

SPECIALTY TRAINING CURRICULUM

FOR

RHEUMATOLOGY

AUGUST 2010

Joint Royal Colleges of Physicians Training Board

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1 Introduction

Rheumatology incorporates the investigation, diagnosis, management and rehabilitation of patients with disorders of the musculoskeletal system i.e., the locomotor apparatus, bone and soft connective tissues. The rheumatological disorders thus include diverse conditions such as inflammatory arthritis, autoimmune rheumatic disorders, soft tissue conditions including injuries, osteoarthritis, spinal pain and other chronic pain syndromes and metabolic bone disease. Many rheumatologists practice the specialty exclusively but others practice in internal medicine, rehabilitation, or sports medicine. Rheumatology requires interdisciplinary knowledge and awareness of new developments in internal medicine, immunology, orthopaedics, neurology/pain management, rehabilitation, psychiatry, nursing and professions allied to medicine. Rheumatologists practising in adult medicine must understand the sequelae of childhood and adolescent rheumatological disease.

2 Rationale

2.1 The Purpose of the Curriculum

The purpose of this curriculum is to define the training for a specialist in Rheumatology. The curriculum describes the competencies required to satisfactorily achieve a certificate of completion of training (CCT) and to be registered on the Specialist Register in Rheumatology. The CCT specialist will be able to work as a consultant specialist within the National Health Service and will have the knowledge, skills and behaviours required to do this, i.e. be capable of providing a high standard of professional service.

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

2.2 The Development of the Curriculum

This curriculum was developed by the Specialty Advisory Committee for Rheumatology under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB). 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 leadership, health inequality and common competencies.

The content of the curriculum and the teaching / learning methods described were chosen by the Specialty Advisory Committee (SAC) in Rheumatology. The knowledge, skills and behaviours required for a trained specialist were drawn up by the SAC in 2004 and have been reviewed annually. Regular meetings were held by the SAC involving all relevant stakeholders (guidance was given by the Joint Committee on Higher Medical Training and officials from GMC). The SAC membership represents teachers, trainers and trainees in the specialty and the opinions of the British Society for Rheumatology was gained through its representation on the SAC. The views of lay members were also sought through membership on the SAC. The input of those responsible for Rheumatology trainees regionally was sought through consultation with the Regional Specialty Advisors in Rheumatology.

2.3 Enrolment with JRCPTB

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

2.4 Training Pathway

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

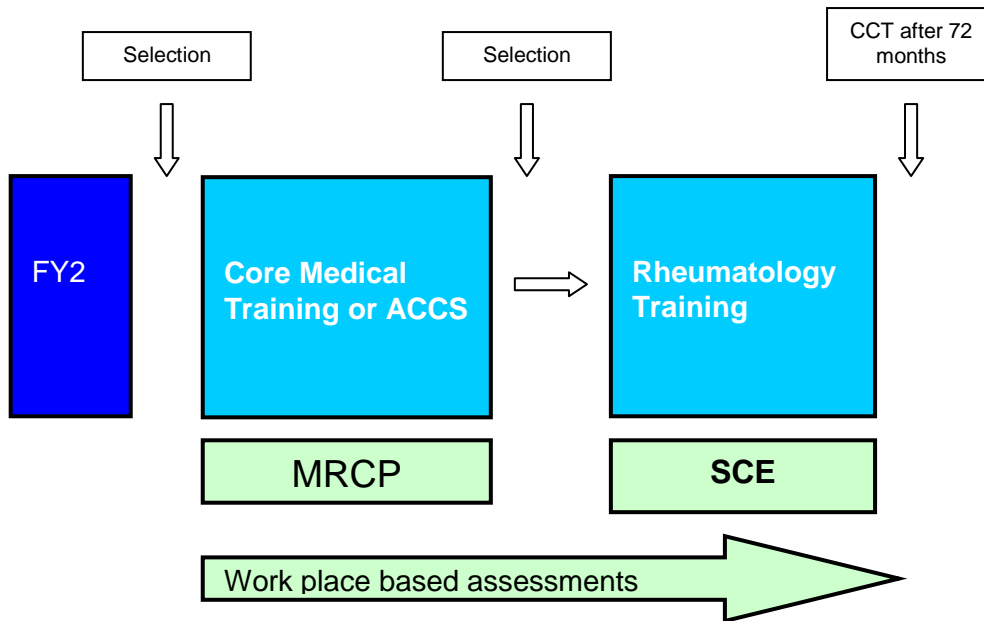
Core training may be completed in either a Core Medical Training (CMT) or Acute Care Common Stem (ACCS) programme. The full curriculum for specialty training in Rheumatology therefore consists of the curriculum for either CMT or ACCS plus this specialty training curriculum for Rheumatology.

