SPECIALTY TRAINING CURRICULUM

FOR

REHABILITATION MEDICINE

AUGUST 2010

Joint Royal Colleges of Physicians Training Board

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1 Introduction

Rehabilitation Medicine focuses on the diagnosis and management of disease and its effects on the functioning of the individual. The WHO definition of rehabilitation, approved by the World Health Assembly, (WHA May 2001) is 'The use of all means aimed at reducing the impact of disabling and handicapping conditions and at enabling disabled people to achieve optimal social integration'. RM follows this definition and works using the WHO International Classification of Functioning, Disability and Health (ICF). This framework recognizes the underlying organ structure (pathology) and function (pathophysiology) and the potential for restoring/optimizing personal function or preventing further limitation of activity. It also recognises that the ability to participate depends not only on activities or personal functioning but also on a corresponding number of contextual factors affecting personal life and the individual's environment. The specialty is involved with the prevention and reduction of the disability and handicap arising out of physical impairments and with the medical management of disability from a physical, psychological and vocational point of view. The focus of the specialty is on people with complex disabilities; many of these are younger adults although the expertise of a Rehabilitation Medicine Consultant can often make a contribution to the management of children and of elderly people. The specialty is expert in the management of those disorders which can potentially produce significant disability in the adult. These include neurological conditions, acquired brain injury, spinal cord injury or disease, musculoskeletal disorders, limb amputation and the psychological consequences and complications of these disorders.

The content of the training curriculum reflects the importance of these areas but also makes provision for training in the rehabilitation needs of individuals with a broad range of other disabling long term conditions. This diversity is reflected in the composition of the SAC which, apart from consultant and trainee members of the specialty also comprises representatives from the Neurology, Rheumatology and Paediatrics SACs. The specialist in Rehabilitation Medicine (RM) has a holistic approach to patient care, facilitating self management and working in partnership with the patient to ensure their perspectives, such as the need to work, are reflected in any management plan.

2 Rationale

2.1 Purpose of the Curriculum

The purpose of this curriculum is to define the process of training and the competencies needed for the award of a certificate of completion of training (CCT) in rehabilitation medicine and to be registered on the Specialist Register in Rehabilitation Medicine.

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

Rehabilitation Medicine focuses on the diagnosis, assessment and management of disease and its effects on the functioning of the individual. The curriculum addresses the knowledge, skills, behaviours required to do this using the 4 domains of the Good Medical Practice Framework for Appraisal and Assessment. There is a holistic approach to encompass the person's medical, physical, psychological, social and vocational needs, facilitating self management and working in partnership with the patient to ensure their perspectives, such as the need to work, are reflected in any management plan. The need for such specialists is reflected in the wide range of recent DoH publications on these topics such as the NSF for Long-term Neurological

Conditions (2005) and the Dame Carol Black's report on Working for a Healthier Tomorrow (2008).

The focus of the specialty is on people with complex disabilities, many of whom are younger adults, although the expertise of a Rehabilitation Medicine Consultant can also make a contribution to the management of children and of elderly people. The Consultant in Rehabilitation Medicine will be expert in managing the effects of acquired or congenital brain and spinal cord disease and injury, progressive neurological disorders, musculoskeletal disorders, congenital limb disorders, limb amputation and related symptoms.

The trainee at the end of completion of CCT in Rehabilitation Medicine will be able to work within the domains of 'Good Medical Practice' to take a history, and examine a patient, creating an accurate record of this, with particular reference to individuals with disabling conditions due to acquired, inherited or progressive brain, spinal cord or peripheral neurological disease, amputation and limb disorders, and musculoskeletal disorders. The trainee will be able to confirm or inform the diagnosis and prognosis and prescribe appropriately and safely a range of therapeutic interventions.

The trainee will be able to assess and record the common psychological disorders, psychosocial and behavioural consequences commonly seen in disabling disorders, and also the corresponding contextual factors that influence activity and participation. The trainee will be able to formulate a management plan that respects and includes the patient and addresses these factors. The trainee will be able to coordinate the care of individuals with disabling conditions in a wide range of settings from the acute hospital environment to the individual's home in the community. This requires knowledge of the different disability concepts including the ICF (WHO), disability legislation including the Disability Discrimination Act, the Mental Capacity Act, the professional standards for rehabilitation services developed and published by BSRM and the rights and expectations of people with disabling disorders and their representatives in the voluntary sector.

The trainee will have the knowledge and skills to promote the health and wellbeing of people with disability, and will be aware of and understand the social and cultural factors which influence disability and their impact on the rehabilitation process.

The trainee will have the knowledge and skills necessary to work with rehabilitation teams in different settings, and within and across health, social and community based organisations. The trainee will have developed leadership skills such that they can deliver, manage and develop a rehabilitation service. These leadership skills are seen as key, without which trainees will be unable to take up a consultant role.

2.2 Development

The curriculum was developed by a curriculum committee representing both the Specialty Advisory Committee Medicine under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB), the British Society of Rehabilitation Medicine, and the British Association of Spinal Cord Injury Surgeons. The members of this committee were selected as an expert group of senior trainers who represented the four specialty areas contained with rehabilitation medicine; amputee, musculoskeletal, spinal injury and neurological rehabilitation. It was subsequently reviewed by (a) the SAC in rehabilitation medicine including a lay representative, and a trainee representative, (b) a small sub group of trainees.

It replaces the previous version of the curriculum dated May 2007 with changes to ensure the curriculum meets GMC's standards for Curricula and Assessment, and to incorporate revisions to the content and delivery of the training programme. Major changes from the previous curriculum include the incorporation of common, leadership and health inequalities competencies. In addition advanced competencies are listed. Trainees must obtain advanced competences in one of the four specialty areas and these should reflect the settings in which their training takes place (c.f. section 2.4.)

2.3 Entry Requirements

Entrants to specialist training in rehabilitation medicine must have successfully completed Core Medical Training including the MRCP(UK) examination, Core surgical training including the MRCS examination, core psychiatry training including MRCPsych or General Practice specialty training including MRCGP. Current specialists in RM have had diverse basic specialty training in either medical, surgical, psychiatric or general practice, and the intention is to continue to recruit medical practitioners from a wide background of expertise.

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

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

The curriculum describes the level of achievement expected from each of the years of training and how competency is attained and assessed.

2.4 Duration of Training

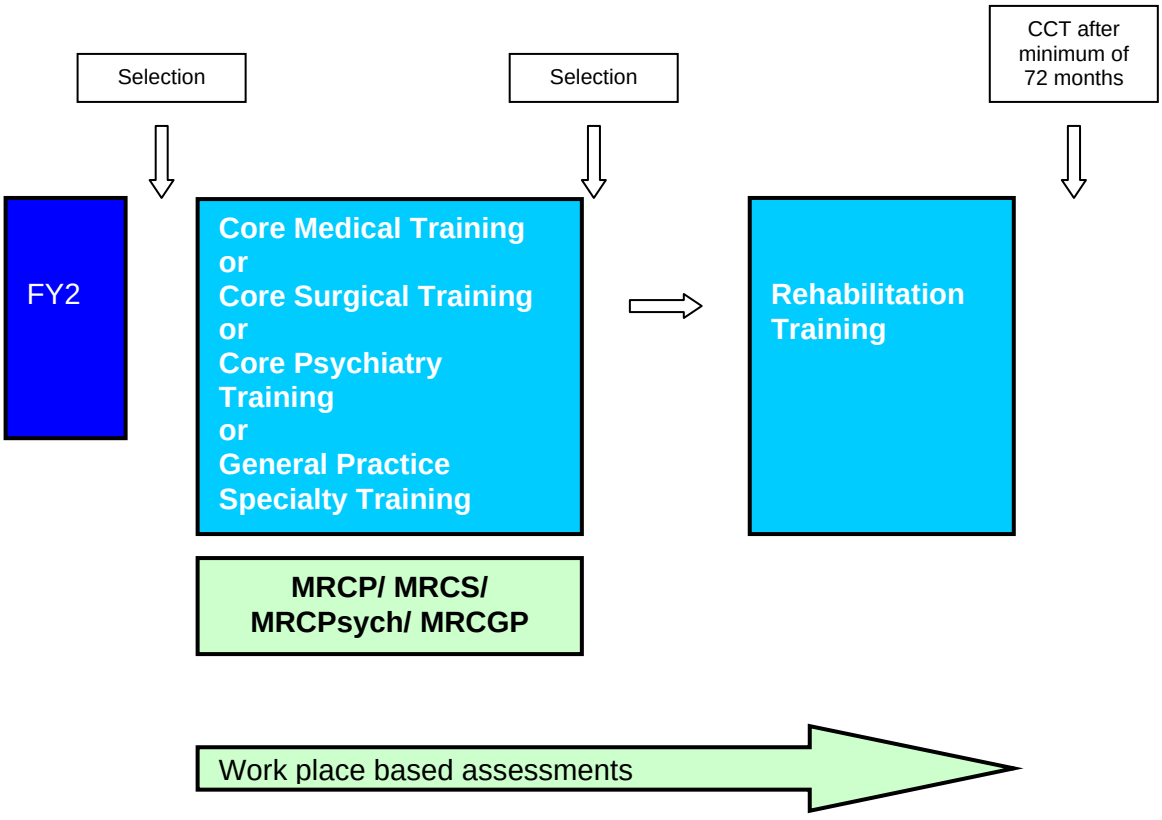
Although this curriculum is competency based, the SAC has advised that training from ST1 will usually be completed in 6 (SIX) years in full time training (2 years core plus 4 years specialty training).

