Neck pain/Injury – oncological
5	9	2	Bone cysts/tumours
5	9	3	Osteosarcoma

Conditions in category 2B			
6			**Eye**
6	**1**		**Eye Disorders**
6	1	30	Hyphaema
6	1	31	Neuromuscular – myasthenia gravis: LEMS
6	1	32	Myopathic
6	1	33	Cranial nerve (III,IV,VI)
7			**Ear, Nose and Throat**
7	**4**		**ENT Neoplasm**
7	4	1	Acoustic neuromas
7	4	2	Nasopharyngeal and oral cancers
8			**Female Reproductive**
8	**1**		**Uterus**
8	1	4	Endometriosis/adenomyosis
8	1	5	Leiomyoma
8	1	6	Endometrial cancer
8	**2**		**Cervix**
8	2	4	Incompetent
8	2	5	Carcinoma Cervix
8	**7**		**Complicated Pregnancy**
8	7	12	Foetal distress
8	7	13	Gestational trophoblastic disease
8	7	14	Molar pregnancy
8	**9**		**Toxic shock syndrome**
8	**10**		**Ovarian neoplasms**
9			**Neurological**
9	**1**		**Diseases of Peripheral Nerves**
9	1	3	Guillain-Barre syndrome (Acute IDP)
9	1	4	Chronic IDP
9	**2**		**Movement Disorders**
9	2	6	Huntington's disease
9	2	7	Parkinson's plus
9	2	8	Young onset movement disorders
9	**6**		**Vascular Diseases**
9	6	2	Vasculitis
9	**7**		**Infectious/inflammatory disorders**
9	7	7	Prion disease
9	7	8	Whipple's
9	7	9	Tropical disease

Conditions in category 2B			
9			**Neurological** *(continued)*
9	**8**		**Other Neurological Conditions**
9	8	15	Myasthenia gravis
9	8	16	Cerebral Palsy
9	8	17	Sarcoid
10			**Endocrine & Metabolic**
10	**5**		**Diseases of the Pituitary Gland**
10	5	1	Acromegaly
10	5	2	Diabetes insipidus
10	**7**		**Other metabolic and endocrine**
10	7	3	Phaeochromocytoma
11			**Renal & Genito-Urinary**
11	**2**		**Renal Diseases**
11	2	4	Polycystic kidney disease
11	2	5	Vasculitis
12			**Skin**
12	**1**		**Eczematous Eruptions**
12	1	9	Dyshidrosis
12	1	10	Lichen simplex chronicus
13			**Haematological**
13	**1**		**Anaemias**
13	1	6	G6PD deficiency
13	1	7	Haemolytic anaemia
15			**Infections**
15	**2**		**Bacterial/Mycobacterial Disease**
15	2	5	Tetanus
15	2	6	Cholera
15	2	7	Diphtheria
15	2	8	Botulism
15	2	9	Atypical mycobacterial disease
15	**3**		**Parasitic Disease**
15	3	5	Toxoplasmosis
15	**4**		**Viral Disease**
15	4	10	Rabies
15	4	11	Cytomegalovirus infections

Appendix 2: Summary of questions asked in document

Question 1 (page 8)
Do you believe that the practitioner should have access to a prescribing formulary identical to that of their supervising physician to be used within local agreed guidelines?

Question 2 (page 18)
What are your views on the proposed standard of proficiency as set out in the preceding sections, which focus on competence, procedural skills and core clinical conditions, in terms of the level at which the practitioner will practice upon registration?

Question 3 (page 24)
Would you agree that there should be a period of 'probationary practice' post academic qualification and prior to formal registration as an MCP?

Question 4 (page 24)
If you agree that there should be this period, how long should it be and what should be the outcomes?

Question 5 (page 24)
During this period would you agree that the practitioner should have their own caseload?

Question 6 (page 24)
During this period would you agree that the MCP should be able to refer on to other practitioners including hospital consultants, therapists and other specialist medical services?

Question 7 (page 26)
Would you agree that arrangements need to be put in place to assimilate practitioners who meet the competences of the MCP into the regulatory process?

Question 8 (page 26)
Who should be responsible for this?

Question 9 (page 26)
Do you think that the above proposals regarding the APEL process provide sufficient protection for public safety whilst not being too restrictive?

Question 10 (page 30)
What are your views on the proposal for a single national assessment for the profession?

Question 11 (page 30)
The assessment of professional examinations through either an examination board or a professional body is the usual route prior to regulation. However on becoming part of a statutory register there is a requirement for qualifications to be independently assessed and quality assured and therefore requires professional body examinations to be embedded within the HEI sector. Should the regulator be the sole assessor of educational programmes?

Question 12 (page 30)
The steering group members who have written this document have the combined expertise to validate educational programmes for the role in the interim period. What are your views?

Question 13 (page 31)
Periodic re-registration through the passing of a re-accreditation examination is a relatively new process for healthcare professions. Do you forsee any issues with the introduction of this process?

Question 14 (page 31)
What are your views on compulsory periodic re-assessment?

Question 15 (page 31)
Do you have any suggestions regarding how this periodic re-assessment will be funded whilst remaining independent?

Question 16 (page 33)
This list is not exhaustive, but do you think that there is a core theoretical knowledge area that is missing?

Question 17 (page 33)
What is your opinion of the weighting that should be given to each core theoretical knowledge area i.e. what are the priority theoretical knowledge areas?

Question 18 (page 34)
Do you think it is appropriate that until the regulatory body is established that the accreditation function be carried out by a panel drawn from the Curriculum Framework and Competence Steering Group, the MCP National Programme Board and participating HEIs?

If not, what alternatives would you suggest?

Question 19 (page 36)
The issue of the eventual title of the role has been contentious. Ultimately the title should be one that the public are able to recognise as a descriptor of the role. The title is not a beauty contest and neither should it be a descriptor of 'rank' in a team. Do you have a suggestion that meets the needs of the patient and one that the profession will be happy to adopt?

Question 20 (page 38)
Do you anticipate that the proposed timeframe is adequate?

Question 21 (page 38)
Have you any further comments regarding the process, the document and the role?

The Competence and Curriculum Framework for the Medical Care Practitioner was developed by a working party with representatives from the following organisations

NHS
National Practitioner Programme

Royal College of General Practitioners

Royal College of Physicians
Setting higher medical standards

Skills for Health

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