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

Completion of CMT or ACCS and acquisition of full MRCP (UK) will be required before entry into Specialty training at ST3 (2011 onwards).

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

A proportion of trainees will choose to undertake training to achieve a dual CCT with General Internal Medicine (GIM) in addition to the Rheumatology competencies (See section 2.8).



2.5 Duration of Training

Although this curriculum is competency based, the duration of training must meet the European minimum of 4 (four) years for post registration in full time training adjusted accordingly for flexible training. 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). Trainees who are dual training in GIM in addition to Rheumatology will usually complete training in 7 (seven) years in full time training (2 years core plus 5 years specialty training).

2.6 Less Than Full Time Training (LTFT)

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

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

The above provisions must be adhered to. LTFT trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

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

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

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 Flexible 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.

2.7 Relevance to Programmes of Training

The curriculum will be achieved by completing the necessary posts within educationally approved training programmes in Rheumatology (and General Internal Medicine for those achieving a dual CCT in GIM).

2.8 Dual CCT

Trainees who wish to achieve a CCT in General Internal Medicine (GIM) as well as Rheumatology 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, with assessment evidence, as described in both the Rheumatology and GIM curricula. Individual assessments may provide evidence towards competencies from both curricula. 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

Defining the objectives of the generic skills of the specialist trainees in training in any of the medical specialties has relied on two documents; the first is "Good Medical Practice" produced by the General Medical Council; the second is the Common Competences Framework produced by the Academy of Medical Royal Colleges. In the following section, we have defined the learning content using the following framework:

- A general outline of the objectives of higher medical training in rheumatology.
- We have then described the specific outcomes, in terms of clinical knowledge, skills and attitudes required to gain a CCT in Rheumatology, together with mapping of how these will be assessed.
- We have then mapped the generic standards outlined in 'Good Medical Practice' (GMC 2008) to the rheumatology curriculum.

Post graduate training leading to recognition as a specialist should furnish the doctor with knowledge and skills which will enable them to become competent in the field of rheumatology. The curriculum will enable trainees to become competent in the:

- Establishment of a differential diagnosis for patients presenting with clinical features of rheumatological conditions by appropriate use of history, clinical examination and investigation.
- Performance of the core investigations required for all physicians practising rheumatology

- Development of management plans for the “whole patient” with a sound knowledge of the appropriate treatments including health promotion, disease prevention and long term management plans.
- Communication of the diagnosis and management options with the patient and other members of the multidisciplinary team.
- Application of sufficient knowledge and skill in diagnosis and management to ensure safe independent practice.
- Provision of effective team working and leadership skills
- Application of knowledge of the appropriate basic sciences relevant to rheumatology
- Management of time and other resources to the benefit of their patients and colleagues
- Facilitation of effective learning by other clinical and allied staff.
- Maintenance of professional standards through continuing development and learning
- Critical appraisal and analysis of clinical research methodology and results.

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

3.3 Knowledge

The overall aim is to acquire a sound knowledge of the natural history and pathophysiology of rheumatological disease and the basic scientific principles and evidence base underpinning the current practice of rheumatology. This knowledge base will be applied to ensure safe and competent clinical practice.