The curriculum document of January 2007 recommends minimum length of training in the different modules that constitute RM expertise and at present those are being observed. Longer periods of time in some modules are required for practising as a consultant with that special interest. Basic requirements include at least 12 months in Neurorehabilitation, 6 months in musculoskeletal medicine, 3 months in spinal injuries, 3 months in prosthetics, orthotics, special seating. The remaining 24 months is spent in a range of rehabilitation environments addressing both generic and specialist training requirements across the curriculum. Those doctors wishing to practise with a special interest in neurorehabilitation will require at least 24 months, spinal injuries at least 36 months, prosthetics, orthotics and special seating will require at least 12 months experience in that specialist area, and to acquire

advanced competencies in that specialist area. cf. section 2.2. Common skills are addressed throughout the 48 month training programme, and include working with other disciplines, and services and across organisational boundaries, as well as defining the skills and behaviours trainees need to work with patients who as well as experiencing physical disability often have cognitive and communication difficulties and the consequent emotional distress.

Run-through training and competency based training will influence length of training for some trainees outside these recommendations. The SAC will continue to advise, moderate and be accountable for these decisions through its educational role.

The minimum period of higher specialty training in RM is four years and is based on experiential learning. It is recognised that some recruits may take longer to complete the curriculum and achieve the required level of competencies, depending on their previous background medical experience.



2.5 Less Than Full Time Training (LTFT)

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

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

The above provisions must be adhered to. LTFT trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours

commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

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

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

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed during annual appraisal by their TPD and chair of STC and Deanery Associate Dean for LTFT training. As long as the statutory European Minimum Training Time (if relevant), has been exceeded, then indicative training times as stated in curricula may be adjusted in line with the achievement of all stated competencies**.**

2.6 Dual CCT

Trainees may wish to dually train and accredit in rehabilitation medicine and neurology or rheumatology to achieve two CCTs. In this case they must have applied for and successfully entered a training programme which was advertised openly as a dual training programme. Trainees will need to achieve the competencies as described in both curricula and there must be jointly agreed assessments (proposed by both SACs in rehabilitation medicine and neurology or rheumatology, and approved by GMC). Postgraduate deans wishing to advertise such programmes should ensure that they meet the requirements of both SACs.

3 Content of Learning

3.1 Programme Content and Objectives

The trainee will follow the specialty training curriculum, which includes common competencies. The specialty curriculum identifies competencies which are expressed as the knowledge, skills, attitudes and behaviours that trainees must achieve.

The trainee in RM follows a modular training programme which addresses four main areas of practice which include (1) Neurorehabilitation (2) Spinal Injuries (3) Amputee or Prosthetic medicine and Orthotics (4) Musculoskeletal medicine. All trainees are required to achieve competencies in all these areas but may opt to specialise in one or other area by opting to acquire higher level competencies in their chosen area. This is achieved by focussing a greater part of their experiential training programme in these areas. Minimum periods of training for acquiring these special interests are described in section 2.4 Duration of training.

The modules detailed below may be studied concurrently or sequentially, though most training programmes offer sequential experience. The order of module exposure is not fixed although individual trainee needs are usually taken into account when a new trainee is accepted onto a training programme. This usually allows for a high level of supervision in the early years and at the beginning of every module, with a gradual titration downwards of amount of supervision so that eventually each

trainee has the experience of managing patients independently within a supervised environment (sees how, knows how, and does).

3.2 Good Medical Practice

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

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

The competences needed for a CCT in rehabilitation medicine are set out under these four headings

3.3 Syllabus

The tables below are laid out under the four domains of Good Medical Practice. The "Assessment Methods" shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed and that where they are assessed not every method will be used. See section 5.2 for more details.

This specialty curriculum includes common competencies which apply to all 28 physicianly specialties. The common competencies follow the headings of good medical practice and run through from core training to CCT. Common competencies are required at all stages of training.

Where there is a * in the syllabus this competency will be assessed, in the future, by a knowledge-based assessment method. Please see section 5.3 for further details.

Syllabus Contents

DOMAIN 1. KNOWLEDGE, SKILLS AND PERFORMANCE

Attribute: Maintain Professional Performance

To Maintain Knowledge of the Law and Other Regulation Relevant to Practice

The trainee can work within the frameworks offered by law

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of the legislation required to practice safely and effectively, including: • Provision of services through the NHS, Local authorities, departments of social security, transport, housing and other departments relevant to the lives with people with disability • Aspects of disability including the DDA and its relevance to employment, driving legislation, court of protection, living will, minimal awareness states and medico-legal reports. • Equal opportunities legislation • An awareness of the different legal frameworks operating in the various countries of the UK • The requirements of the DVLA • Mental capacity bill 2005 • Be familiar with and uphold the rights of children and vulnerable adults	CbD, *
Skills	
The trainee is able to consistently and safely: • Provide accurate advice to patients and colleagues about their rights and responsibilities with regard to person with a disability and their carers • Understand and interpret relevant legislation and accountability frameworks	CbD, mini-CEX, MSF
Behaviours	
The trainee consistently: • Shows respect for the law • Acts within the law at all times • Demonstrates a positive attitude to decision making within a legal framework and is prepared to seek advice when necessary • Act with appropriate professional and ethical conduct in challenging situations	CbD

To Keep Knowledge and Skills Up-To-Date

The trainee can maintain good clinical practice

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of: • The importance of CPD • The obligations imposed on doctors by the GMC • Ethical aspects of rehabilitation medicine including resource allocation, selection for	CbD, *

treatment, withdrawal of treatment in progressive disability and in minimally aware states • Organisation within the medical profession, including the roles of the GMC, Royal Colleges, JCHMT and SAC/GMC BMA and specialist societies both for physicians and other professions involved in rehabilitation	
Skills	
The trainee can: • Identify gaps in knowledge and plan actions to fill them • Translates knowledge and new learning into practice • Maintains a portfolio of CPD	CbD, mini-CEX, MSF
Behaviours	
The trainee consistently: • Demonstrates an awareness of the responsibilities of doctors • An understanding of the ethical framework within which decisions are made • Respect for how others ethical, moral or religious frameworks inform their decision making • Is eager to reflect on his/her own learning to improve his/her skills • Is able to accept and act upon feedback • Demonstrates a commitment to CPD and life long learning • Shows respect for his/her trainer, the Postgraduate Dean and the Royal College of Physicians • Actively seeks opportunities and challenges for personal learning and development • Are honest about mistakes and treats them as learning opportunities • Change their behaviour in the light of feedback and reflection • Look to the future by scanning for ideas, best practice and emerging trends that will shape the system • Develop and communicate aspirations	CbD MSF

To Apply Best Available Evidence to Patient Care

The trainee is able to critically appraise scientific, clinical and sociological research literature	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • Quantitative research including design of randomised control trials and CONSORT guidelines • Qualitative research including an understanding of theoretical approaches and data analysis • Principles of statistics, both parametric and non parametric • Psychometric principles of measurement • The management skills to incorporate research findings into clinical practice • Clinical guidelines relevant to rehabilitation medicine	CbD, *
Skills	
The trainee is able to consistently and safely: • Evaluate scientific, clinical and sociological papers, reviews reports and meta-analyses critically	TO

• Prepare reviews for relevant journals on scientific, clinical and sociological papers	
Behaviours	
The trainee consistently: • Actively seeks to apply the best available evidence to patient care and encourages others to do • The trainee shows a commitment to life-long learning and evidence based clinical practice • Use information to challenge existing practices and processes • Influence others towards innovation and change	MSF

To Evaluate Interventions and Services

The trainee is able to complete a clinical audit study from the planning to final report stage	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • Quantitative research including design of randomised control trials and CONSORT guidelines • Qualitative research including an understanding of theoretical approaches and data analysis • Principles of statistics, both parametric and non parametric • Psychometric principles of measurement (cf. NR 2.2) • The principles and practice of research governance including data protection • The structure of LREC and MRECs • Importance of informed consent in accordance with Declaration of Helsinki • International Conference on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use (**ICH**) Good Clinical Practice guidelines • Audit theory and practice	AA
Skills	
The trainee is able to consistently and safely: • Design and write a comprehensive study protocol using standard headings • Complete ethics and trust R&D forms if necessary • Recruit, and consent study subjects • Collect data and store it appropriately • Analyse data appropriately • Prepare written and verbal reports • Explain implications for practice and steps required to incorporate any changes deemed necessary as a result of the study • Obtain and act on patient / service user feedback and experience • Assess and analyse processes using up-to-date improvement methodologies • Identify healthcare improvements and create solutions through collaborative working • Appraise options, plan and take action to implement and evaluate improvements • Build learning from experience into future plans	AA
Behaviours	

The trainee consistently: • Recognises the importance of, and displays enthusiasm towards, the advancement of research within rehabilitation • Is supportive of the research efforts of others • Is realistic about the benefits and challenges of rehabilitation research and is usually supportive of research within his/her area of work • Undertake analysis against an evidence based criteria set • Analyse information from a range of sources about performance • Take action to improve performance and reputation • Take responsibility for tackling difficult issues	AA

To Present Both Orally and in Written Form

The trainee is able to present research/audit study results orally and in written form	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • Use of word processing packages • Use of PowerPoint to produce slides and posters	AA
Skills	
The trainee is able to consistently and safely: • Design a presentation using power point or similar package, • Prepare a poster using PowerPoint or similar package following BSRM guidelines • Write a paper using standard formats including an awareness of the role of structured abstracts, methodological headings, and structured discussion • Present research findings in a formal setting. • Teach others effectively	AA, TO
Behaviours	
The trainee consistently: • Is aware of the importance of reporting audit and research findings and is committed to doing so • Is supportive of others who are reporting audit and research findings	AA

Attribute: Apply Knowledge and Experience to Practice

To Apply the Skills, Attitudes and Practice of a Competent Teacher/Trainer

The trainee can teach in a multidisciplinary setting including when patients are present