Basic science underpinning the musculoskeletal and immune systems

The trainee will be able to:

- Describe the anatomy of the musculoskeletal system
- Identify surface anatomy of the musculoskeletal system
- Describe the physiology and biochemistry of the musculoskeletal system, including joints, bones, muscles and soft tissues
- Describe the structure and function of the musculoskeletal system in health and disease
- Explain the innate and adaptive immune systems, including cellular and humoral immunity

- Evaluate the concept of autoimmune disease in the light of the normal functions of the immune system

GMP 1

Pharmacology underpinning rheumatological practice

The trainee will demonstrate

- Knowledge of the pharmacology of all drugs used in rheumatological practice, including analgesics, non-steroidal anti-inflammatory drugs, slow acting anti-rheumatic drugs, immunosuppressive agents, biologic agents, drugs used in treating patients with metabolic bone diseases, non-analgesic drugs used in the management of patients with chronic pain, drugs used in the management of gout, corticosteroids
- Ability to identify and evaluate, information on new drugs
- Ability to identify, evaluate and notify appropriate authorities of, potential adverse drug effects noticed within their clinical practice

GPM 1,2

Rheumatological Disorders

For each of the following conditions, the trainee should demonstrate knowledge of:

- Epidemiology
- Aetiology
- Pathogenesis
- Pathology
- Clinical features
- Natural history
- Potential impact, physical, psychological and functional on the individual
- Potential impact on the individual's carers
- Potential impact on society
- Investigation
- Pharmacological and non-pharmacological management, including the evidence base thereof or how to access the evidence base.

Musculoskeletal pain problems and soft tissue rheumatism

Including:

- Neck pain
- Spinal pain
- Intervertebral disc disorders
- Spinal canal or foraminal stenosis & related syndromes
- "Whiplash"
- Limb pain syndromes:
 - Rotator cuff disease
 - Enthesopathies including epicondylitis, plantar fasciitis
 - Bursitis
 - Non-specific limb pain
 - Complex regional pain syndromes – algodystrophy
 - Chest wall pain syndromes
 - Fibromyalgia and related somatoform disorders
 - Benign joint hypermobility
 - Pain problems specific to childhood – eg nocturnal limb pain, Osgood-Schlatter's disease, Perthe's disease
 - Occupational and sports related problems

Osteoarthritis and related conditions:

Including:

- Osteoarthritis of large joints
- Generalised osteoarthritis
- Diffuse idiopathic skeletal hyperostosis
- Neuropathic arthritis

Crystal associated arthropathies

- Gout
- Pseudogout
- Apatite deposition disease
- Oxalate metabolism disorders

Rheumatoid arthritis

- Articular manifestations
- Systemic manifestations
 - including respiratory, ocular, neurological, haematological, dermatological manifestations
- Complications
 - including cervical myelopathy, amyloid, septic arthritis

Spondyloarthropathies

- Ankylosing spondylitis
- Psoriatic arthritis
- Enteropathic arthropathies
- Reactive arthritis
- Whipple's disease

Juvenile Idiopathic Arthritis

in relation to young adult and adult patients

Autoimmune connective tissue diseases

- Systemic lupus erythematosus
- Antiphospholipid syndrome
- Systemic sclerosis
- Sjogrens syndrome
- Inflammatory muscle disease
- Overlap syndromes
- Relapsing polychondritis
- Vasculitides, including:
 - Giant cell arteritis (and polymyalgia rheumatica)
 - Wegener's granulomatosis
 - Polyarteritis nodosa and micropolyarteritis
 - Churg Strauss vasculitis
 - Behcet's disease
 - Takayasu's arteritis
 - Cutaneous vasculitis
 - Panniculitis
 - Henoch Schonlein purpura
 - Cryoglobulinaemia

Bone disorders

Including

- Osteoporosis

- Rickets and osteomalacia
- Bone & joint dysplasias
- Renal bone disease
- Regional disorders:
 - Paget's disease, hypertrophic pulmonary osteoarthropathy, osteonecrosis, Perthe's disease, osteochondritis dissecans, transient regional osteoporosis

Metabolic, endocrine and other disorders

Including:

Endocrine disorders affecting bone, joint or muscle (eg thyroid, pituitary, parathyroid disorders)

Metabolic disorders affecting joints (eg alkaptonuria, haemochromatosis)

Heritable collagen disorders

Haemoglobinopathies as they relate to the musculoskeletal system

Haemophilia and other disorders of haemostasis as they relate to the musculoskeletal system

Infection and arthritis:

Septic arthritis

Osteomyelitis

Post-infectious rheumatological conditions, including rheumatic fever, post-meningococcal arthritis

Lyme disease

Mycobacterial, fungal & parasitic arthropathies

Viral arthritis

Human Immunodeficiency virus and Acquired immunodeficiency syndrome

Hepatitis C

Neoplastic disease

Paraneoplastic musculoskeletal syndromes

Primary and secondary neoplastic conditions of connective tissue

Tumours of bone

Pigmented villonodular synovitis

Miscellaneous disorders:

Sarcoidosis

Eosinophilic fasciitis

Familial Mediterranean fever

Hypogammaglobulinaemia & arthritis

Amyloidosis

Sweets syndrome (neutrophilic dermatoses)

GMP 1

Rheumatological disorders in the elderly

The trainee will be able to:

- Describe the epidemiology of rheumatological disorders in the elderly
- Evaluate the impact of rheumatological diseases on the elderly

GMP 1

Paediatric and Adolescent Rheumatology

The trainee will:

- Be aware of the spectrum of disorders that present as musculoskeletal symptoms in childhood and adolescence.

- Understand the differential diagnosis of musculoskeletal pain in children and adolescents
- Identify and appreciate their own limitations in assessing and managing children and adolescents with musculoskeletal symptoms.
- Understand the principles underpinning the management of children and adolescents with rheumatic disease.
- Classify the arthritides occurring in children.
- Understand the different models of clinical care of children and adolescents with arthritis.
- Describe and evaluate the sequelae of childhood and adolescent rheumatological disease
- Identify and appreciate the particular requirements of adolescents and young adults with arthritis in the transition period as they come under the care of adult rheumatologists

GMP 1

Investigations used in Rheumatological practice

For each of the following investigations the trainee will be able to:

- Select the appropriate investigation in the light of their clinical assessment of a given patient
- Provide a rationale for the investigation
- Interpret the investigation result in the context of the given patient

Blood tests:

Haematology:

- Full blood count; clotting screen; lupus anticoagulant; erythrocyte sedimentation rate; plasma viscosity; Haemoglobin electrophoresis; Coombs test; haematinics; blood film report

Biochemistry:

- Renal, hepatic and bone biochemistry; muscle enzyme levels; sex hormones; endocrine function tests; Immunoglobulin levels and serum/urine electrophoresis; lipid profile

Immunology:

- Autoantibody assays, including Rheumatoid factor, anti CCP antibodies , ANA, anti-DNA antibodies, antibodies to ENA, anti-cardiolipin antibodies, ANCA; Complement levels, cryoglobulins; cold agglutinins

Synovial fluid analysis

- To perform polarised light microscopy
- To interpret the results of gram stain and culture, cytology

Microbiology/Serology:

- Blood/synovial fluid/sputum/urine/CSF microscopy and culture
- Serological tests for viral infections, including hepatitis
- HIV testing

Pathology:

- Histology reports of tissue biopsies of synovium, skin, liver, lung, kidney and lymph node
- Cytology reports from body fluids including sputum, urine and synovial fluid

Imaging:

- Radiographs of chest, joints, abdomen
- Isotope bone scans
- Dual energy X ray absorptiometry scans
- V/Q scans

- Reports of CT scans, MRI scans, ultra sound scans, arthrography

Neurophysiology:

- Reports of nerve conduction studies and electromyographic studies

GMP 1,3**The role and activities of other members of the multi-disciplinary team**

Sound rheumatological practice relies upon an effective multi-disciplinary team, including input from nurses, therapists, chiropodists/podiatrists, orthotists, dieticians and clinical psychologists. For these team members, it is essential that the rheumatologist can:

- Describe their role
- Describe, in principle, their activities
- Identify which patients may benefit from their input
- Recognise effective ways of communication with them and between members of the team

GMP 1,2,3

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Orthopaedic surgery in the context of rheumatological practice

Rheumatology has a close interface with orthopaedic surgery: patients with the same conditions are often seen by practitioners from both specialties; a significant number of patients with rheumatological conditions benefit from surgery.