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of: • The principles of effective teaching in a range of settings, lecture theatre, small group, bedside teaching	TO
Skills	
The trainee is able to: • Teach undergraduate and postgraduate doctors and allied health professionals • Develop teaching plans with appropriate learning objectives • Supplies supporting materials • Encourages formal feedback	TO
Behaviours	
The trainee consistently: • Recognises and fulfils their obligation to teach and train others • Recognises the benefits of peer review	MSF

To Make an Adequate Assessment of the Patient's Condition

The trainee is able to take a history from individuals with disabling conditions, with particular reference to long term neurological conditions, spinal injury, musculoskeletal disorders and amputation & limb deficiencies

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Epidemiology of the range of disabling disorders including those related to: o The nervous system including head injury, stroke, Parkinson's disease and other movement disorders, multiple sclerosis and other demyelinating disease, motor neurone disease, traumatic and non-traumatic spinal cord injury, Guillain-Barre syndrome, neuropathies, cerebral palsy, o The spinal cord including both traumatic and non-traumatic disorders of the spine o The musculoskeletal system including rheumatoid disease, the spondyloarthritides, osteoarthrosis, soft tissue rheumatism, spinal disorders, osteoporosis, and congenital & acquired disorders of muscle o Acquired amputations and NASDAB o The vascular system that determine the development of peripheral vascular disease o Common psychological disorders particular those frequent in disabling disorders o Developmental disorders o Survivors of multiple trauma • Aetiology of the range of disabling disorders	CbD, *

Skills	
The trainee consistently takes a history effectively by: • Respecting the individuals privacy, dignity, wishes and beliefs and obtaining informed consent wherever appropriate • Providing support and information to the individual throughout the assessment • Identifying premorbid levels of functioning • Identifying the most appropriate assessment to use, including when to take a psychiatric history • Ensuring that the symptoms being presented by the individual have been fully addressed	mini-CEX
Behaviours	
The trainee: • Fully addresses patients concerns, expectations and ideas • Respects patient confidentiality • Maintains cultural awareness and identity • Values patient comprehension • Works to minimise the perceived stigma associated with mental health problems • The trainee consistently reflects on his/her personal response to unusual behaviours and recognises the need to reflect on the framework by which one makes judgements	mini-CEX

To Make an Adequate Assessment of the Patient's Condition

The trainee is able to examine individuals with disabling conditions, with particular reference to long term neurological conditions, spinal injury, musculoskeletal disorders and amputation & limb deficiencies

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of the • Pathophysiology of various specific impairments including cardiac dysfunction, respiratory failure, spasticity, ataxia, LMN weakness, dysphagia, disorders of speech and language, cognitive dysfunction including perception, memory, attention, concentration, sequencing, planning and executive functions, sensory impairment due to visual and hearing loss, neuropsychological dysfunction, bladder and bowel dysfunction, sexual dysfunction and infertility, • Pathophysiology features of diseases bones, joints and the spine including and understanding of normal and abnormal movement, including biomechanics, kinetics and kinematics. • Pathophysiology and clinical features of wound breakdown, osteomyelitis, infection, haematoma, deep vein thrombosis and ischaemia • Pathophysiology and clinical features of dermatitis, psoriasis, terminal congestion, corns and bursitis in the context of an amputated limb • Pathophysiology and clinical features of somatic, referred, ischaemic, and neuropathic pain, complex regional pain syndrome and fibromyalgia • Describe the usual level of mobility and function with different levels of amputation amongst patients who are otherwise in good health	CbD, *
Skills	
The trainee consistently examines effectively by:	mini-CEX

• Respecting the individuals privacy, dignity, wishes and beliefs and obtaining informed consent wherever appropriate • Examining the patient comprehensively and accurately exercising good judgement in the selection of examination techniques • Identifies functional limitations accurately • Identify normal and abnormal wound healing • Identify stump problems in an amputated limb, including identifying when stump swelling is part of a generalised disorder and when it is localised, and identifies the contribution of socket to the stump problem in uncomplicated transtibial or more distal amputation • Identifies problems with socket fit, suspension, alignment, length and type of components. • Identifies problems due to localised stump problem e.g. neuroma and infection. • Identifies vascular and cord claudication, arthritis. • Identifying prognostic factors including anticipated length of stump, quality of skin cover, range of joint movements for those patients with limb loss	
Behaviours	
The trainee: • Respects a patients dignity, cultural background and other beliefs • Recognises the importance of patient consent	mini-CEX, MSF

Principles of Diagnosis

The trainee is able to make a diagnosis and provide prognostic information for individuals with disabling conditions, with particular reference to long term neurological conditions, spinal injury, musculoskeletal disorders and amputation & limb deficiencies	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of the: • Diagnostic features of the range of disabling disorders including the clinical features of common cognitive deficits, including attention, executive function, memory, language, and spatial disorders, including the common patterns of these disorders and the behavioural consequences of these deficits • A knowledge of the anatomy and surface landmarks of major joints and soft tissue structures • Different types of surgical amputation • Range of behaviours seen in patients with brain injury both in the acute, post acute and long term • Prognosis and prognostic features of the range of disabling disorders • Mechanisms of recovery, neural plasticity, learning and skill acquisition • Influence of psychological factors	CbD, *
Skills	
The trainee consistently makes an accurate diagnosis by: • Identifying the factors that contribute to the patients symptoms • Proposing a differential diagnosis and most likely diagnosis • Discussing the diagnosis with the individual • Arranging further investigation and assessment as appropriate	mini-CEX

• Providing information about the nature of investigations and further assessment to the patient • Give an appropriate prognosis for the range of disabling disorders, including neurological, spinal cord , musculoskeletal disorders and limb loss	
Behaviours	
The trainee • Works to adapt their communication style to the needs of the patient	mini-CEX, MSF

To Provide or Arrange Advice, Investigations or Treatment as Necessary

The trainee is able to provide or arrange investigations where necessary	
Knowledge	**Assessment Methods**
The trainee consistent demonstrates a knowledge of the: • Performance and interpretation of a range of common neuro-physiological, neuro-radiological and neuro-psychological tests • Common laboratory, imaging and other diagnostic tests in the diagnosis of bones, joints and other connective tissues • The range of tests available to evaluate cognitive disorders • Methods of investigation for somatic, referred, ischaemic, and neuropathic pain, complex regional pain syndrome and fibromyalgia	CbD, *
Skills	
The trainee • Arranges further investigation and assessment as appropriate • Provides information about the nature of investigations and further assessment to the patient • Reviews the results of investigations, interprets and records the results, acts upon and imparts them to the individual in a timely fashion including interpreting cognitive assessments and explaining their implications for the rehabilitation process, the patients and their family	CbD
Behaviours	
The trainee • Recognises the importance of reviewing investigations in a timely manner • Recognises the importance of communicating results to patients clearly and promptly	CbD

To Prescribe Drugs or Treatment, Safely and Appropriately

The trainee is able to prescribe appropriately and safely a range of interventions for individuals with disabling conditions, with particular reference to long term neurological conditions, spinal injury, musculoskeletal disorders and amputation & limb deficiencies	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • Management of acute spinal cord injury • Both pharmacological and non-pharmacological treatment options for the range of disabling disorders including • Neurological disorders such as head injury, stroke, Parkinson's disease and other	CbD, *

movement disorders, multiple sclerosis and other demyelinating disease, motor neurone disease, traumatic and non-traumatic spinal cord injury, Guillain-Barre syndrome, neuropathies, cerebral palsy

- Musculoskeletal disorders including inflammatory and non-inflammatory connective tissue disorders, diseases of bone (particularly osteoporosis), muscle (congenital and acquired) and tendon.
- Non-pharmacological treatment options for disabling disorders include role of surgery education, self management, occupational therapy, physiotherapy, exercise and rest, safe injection techniques, biomechanical modalities such as prosthetics, orthotics and splinting, assistive devices and environmental adaptation
- Management approaches for specific impairments including spasticity, ataxia, LMN weakness, sensory impairment due to visual and hearing loss, neuropsychological dysfunction including behavioural disturbance, bladder and bowel dysfunction, sexual dysfunction and infertility, dysphagia, disorders of speech and language, feeding difficulties, neurogenically disturbed respiratory function, cognitive dysfunction including perception, memory, attention, concentration, sequencing, planning and executive functions
- Long term management approaches for specific impairments including spasticity, respiratory failure and need for long term ventilation, pain, pressure sores, contractures, limb and spinal deformity.
- Different types of prostheses and their function
- Different types of orthotics and their application
- Different treatment options and resources; both drug and non-drug, available for such psychiatric disorders, and cognitive deficits (including post traumatic amnesia)
- Benefits and limitations of counselling approaches
- Expert patient programme
- Common approaches used to manage abnormal behaviours
- Provisions of the mental health act and mental capacity bill 2005

Skills

The trainee is able to: CbD, mini-CEX

- Identify the therapeutic interventions that are available and explain those to the individual and, if appropriate, those involved in their care
- Prescribe medication appropriately, informing the patient about risks and benefits accurately
- Select appropriate components and socket design for uncomplicated transtibial amputation, and identify problems with length, alignment, socket fit, suspension and components at delivery
- Treat dermatitis, psoriasis, terminal congestion, corns, bursitis and excess sweating in the context of an amputated limb
- Treat somatic, referred, ischaemic, and neuopathic pain, complex regional pain syndrome and fibromyalgia
- Agree the delivery of therapeutic interventions, including if appropriate operative treatment, that takes account of the needs of the individual and all other relevant factors
- Schedule the delivery of therapeutic interventions as agreed with the individual
- Confirm the delivery of therapeutic interventions with all relevant practitioners and agencies
- Establish when the effect of the therapeutic intervention will be reviewed
- Identify patients who pose a threat to themselves and take appropriate action
- Refer on to appropriately both to psychiatrists and to others who provide

psychological support such as psychotherapists, clinical psychologists, counsellors, or other professionals such as social workers or community psychiatric nurses • Choose the most appropriate approach to managing a person with a cognitive disorder or a behavioural disorder • Work with the multidisciplinary team to identify and implement the most appropriate intervention for an individual with a cognitive disorder	
Behaviours	
The trainee: • Recognises the benefit of minimizing the number of medications taken by a patient • Recognises the importance of communicating complex multidisciplinary treatment plans clearly to all concerned. • Promotes the expert patient programme • Recognises the importance of providing enough information to the patient to allow them to make an informed choice regarding treatment options • Is able to describe sources of advice and support to patients • Recognises the role of a second opinion for both patient and clinician	CbD, mini-CEX

Attribute: Take Steps to Alleviate Pain and Distress Whether or Not a Cure is Available

To Prescribe Drugs or Treatment, Safely and Appropriately

The trainee will understand the social and cultural factors which influence the impact of disability, and their impact on the rehabilitation process

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of: • Causes and effect of societal attitudes to disability and methods of assessing negative attitudes to disability. • Influence of the culture and ethnicity on the impact of disability • The impact of disability on social functioning including housing employment, financial leisure transport and interpersonal relationship	CbD, *
Skills	
The trainee is able to consistently and safely: • Perform a home based assessment of the impact of disease and disability within the home setting. • Liaise with other members of community based professions and provide a joint home based assessment	CbD, mini-CEX
Behaviours	
The trainee consistently: • Appreciates the factors in the community setting which are relevant to pre discharge planning and effective evaluation of long term outcomes of hospital admissions • Appreciates the roles of stigmatisation and psychosocial factors on the individual's coping skills • Appreciates the social and cultural factors which influence individual's coping skills • Recognises how health systems can discriminate against patients from diverse backgrounds and works to minimise this discrimination	CbD

Attribute: Keep Clear, Accurate and Legible Records

To Keep Clear, Accurate and Legible Records of Clinical Findings, Decisions, Information Provided to Patients, Drugs Prescribed and Other Information or Treatment

The trainee is able to keep clear, accurate and legible records of clinical findings, decisions, information provided to patients, drugs prescribed and other information or treatment	
Knowledge	**Assessment Methods**
The trainee consistent demonstrates a knowledge of the: • Freedom of Information Act	*
Skills	
The trainee manages information effectively by: • Keeps contemporaneous, accurate, legible and complete records and comply with all the relevant legal, professional and organisational requirements and guidelines	CbD, mini-CEX
Behaviours	
The trainee: • Takes responsibility for note keeping, referrals, letters and discharge summaries • Recognises the patient safety and medico-legal aspects of poor note keeping • Recognises the importance of confidentiality • Takes responsibility for offering the patient to share written information about themselves	CbD

DOMAIN 2. SAFETY AND QUALITY

Attribute: Put into Effect Systems to Protect Patients and Improve Care

To Take Part in Systems of Quality Assurance and Quality Improvement

The trainee is able to monitor the delivery and outcomes of the rehabilitation programme

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of measurement and evaluation in practice including: • Measures of impairment, activity, participation and quality of life • The roles of disease specific versus generic measures • The distinction between patient based and clinician based outcomes • Basic psychometric concepts such as validity, reliability and responsiveness • Factors affecting the choice of an outcome measure • The development of new measures • Sources of different clinical guidelines • Different examples of audit and evaluation in practice	CbD, *
Skills	
The trainee consistently: • Identifies suitable evaluation methods that are realistic and achievable • Identifies and uses all sources of information about the effectiveness of health care programmes • Consults with all relevant people on the implementation of the health care programmes • Establishes criteria for determining the effectiveness of health care programmes • Assesses the results of health care programmes against specified criteria • Presents the results of the evaluation to all relevant people • Identifies any problems with the health care programmes and identifies potential solutions • Recommends options to improve the effectiveness of health care programmes to the appropriate people	AA
Behaviours	
The trainee • Understands the importance of patient's perspective when measuring outcome1) • Participate in and contribute to organisational decision making processes • Act in a manner consistent with the values and priorities of their organisation and profession • Educate and inform key people who influence and make decisions • Contribute to a clinical perspective to organisation and system decisions • Test and evaluate new service options • Standardise and promote new approaches • Overcome barriers to implementation	AA, PS

- Formally and informally disseminate good practice
- Identifying and quantify risk to patients using information from and range of sources.
- Use evidence to identify options.
- Use systematic ways of assessing and minimising risk
- Monitor the effects and outcomes of change

DOMAIN 3. COMMUNICATION, PARTNERSHIP AND TEAMWORK

Attribute: Communicate Effectively

To Listen to Patients and Respect Their Views About Their Health

The trainee is able to communicate effectively with people with neurological conditions, and those involved in their care

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of: • A knowledge of the pathophysiological basis of dysphasia, articulatory dyspraxia and dysarthria • An understanding of the impact of a range of communication differences and can identify strategies for compensating for and managing these • An understanding of the conditions required for the communication of complex information and bad news	*
Skills	
The trainee is able to consistently communicates effectively by: • Respecting the individuals privacy, dignity, wishes and beliefs and obtaining informed consent wherever appropriate • Ensuring that the environment is appropriate to the communication • Establishing any communication differences with the individual such as language or speech impairment, cognitive impairment, English as a second language, sensory impairment, cultural differences • Confirming with the individual who they wish to be involved in the communication process • Clarifying the purpose of the communication with the individual and those involved in their care, and identify their preferred ways of communicating • Using a range of structures & styles to • Elicit concerns across physical, psychological and social domains • Establish extent of awareness about illness and prognosis • Impart information sensitively according to wishes and needs of individual • Facilitate decision making and promote autonomy in individuals • Identify obstacles to communication and strategies to overcome them • Answering correctly any questions raised by the individual and identify the means of answering any questions that cannot be answered immediately	CbD, mini-CEX
Behaviours	
The trainee consistently demonstrates: • The need for a range of communication skills and reflects on his or her practice to ensure his/her skills are maintained • Communicate openly, honestly and inclusively • Recognise and articulate their own value and principles, appreciating how these may differ from those of other individuals and groups • Identify their own strengths, limitations and the impact of their behaviour • Identify their own emotions and prejudices and understand how these can affect	mini-CEX, MSF

their judgement and behaviour • Obtain, value and act on feedback from a variety of sources

To Work with Patients and a Multidisciplinary Team to Plan a Rehabilitation Programme

The trainee is able to plan and agree the delivery of a multidisciplinary goal-centred rehabilitation programmes	
Knowledge	**Assessment Methods**
The trainee demonstrates a knowledge of: • The rationale, benefits and limitations of goal setting • Different approaches to goal setting • The evaluation of goal setting	CbD, *
Skills	
The trainee consistently: • Works with the individuals and, if appropriate, their families or carers to identify treatment priorities • Identifies and uses all sources of information about the health, and functional abilities of individuals • Clearly identifies the options for addressing ill- health and functional limitations of individuals, including both benefits and risks of each option • Works in partnership with other practitioners and agencies to agree roles and responsibilities for meeting the health needs and functional goals of individuals • Plans the delivery of health care according to the resources available and the impact it will have on the individual • Identify any problems with achieving these plans and resolve them effectively	cCAT, MSF
Behaviours	
The trainee consistently: • Works with the individuals to support self management • Recognises that individuals may make choices that conflict with the physicians value system, reflects on his/her personal response to these choices and recognises the need to reflect on the framework by which one makes judgements • Provide encouragement and opportunity for people to engage in decision-making • Respect, value and acknowledge the roles, contributions and expertise of others • Employ strategies to manage conflict of interests and differences of opinion • Keep the focus of contribution on delivering and improving services to the patients	cCAT, MSF

Attribute: Work Constructively with Colleagues and Delegate Effectively

Time Management

The trainee will be able to manage their time and those of others in the multidisciplinary team effectively

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of: • Simple time management techniques • Simple conflict resolution approaches	CbD, *
Skills	
The trainee is able to consistently and safely: • Delegate appropriately within the multidisciplinary team • Lead the MDT in range of settings demonstrating different approaches to manage conflict • Organise and chair a multidisciplinary case conferences, family meetings and other meetings effectively and efficiently	cCAT
Behaviours	
The trainee consistently: • Recognises when they or the team are struggling and take steps to rectify the situation • Is confident of their ability to lead multi multidisciplinary case conference • Is confident of their ability to organise and chair a family meeting • Manage the impact of their emotions on their behaviour and actions • Are reliable in meeting their responsibilities and commitments to a consistently high standard • Ensure that their plans and actions are flexible, and take into account the needs, requirements and work patterns of others • Plan their workload and activities to fulfil work requirements and commitments with regard to their own personal health	cCAT, MSF

To Provide Effective Leadership

The trainee will be able to co-ordinate the care of individuals with disabling condition

Knowledge	Assessment Methods
The trainee consistently demonstrates a knowledge of: • Differing concepts about disability including the WHO ICIDH, the ICF as well as though advocated by the disability movement • Relevant legislation including the disability discrimination act, and the mental capacity bill • Roles and expertise of the different members of the multidisciplinary team, including the role of the doctor, both professionally and personally defined • The standards for specialist in-patient and community rehabilitation services	CbD, *

published by the BSRM, and the evidence base and rationale for these • The differing needs of patients with acute, chronic and progressive disability at differing stages in their lives	
Skills	
The trainee is able to consistently and safely: • Construct a list of impairments, activity and participation issues following assessment • Work with the MDT and the patient to select the most appropriate form on management • Lead the MDT in range of settings • Work as an advocate on behalf of people with a disability including working across administrative barriers between different service providers to achieve continuity of care • Contribute to the appropriate negotiation of goals, application of resources and review of achievements in different settings • Communicate effectively with patients and relatives • Organise and chair a multidisciplinary meeting • Organise and chair a family meeting	cCAT, MSF
Behaviours	
The trainee consistently: • Respects the wishes and needs of the patients, • Recognises the role of the multidisciplinary team • Values the contribution and expertise of the multidisciplinary team, working with them to develop consistent, fair approaches to management • Negotiates the best outcome for the patient • Is aware of need to search for evidence to support clinical decision making • Work as an advocate on behalf of people with a disability including breaking down administrative barriers between different service providers • Contribute to the appropriate negotiation of goals, application of resources and review of achievements in different settings • Communicate effectively with relatives • Is confident of their ability to lead multidisciplinary case conferences and family meetings • Acts as a positive role model in all aspects of communication • Identify opportunities where working with others can bring added benefits • Create opportunities to bring individuals and groups together to achieve goals • Promote the sharing of information and resources • Actively seek the views of others	CbD MSF

To Manage an Effective Service

The trainee can lead and manage the clinical service and rehabilitation team	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of • The principles of clinical governance including the role of audit, health and safety	CbD, *

and risk management, and the use of information technology to support these processes • Management principles including different styles of leadership, team dynamics, change management, decision making, conflict management, delegation and time management • The process necessary to appoint staff including equal opportunities legislation • Staff development, including personal career plans, appraisal and in service education opportunities and the issues surrounding the introduction of Agenda for Change and the Key Skills Framework	
Skills	
The trainee is able to consistently and safely: • Participate in clinical governance processes including day to day management issues such as organising medical cover rotas, or teaching programmes as well as audit and is able to document such processes • Apply the management principles listed above within the MDT and deal with issues such as change, and conflict positively • Able to participate in appointments panels • Co-operate with colleagues in producing an appropriate personal development plan	CbD MSF
Behaviours	
The trainee consistently: • Values the professional and personal values of staff and their contribution to the MDT • Recognises when an individual within the team needs support • Is aware of the tensions that can exist in MDT • Has insight into his or her own role and interactions within the team • Is willing to address areas of difficulty in working with an MDT • Demonstrates a positive attitude to equal opportunities legislation • Listens to others • Empathise and take into account the needs and feelings of others • Communicate effectively with individuals and groups • Gain and maintain trust and support of colleagues	MSF

To Develop an Effective Service

The trainee understands the principles and practice that influence service development and delivery	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of • The roles of generic and specific rehabilitation services such as spinal injuries centres, disablement services centres community teams in the provision of a comprehensive rehabilitation service • The roles of different agencies in service provision and the influence of their differing priorities • The various pressures that inform service planning and how these may be influenced e.g., by objective data, pressure group lobbying, political decisions • A knowledge of the commissioning process	CbD, *

• Budgetary management at a local level, and an understanding of delegation of financial responsibility, accountability, and planning • The range of agencies that can support the disabled worker and disabled job-seeker	
Skills	
The trainee is able to consistently and safely work with different agencies	CbD MSF
Behaviours	
The trainee consistently: • Is aware that locally desired goals must be integrated with wider agendas such as those dictated by local or national policies • Support plans for clinical services that are part of the strategy for the wider healthcare system • Gather feedback from colleagues and patients and service users to inform the development of plans • Contribute expertise into the planning process • Appraise options in terms of benefits and risks • Accurately identify the appropriate type and level of resources required to deliver safe and effective clinical services • Ensure services are delivered with allocated resources • Minimise waste • Take action where resources are not being used efficiently and effectively • Questions the status quo • Act as a positive role model for innovation • Encourage dialogue and debate with a wide range of people • Develop creative solutions to transform services and care • Model the change expected • Articulate the need for change and its impact on people • Promote changes leading to systems re-design • Energise and focus a group to accomplish change together	MSF

To Pass on Information to Colleagues Involved In, or Taking Over, Your Patient's Care

The trainee will be able communicate effectively with patients professionals and agencies in planning packages of community based care and rehabilitation	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of • Those factors relevant to the planning of discharge from hospital of individuals with complex disabilities. • Services provided by statutory bodies voluntary agencies and charities and the regulations and legislation under which they operate • Community care plans, the planning of services and the process of multi agency assessments • The interface between specialist community services and hospital based rehabilitation services and incorporation of shared guidelines • The interface of specialist community rehabilitation services with primary care and generic community rehabilitation services including community therapy and nursing	CbD, *

services • The work of voluntary and self help groups and their inclusion in the planning and rehabilitation of disabled people and their carers	
Skills	
The trainee is able to consistently and safely: • Assess an individual's long term needs and establish a management plan • Provide a written report of these assessments and plans • Co-ordinate and participate in multi agency case conferences • Chair multi agency case conferences • Establish monitoring processes for the care packages of individual patients • Identify carers needs and ensure that these are reflected in the patient's management plan, including the provision of respite care	cCAT
Behaviours	
The trainee consistently: • Contributes to the planning of complex discharges acknowledging the importance of their commitment to the process • Respects the individuals employed by and services provided by other agencies, acknowledging their areas of expertise and the constraints under which they work • Acknowledges the nature and importance of the work provided by informal carers, • Negotiates the best outcome for the patient • Is confident of their ability to work with agencies • Have a clear sense of their role, responsibilities and purpose within the team • Adopt a team approach, acknowledging and appreciating efforts, contributions and compromises • Recognise the common purpose of the team and respect team decisions • Are willing to lead a team, involving the right people at the right time • Provide guidance and direction for others using the skills of team members effectively • Review performance of the team members to ensure that planned service outcomes are met • Support Team members to develop their roles and responsibilities • Support others to provide good patient care and better services	cCAT, MSF

To Work with Other Teams and Services

The trainee will be able to work across organisational barriers	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates broad knowledge of available services for the delivery of care in different settings including: • Organization of services locally including linkage with paediatric and older peoples services • Practice across the interface between rehabilitation medicine, learning disabilities, psychiatry, neuropsychiatry, and neuropsychology • Practice across the interface between primary and secondary care, health and social services, vocational and voluntary services	CbD, *

Skills	
The trainee consistently: • Exercises good judgement in formulating a management plan appropriate to available services. • Can judge risks versus patient wishes.	cCAT, MSF
Behaviours	
The trainee consistently shows: • Willingness to work with what is available. • Adaptability and flexibility. • Sensitivity to patient wishes • Recognises the importance of sharing information with primary care and community teams	cCAT, MSF

Attribute: Establish and Maintain Partnerships with Patients

To Encourage Patients to Take an Interest in Their Health and Take Action to Improve or Maintain It

The trainee will be able to promote the health of individuals and communities	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • Basic exercise physiology • The current UK screening programme • The expert patient programme • How to access and use local health data • How to access resources for community action and advocacy	CbD, *
Skills	
The trainee is able to: • Identify the health promotion needs of people with disability • Institute appropriate management to promote long term health and well being in people with disability • Advise individuals about the risks and benefits of specific exercise programmes	CbD
Behaviours	
The trainee consistently: • Is aware of the impact difficulties with access and communication have on individuals abilities to use screening programmes • Is aware of the risk of mood disorders in people with significant disability	PS

To Work to Develop Services

The trainee can make an effective contribution to the planning of community services for specific groups of disabled people	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • The available services for short-term, intermittent and longer term rehabilitation and services for people in institutional care, as well as respite care services • The work of voluntary and self-help groups and their inclusion in the planning and rehabilitation of disabled people and their carers • The physical, psychological and social impact of living in residential care and of shared care arrangements	CbD, *
Skills	
The trainee is able to consistently and safely: • Participate in the planning of services when requested by voluntary and statutory bodies	CbD, mini-CEX, MSF
Behaviours	

The trainee consistently:	CbD
• Respects individuals decision about their place of residence	
• Is aware of the need to involve service users and carers when planning services	
• Is aware of their personal limitations and authority for planning services	

DOMAIN 4. MAINTAINING TRUST

Attributes:

Treat Patients and Colleagues Fairly and Without Discrimination

Act with Honesty and Integrity

To Behave in a Professional Manner

The trainee behaves in a professional manner in a wide range of settings	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • Equality and diversity issues • Bullying and harassment policies • The resources available to support the sick doctor • The standards of Good Medical Practice demanded by GMC	CbD, *
Skills	
The trainee is able to: • Respond to complaints in a timely, non-confrontational manner	CbD, mini-CEX, MSF
Behaviours	
The trainee consistently: • Recognises the vulnerability of patients and professionals particularly when attending patients in their own home • Reflects on complaints and how they can inform clinical practice both at an individual and team level. • Uphold personal, professional ethics and values, taking into account the values of the organisation and the culture and beliefs of individuals • Take appropriate action where ethics and values are compromised • Recognises that their personal beliefs and biases can impact on the delivery of services	MSF

ADVANCED COMPETENCIES: NEUROLOGICAL REHABILITATION

DOMAIN 1. KNOWLEDGE, SKILLS AND PERFORMANCE

Attribute: Apply Knowledge and Experience to Practice

Adequate Assessment of the Patient's Condition – History Taking

The trainee is able to take a history from individuals with disabling conditions, with particular reference to neurological conditions

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Epidemiology, and aetiology of less common neurological disorders, such as infections, neurodegenerative conditions, malignant and non-malignant brain tumours, consequences of HIV and Aids, spina bifida and inherited neuromuscular disorders • Complications arising from the treatment of neurological conditions including the late complications of radiotherapy etc • Long term sequelae of neurogenic bowel • Long term sequelae of neurogenic bladder • Methods of assessing sexual function and fertility • The consequences of pregnancy on neurological conditions including epilepsy • Long term sequelae of ageing in stable neurological conditions • Needs of an individual undergoing different types of transition, e.g., childhood to adult hood, entering and leaving the workplace	CbD, *
Skills	
The trainee is able to take a history from a both child and family in such a way as enables both parties to express their needs	CbD, mini-CEX, MSF

Adequate Assessment of the Patient's Condition - Examination

The trainee is able to examine individuals with disabling conditions, with particular reference to neurological conditions

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the assessment of: • Benign paroxysmal positional vertigo • Respiratory dysfunction in neurological disease • Long term sequelae of respiratory dysfunction such as pulmonary hypertension, thromboembolic disease and restrictive lung disease • Clinical features of musculoskeletal complications of neurological disease • Effects of spinal deformity on respiratory function • Need for ITB	CbD, *

To Principles of Diagnosis

The trainee is able to make a diagnosis, interpretation and provide prognostic information for individuals with disabling conditions, with particular reference to neurological disorders

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Prognosis of less common neurological disorders, such as infections, neurodegenerative conditions, malignant and non-malignant brain tumours, consequences of HIV and Aids, spina bifida and inherited neuromuscular disorders • Describes different mechanisms of coping	CbD, *
Skills	
The trainee is able to • Discuss prognosis in an appropriate manner	CbD, mini-CEX, MSF

To Prescribe Drugs or Treatment, Safely and Appropriately

The trainee is able to prescribe appropriately and safely a range of interventions for individuals with disabling conditions, with particular reference to neurological disorders

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Current management of common neurological disorders • Management of the less common neurological disorders, such as infections, neurodegenerative conditions, malignant and non-malignant brain tumours, consequences of HIV and Aids, spina bifida and inherited neuromuscular disorders • Standard and interventional approaches to pain management • Role of intravesical anticholinergics and botulinum toxin in the management of the neurogenic bladder • Role of surgical intervention and functional electrical stimulation in the management of neurogenic bladder • Role of surgical intervention and functional electrical stimulation in the management of neurogenic bowel • Of pharmaceutical and other treatments of sexual dysfunction • Identify appropriate orthoses for use in the upper and lower limb • Identify the place of surgical intervention and FES for use in affected upper limb and lower limbs (s) • Different ventilatory techniques including the use of assisted cough • Describe the effects and possible complications of ITB therapy • Knowledge of tissue viability treatments including surgical debridement, vacuum pump dressings, maggot therapy and plastic surgery • Aware of the place of local nerve block and spinal cord stimulation in the management of spasticity	CbD, *
Skills	
The trainee is able to: • Perform complicated programming of ITB pumps, such as bolus treatments and multiple daily dosing regimes	CbD, mini-CEX, MSF

To Provide or Arrange Advice, Investigations or Treatment as Necessary

The trainee is able to collate and manage information relevant to individuals with disabling conditions, with particular reference to neurological disorders

Skills	
The trainee is able to: • Interpret urodynamic studies • Identify when needed and interpret investigations such as DEXA, bone scan etc • Interpret nerve conduction studies and EMG	CbD, mini-CEX, MSF

ADVANCED COMPETENCIES: SPINAL INJURIES REHABILITATION

DOMAIN 1. KNOWLEDGE, SKILLS AND PERFORMANCE

Attribute: Apply Knowledge and Experience to Practice

Adequate Assessment of the Patient's Condition – History Taking

The trainee is able to take a history from individuals with disabling conditions, with particular reference to spinal injury

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the • Epidemiology, aetiology & classification of spinal cord injury • Long term sequelae of neurogenic bowel • Long term sequelae of neurogenic bladder • Of the methods of assessing sexual function and fertility • Describe the effects of pregnancy in spinal cord injury • Long term sequelae of ageing in spinal cord injury • Long term sequelae of ageing in stable neurological conditions • Needs of an individual undergoing different types of transition, e.g., childhood to adult hood, entering and leaving the workplace	CbD, *

Adequate Assessment of the Patient's Condition - Examination

The trainee is able to examine individuals with disabling conditions, with particular reference to spinal injury

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • The level of upper limb function expected at different levels of cord injury • Respiratory dysfunction in acute and chronic spinal injury • Pathophysiology and clinical features of sleep apnoea in spinal cord injury • Long term sequelae of respiratory dysfunction such as pulmonary hypertension, thromboembolic disease and restrictive lung disease • Effects of spinal deformity on respiratory function • Requirements of basic annual assessment • Assessment process for ITB	CbD, *
Skills	
The trainee consistently and effectively: • Examines a patient with spinal cord injury using the ASIA scale. • Identifies the effect associated injuries such as injuries to bone, joint and brachial plexus have on upper limb function	CbD, mini-CEX, MSF

Principles of Diagnosis

The trainee is able to make a diagnosis, interpretation and provide prognostic information for individuals with disabling conditions, with particular reference to spinal injury

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Prognosis based on the ASIA scale • Causes and effects of autonomic dysreflexia	CbD, *
Skills	
The trainee is able to: • Discuss prognosis and functional level expected from the ASIA in an appropriate manner	CbD, mini-CEX, MSF

To Prescribe Drugs or Treatment, Safely and Appropriately

The trainee is able to prescribe appropriately and safely a range of interventions for individuals with disabling conditions, with particular reference to spinal injury

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Management of the seriously ill patient, including cardiac dysfunction, or respiratory failure requiring ventilation • Management of associated injuries • Management and further investigation of autonomic dysreflexia • Role of intravesical anticholinergics and botulinum toxin in the management of the neurogenic bladder • Role of surgical intervention and functional electrical stimulation in the management of neurogenic bladder • Role of surgical intervention and functional electrical stimulation in the management of neurogenic bowel • Of pharmaceutical and other treatments of sexual dysfunction • Identify appropriate orthoses for use in the affected upper limb • Identify the place of surgical intervention and FES for use in the affected upper limb(s) • Different ventilatory techniques including the use of assisted cough • Role of surgical intervention and functional electrical stimulation in the management of ventilatory failure e.g., diaphragmatic pacing/phrenic nerve stimulation • Describe the effects and possible complications of ITB therapy • Knowledge of tissue viability treatments including surgical debridement, vacuum pump dressings, maggot therapy and plastic surgery • Aware of the place of local nerve block and spinal cord stimulation in the management of pain • Aware of the place of local nerve block and spinal cord stimulation in the management of spasticity	CbD, *
Skills	
The trainee is able to:	CbD, mini-CEX, MSF

- Educate patient and others about autonomic dysreflexia
- refers appropriately for tendon transfer and joint stabilization
- perform complicated programming of ITB pumps, such as bolus treatments and multiple daily dosing regimes

To Provide or Arrange Advice, Investigations or Treatment as Necessary

The trainee is able to collate and manage information relevant to individuals with disabling conditions, with particular reference to spinal injury

Skills	Assessment methods
The trainee is able to: • Interpret urodynamic studies • Identify when needed and interpret investigations such as DEXA, bone scan etc	CbD, mini-CEX, MSF

ADVANCED COMPETENCIES: MUSCULOSKELETAL REHABILITATION

DOMAIN 1. KNOWLEDGE, SKILLS AND PERFORMANCE

Attribute: Apply Knowledge and Experience to Practice

Adequate Assessment of the Patient's Condition

The trainee is able to take a history from individuals with disabling conditions, with particular musculoskeletal disorders

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the • Epidemiology of full range of disabling disorders including those related to • The musculoskeletal system including • Rheumatoid disease, the spondyloarthritides, • Osteoarthrosis, soft tissue rheumatism, spinal disorders, osteoporosis, and congenital & acquired disorders of muscle • Prevalence & incidence of musculoskeletal disorders in other disabling conditions.	CbD, *

Adequate Assessment of the Patient's Condition

The trainee is able to examine individuals with disabling conditions, with particular reference to musculoskeletal disorders

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Abnormal movement & posture; atypical presentation of common conditions, and common conditions in context of coexisting disabling conditions	CbD, *

Principles of Diagnosis

The trainee is able to make a diagnosis, interpretation and provide prognostic information for individuals with disabling conditions, with particular reference to musculoskeletal disorders

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the: • Specialist investigations. • Significance of findings in a complex picture. • Be able to provide a prognosis in the context of complex disability.	CbD, *

To Prescribe Drugs or Treatment, Safely and Appropriately

The trainee is able to prescribe appropriately and safely a range of interventions for individuals with disabling conditions, with particular reference to musculoskeletal disorders

Knowledge	Assessment Methods
The trainee consistent demonstrates a knowledge of the • Pharmacological options for full range of disabling disorders including • Musculoskeletal disorders including • Inflammatory and non-inflammatory • Connective tissue disorders, diseases of bone (particularly osteoporosis), muscle (congenital and acquired) and tendon • Non-pharmacological treatment options for disabling disorders include role of surgery education, self management, occupational therapy, physiotherapy, exercise and rest, safe injection techniques, biomechanical modalities such as prosthetics, orthotics • And splinting, assistive devices and environmental adaptation	CbD, *

ADVANCED COMPETENCIES: AMPUTEE REHABILITATION

DOMAIN 1. KNOWLEDGE, SKILLS AND PERFORMANCE

Attribute: Apply Knowledge and Experience to Practice

Adequate Assessment of the Patient's Condition – History taking

The trainee is able to take a history from individuals with disabling conditions, with particular reference to upper and lower limb loss	
Knowledge	**Assessment Methods**
The trainee consistent demonstrates a knowledge of the epidemiology, aetiology and classification of congenital upper and lower limb abnormalities	CbD, *

Adequate Assessment of the Patient's Condition - Prescribing

The trainee is able to prescribe appropriately and safely a range of interventions for individuals with disabling conditions, with particular reference to upper and lower loss	
Knowledge	**Assessment Methods**
The trainee consistently demonstrates a knowledge of: • The place of local nerve block, spinal cord stimulation in the management of stump or phantom pain	CbD, *
Skills	
The trainee is able to: • Select appropriate components and socket design using departmental policy and catalogues, for complicated and proximal amputation and congenital abnormalities • Provide a prognosis following complicated transtibial or more proximal amputation • Identify problems with socket fit, suspension, alignment, length and type of components for complicated stumps or hip disarticulation • Identify localized stump problems complicated stumps or hip disarticulation	CbD , *

4 Learning and Teaching

Trainees will be expected to help identify their training needs and to look for ways of meeting them through attending specialist regional/ national courses and services. Experience may be sought abroad. Trainees all have access to IT and library facilities to support their learning needs, and will also find professional assistance from the National Society, the BSRM, in identifying other educational opportunities.

Most of the curriculum is suited to delivery by work-based experiential learning and on-the-job supervision. Where it is clear from trainees' experience that parts of the curriculum are not being delivered within their work place, appropriate off-the job education or rotations to other work places will be arranged. The key will be regular work-based assessment by educational supervisors who will be able to assess, with the trainee, their on-going progress and whether parts of the curriculum are not being delivered within their present work place.

4.1 The Training Programme

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

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the entire curriculum is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. However, the sequence of training should ideally be flexible enough to allow the trainee to develop a special interest.

4.2 Teaching and Learning Methods

The curriculum will be delivered through a variety of learning experiences. Trainees will learn from practice, clinical skills appropriate to their level of training and to their attachment within the department.

Trainees will achieve the competencies described in the curriculum through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn. Competencies in RM will be achieved by the trainee during a series of modular attachments to specialist trainers and educational supervisors who practice in a range of clinical settings. These will vary from the acute hospital setting to the community based service but will have key characteristics in common which will include:
(1) Working with a specialist multidisciplinary team
(2) Working to professionally agreed standards of practice

(3) On the job supervision
(4) Regular appraisal and feedback
This work based experiential learning will deliver ~80% of the training.
The remaining 20% will be delivered through independent learning, off the job education through conferences and training courses,

Knowledge of related and relevant specialties is necessary and will be achieved during short placements which will be mutually beneficial, supporting the sharing of transferable skills between RM and the selected specialty. These may include pain management, palliative care, Learning disabilities, psychiatry, orthopaedic medicine, urology stroke medicine and others.

The RM medicine course is modular and covers four specialty areas neurological rehabilitation (minimum 12 months), spinal injuries (3 months), amputee and limb loss (3 months), and musculoskeletal rehabilitation (6 months). Some aspects of rehabilitation medicine are difficult to teach locally and for this reason the BSRM provides three courses for trainees that they will be expected to attend during their training or demonstrate equivalence of experience. These three course are the Advanced rehabilitation medicine course, the EAT course and the Amputee course.

Learning with Peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions. Examination preparation encourages the formation of self-help groups and learning sets.

Peer learning will be encouraged through regular educational activities and through pairing of trainees (new trainee with experienced trainee) where possible.

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

- Medical clinics including specialty clinics. After initial induction, trainees will review patients in outpatient clinics, under direct supervision. The degree of responsibility taken by the trainee will increase as competency increases. As experience and clinical competence increase trainees will assess ‘new’ and ‘review’ patients and present their findings to their clinical supervisor.
- Personal ward rounds and provision of ongoing clinical care on specialist medical ward attachments. Every patient seen, on the ward or in out-patients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness: the experience of the evolution of patients’ problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection of clinical problems.
- Consultant-led ward rounds. Every time a trainee observes another doctor, consultant or fellow trainee, seeing a patient or their relatives there is an opportunity for learning. Ward rounds, including those post-take, should be led by a consultant and include feedback on clinical and decision-making skills.
- Multi-disciplinary team meetings and clinics – an essential and integral part of rehabilitation medicine – in these meetings clinical problems are discussed with therapists and nurses. These provide excellent opportunities for development of clinical reasoning and problem solving skills.

The trainee will work with supervision in a hospital inpatient and outpatient setting, community hospital, Young Disabled Unit, specialist Head Injury units, specialist

spinal Injury units, specialist orthopaedic and limb fitting settings, district or regional rehabilitation or disablement services settings. Specific procedural skills e.g. management of Spasticity are learnt through attendance at supervised consultant led clinics and attendance at specialist courses (off the job learning). This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training with increasing clinical independence and responsibility as learning outcomes are achieved (see Section 5: Feedback and Supervision).

Formal Postgraduate Teaching – The content of these sessions are determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at regional, national and international meetings. Many of these are organised by the Royal Colleges of Physicians.

Suggested activities include:

- A programme of formal bleep-free regular teaching sessions to cohorts of trainees (e.g. a weekly core training hour of teaching within a Trust)
- Case presentations
- Journal clubs
- Research and audit projects
- Lectures and small group teaching
- Grand Rounds
- Clinical skills demonstrations and teaching
- Critical appraisal and evidence based medicine and journal clubs
- Joint specialty meetings
- Attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.

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

- Reading, including web-based material
- Maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- Audit and research projects
- Reading journals
- Achieving personal learning goals beyond the essential, core curriculum

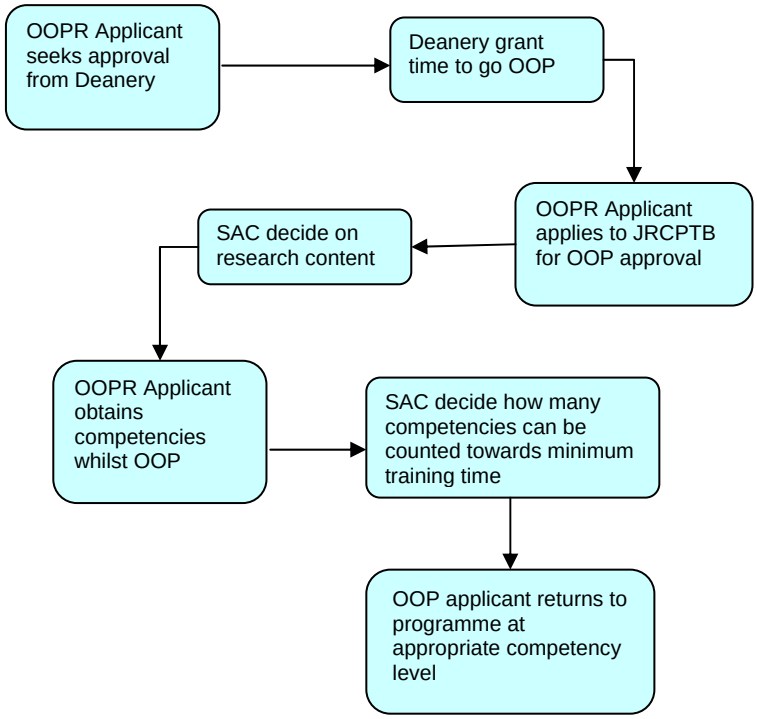
Formal Study Courses - Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management courses and communication courses. All trainees are encouraged to attend the annual BSRM specialist rehabilitation medicine course run by the University of Nottingham in Derby, and to attend one Amputee course and one Electronic Assistive Technology Courses. Appropriate courses are those run by the Special Interest group in Amputee rehabilitation (SIGAM) of the BSRM and the Special Interest group in Electronic Assistive Technology (SIGEAT) of the BSRM. Responsibility for the organization, conduct, content and quality of the courses lies with the BSRM appointed course lead who reports to the Training and Education Subcommittee. Formal feedback is obtained for all courses, collated and analysed and reviewed by the TESC.

4.3 Research

Trainees who wish to acquire research competencies, in addition to those specified in their specialty curriculum, may undertake a research project as an ideal way of obtaining those competencies. For those in specialty training, one option to be considered is that of taking time out of programme to complete a specified project or research degree. Applications to research bodies, the deanery (via an OOPR form) and the JRCPTB (via a Research Application Form) are necessary steps, which are the responsibility of the trainee. The JRCPTB Research Application Form can be accessed via the JRCPTB website. It requires an estimate of the competencies that will be achieved and, once completed, it should be returned to JRCPTB together with a job description and an up to date CV. The JRCPTB will submit applications to the relevant SACs for review of the research content including an indicative assessment of the amount of clinical credit (competence acquisition) which might be achieved. This is likely to be influenced by the nature of the research (eg entirely laboratory-based or strong clinical commitment), as well as duration (eg 12 month Masters, 2-year MD, 3-Year PhD). On approval by the SAC, the JRCPTB will advise the trainee and the deanery of the decision. The deanery will make an application to the GMC for approval of the out of programme research. All applications for out of programme research must be prospectively approved.

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

This process is shown in the diagram below:



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

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

5 Assessment

5.1 The Assessment System

The purpose of the assessment system is to:

- Enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, measure their own performance and identify areas for development;
- Drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience;
- Provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- Ensure trainees are acquiring competencies within the domains of Good Medical Practice*;*
- Assess trainees' actual performance in the workplace;
- Ensure that trainees possess the essential underlying knowledge required for their specialty;
- Inform the Annual Review of Competence Progression (ARCP), identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- Identify trainees who should be advised to consider changes of career direction.

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

Workplace-based assessments will take place throughout the training programme to allow trainees to continually gather evidence of learning and to provide trainees with formative feedback. They are not individually summative but overall outcomes from a number of such assessments provide evidence for summative decision making. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

5.2 Assessment Blueprint

In the syllabus (3.3) the "Assessment Methods" shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed and that where they are assessed not every method will be used.

5.3 Assessment Methods

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

Examinations and Certificates

- Advanced Life Support Certificate (ALS)

The small size of the specialty means that it is not feasible to run a full specialty certificate examination to assess knowledge. The specialty is currently planning to pilot a formative knowledge-based assessment method and, if successful, it is intended that this method will be used in the future.

Where there is a * in the syllabus this competency will be assessed by a knowledge-based assessment method

Workplace-Based Assessments

- Multi-Source Feedback (MSF)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Case-Based Discussion (CbD)
- Patient Survey (PS)
- Case Conference Assessment tool (cCAT)
- Audit Assessment (AA)
- Teaching Observation (TO)

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

Multisource Feedback (MSF)
This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides objective systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administration staff, and other allied professionals. The trainee will not see the individual responses by raters, feedback is given to the trainee by the Educational Supervisor.

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

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

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

Case Conference Assessment Tool (cCAT)

The case conference assessment tool is designed to score and provide feedback on a trainee's performance on the key elements of chairing a case conference. It was developed to respond to concerns that there was no assessment method for a key aspect of a rehabilitation physician's role, that of chairing multidisciplinary case conference.

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

Teaching Observation Tool (TO)
The Teaching Observation form is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

5.4 Decisions on Progress (ARCP)

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

The ARCP Decision Aid is included in section 5.5, giving details of the evidence required of trainees for submission to the ARCP panels.

5.5 ARCP Decision Aid

ARCP Decision Aid for Rehabilitation Medicine

Minimal standards for award of Outcome 1 (Satisfactory Progress)

Curriculum topic(s)	ARCP year 3	ARCP year 4	ARCP year 5	ARCP year 6
Clinical Presentations	Competent in 100% relevant to completed modules experienced so far, and 50% in modules with further attachments (mini-CEX and CbD evidence)	Competent in 100% relevant to modules experienced so far (mini-CEX evidence)	Competent in 100% relevant to modules experienced so far (mini-CEX evidence)	Competent in 100% in all modules including advanced competencies in one specialty area (mini-CEX evidence)
Multidisciplinary and cross provider working	Competent in 100% relevant to completed modules experienced so far, and 50% in modules with further attachments (cCAT evidence)	Competent in 100% relevant to modules experienced so far (cCAT evidence)	Competent in 100% relevant to modules experienced so far (cCAT evidence)	Competent in 100% in all modules (cCAT evidence)
MSF	Satisfactory feedback	Satisfactory feedback	Satisfactory feedback	Satisfactory feedback
Patient survey questionnaire	Satisfactory feedback	Satisfactory feedback	Satisfactory feedback	Satisfactory feedback
ALS	Valid	Valid	Valid	Valid
Additional Evidence	a. Evidence of audit and research projects undertaken, with evidence of ethics submissions, consent procedures, data collection and analysis, report writing and presentation. Copies of Audit Assessment tool b. Record of CPD c. Anonymised copies of reviews undertaken for journals d. Copies of teaching materials used, and evidence of peer review when teaching. Teaching Observation tool e. Anonymised copy letters to demonstrate written communication skills and appropriate management and use of information. f. Anonymised copies of complaints and responses			
Audit and research	Audit protocol defined and data collection commenced	Completed audit report (Report written and presented at meeting) Audit	Audit protocol defined and data collection commenced	Completed audit report (Report written and presented at meeting)

		assessment tool		Audit assessment tool
Minimum number of work place assessments	Minimum of 4 mini-CEX per year + minimum of 4 CbD per year + minimum of 4 cCAT per year + 1 MSF and 1 PSQ per year			

Content of the Assessment Programme

Some of the clinical competencies will be assessed using the mini-CEX. Over the 4 years of training trainees will be expected to undergo mini CEX that reflect their most recent attachment. Over the 4 year training period trainees will be expected to arrange 2 mini-CEXs every 4 months i.e., 24 in total. While it is not possible to be prescriptive about the precise content of assessments an example of the range assessments is attached below.

	Total number	**Symptoms of importance**
Neurological Rehabilitation	6 - Including at least one each of head injury, stroke, a progressive neurological condition such as MS, and a congenital neurological condition such as cerebral palsy	At least 5 of the following symptoms Spasticity Bowel dysfunction Bladder dysfunction Communication difficulties Cognitive problems Behavioural problems Emotional difficulties Ataxia, LMN difficulties Pain
Spinal injuries	2 - Including one each of a cervical lesion and one thoracic	
Amputee and limb loss	2 - Including one each of above and below knee limb loss	
Musculoskeletal rehabilitation	4 - Including one each of LBP, shoulder and lower limb	
Wheelchairs and seating	1	

5.6 Penultimate Year Assessment (PYA)

The penultimate ARCP prior to the anticipated CCT date will include an external assessor from outside the training programme. JRCPTB and the deanery will coordinate the appointment of this assessor. This is known as “PYA”. Whilst the ARCP will be a review of evidence, the PYA will include a face to face component.

5.7 Complaints and Appeals

All workplace-based assessment methods incorporate direct feedback from the assessor to the trainee and the opportunity to discuss the outcome. If a trainee has a complaint about the outcome from a specific assessment this is their first opportunity to raise it.

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

6 Supervision and Feedback

6.1 Supervision

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

Trainees will at all times have a named Educational Supervisor and Clinical Supervisor, responsible for overseeing their education. Depending on local arrangements these roles may be combined into a single role of Educational Supervisor.

The responsibilities of supervisors have been defined by GMC in the document “Operational Guide for the PMETB Quality Framework”. These definitions have been agreed with the National Association of Clinical Tutors, the Academy of Medical Royal Colleges and the Gold Guide team at MMC, and are reproduced below:

Educational Supervisor
A trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee’s educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee’s Educational Agreement.

Clinical Supervisor
A trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee’s clinical work and providing constructive feedback during a training placement. Some training schemes appoint an Educational Supervisor for each placement. The roles of Clinical and Educational Supervisor may then be merged.

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

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

6.2 Appraisal

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

Induction Appraisal

The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. The initial meeting will identify

a) trainees previous experience,
b) trainees expectations of the attachment
c) knowledge and skills to be acquired
d) teaching needs of trainee and how these will be delivered
e) agree timing of mini-CEX
f) study leave requirements
g) audit/research aims

Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the ePortfolio at this time, recording their commitment to the training process.

Mid-Point Review

This meeting between trainee and educational supervisor is mandatory (except when an attachment is shorter than 6 months), but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP. At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal

Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the ePortfolio. This end of attachment appraisal will

a) ensure trainees have obtained necessary knowledge and skills
b) identify any weaknesses and ensure plans for addressing these are passed onto programme director and next educational supervisor

Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed

7 Managing Curriculum Implementation

7.1 Intended Use of Curriculum by Trainers and Trainees

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

The educational supervisors and trainers can access the up-to-date curriculum from the JRCPTB website and will be expected to use this as the basis of their discussion with trainees. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

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

Deaneries are responsible for quality management, GMC will quality assure the deaneries and educational providers are responsible for local quality control, to be managed by the deaneries. The role of the Colleges in quality management remains important and will be delivered in partnership with the deaneries. The College role is one of quality review of deanery processes and this will take place within the SACs on a regular basis.

7.2 Recording Progress

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

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

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

8 Curriculum Review and Updating

The specialty curriculum will be reviewed and updated with minor changes on an annual basis. The curriculum should be regarded as a fluid, living document and the SAC will ensure to respond swiftly to new clinical and service developments. In addition, the curriculum will be subject to three-yearly formal review within the SAC. This will be informed by curriculum evaluation and monitoring. The SAC will have available:

- The trainees' survey, which will include questions pertaining to their specialty (GMC to provide)
- Specialty-specific questionnaires (if applicable)
- Reports from other sources such as educational supervisors, programme directors, specialty deans, service providers and patients.
- Trainee representation on the Deanery STC and the SAC of the JRCPTB
- Informal trainee feedback during appraisal.

Evaluation will address:

- The relevance of the learning outcomes to clinical practice
- The balance of work-based and off-the-job learning
- Quality of training in individual posts
- Feasibility and appropriateness of on-the-job assessments in the course of training programmes
- Availability and quality of research opportunities
- Current training affecting the service

Evaluation will be the responsibility of the JRCPTB and GMC. These bodies must approve any significant changes to the curriculum.

Interaction with the NHS will be particularly important to understand the performance of specialists within the NHS and feedback will be required as to the continuing needs for that specialty as defined by the curriculum. It is likely that the NHS will have a view as to the balance between generalist and specialist skills, the development of generic competencies and, looking to the future, the need for additional specialist competencies and curricula. In establishing specialty issues which could have implications for training, the SAC will produce a summary report to discuss with the NHS employers and ensure that conclusions are reflected in curriculum reviews.

Trainee contribution to curriculum review will be facilitated through the involvement of trainees in local faculties of education and through informal feedback during appraisal and College meetings.

The SAC will respond rapidly to changes in service delivery. Regular review will ensure the coming together of all the stakeholders needed to deliver an up-to-date, modern specialty curriculum. The curriculum will indicate the last date of formal review monitoring and document revision.

9 Equality and Diversity

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

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

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates. Accordingly, it warmly welcomes contributors and applicants from as diverse a population as possible, and actively seeks to recruit people to all its activities regardless of race, religion, ethnic origin, disability, age, gender or sexual orientation.

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

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes;
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post;
- Deaneries must ensure that educational supervisors have had equality and diversity training (at least as an e learning module) every 3 years
- Deaneries must ensure that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e module) every 3 years.
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. Deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual.
- monitoring of College Examinations;
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly disadvantage trainees because of gender, ethnicity, sexual orientation or disability (other than that which would make it impossible to practise safely as a physician). All efforts shall be made to ensure the participation of people with a disability in training.