The trainee will be able to:

- Identify circumstances in which orthopaedic referral is appropriate
- Describe the indications for, principles of and complications of, those orthopaedic procedures commonly carried out on patients with rheumatological conditions. These include joint replacements, arthrodeses, nerve decompressions, spinal decompression procedures, arthroscopic and open joint lavage, procedures for soft tissue problems in the hands, shoulders and knees.
- Recognise effective ways of communicating with orthopaedic surgeons, including the role of combined clinics.

GMP 1,2,3**Other medical specialties in the context of rheumatological practice**

A significant proportion of patients who see rheumatologists need input from other specialists including renal physicians, respiratory physicians, neurologists, neurosurgeons, rehabilitationists, anaesthetists and specialists in pain relieving procedures and psychiatrists.

The trainee will be able to:

- Identify circumstances in which referral to other specialists is appropriate
- Describe the principles of the specialist help provided by other specialists
- Recognise ways of communicating effectively with other specialists

GMP 1,2,3**Complementary therapy and unconventional treatment approaches**

A significant proportion of patients with rheumatological diseases consult alternative practitioners, including chiropractors, osteopaths and homeopaths.

The trainee will be able to:

- Describe, in principle, the main activities of these treatment approaches
- Identify and evaluate the evidence base underlying these approaches
- Identify, in principle, the potential advantages and disadvantages of these approaches

GMP 1,3

Assessment of achievement of knowledge objectives:

Relevant knowledge is assessed by discussion of cases and published articles, and by educational presentations by the trainee.

A new Speciality Certificate Examination is to be implemented from 2010 – see section 6 below.

3.4 Clinical Skills & Attitudes

In the tables below, the “Assessment Methods” shown are those that are appropriate as **possible** methods that could be used to assess each competency. It is not expected that all competencies will be assessed and that where they are assessed not every method will be used. See section 5 Assessment for more details.

“GMP” defines which of the 4 domains of the Good Medical Practice Framework for Appraisal and Assessment are addressed by each competency. See section 2.0 for more details.

The overall aim is to develop the ability to perform a clinical assessment of patients with rheumatological disorders, select and interpret appropriate investigations and formulate a differential diagnosis and management plan. The trainee should be able to communicate their conclusions effectively to the patient and other clinical colleagues.

4 Syllabus

1. History Taking & Clinical Examination - Overview

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<p>History: To be able to elicit and correctly interpret a history of:</p> <ul style="list-style-type: none"> • The presenting symptoms of rheumatological disease ie pain, stiffness, weakness, loss of function & non-articular manifestations • The impact on the individual of the rheumatological disease • The psychosocial problems associated with rheumatological disease • Other general medical problems • Identify and record risk factors for conditions relevant to mode of presentation • Use skills to overcome barriers to communication e.g. use of interpreter and written information • Identify possible cultural or religious barriers to effective communication • Draw a close to a consultation appropriately • Manage alternative and conflicting views from family, carers and friends 	<ul style="list-style-type: none"> • Fully address patients' concerns, ideas and expectations • Respect patient confidentiality • Maintain cultural awareness and identity • Value patient comprehension • Recognise importance of a collateral history in certain situations e.g. unreliable history 	1,3,4	mini-CEX, PS

<p>Examination: To identify:</p> <ul style="list-style-type: none"> • Perform an examination relevant to the presentation and risk factors that is valid, targeted and time efficient • Perform valid examination in more challenging situations (e.g. distracting environment) • Assess mood and cognitive function as appropriate and apply this to interpretation of history • The normal musculoskeletal system and its variations including at extremes of age • The surface anatomical features of the shoulder girdle, elbow, hand/wrist, hip/pelvis, knee, ankle/foot, spine • The normal range of movement (active and passive) of these joints • The actions of major muscle/tendons acting on these • The clinical signs associated with inflammation or structural damage of joints & periarticular structures (muscles, tendons, entheses, bursae and bone) • Non-articular, systemic and other features of rheumatic disease • General medical complications of rheumatological disease • Diffuse or regional pain disorders or somatisation disorders • All trainees should be able to perform and demonstrate a GALS (Gait Arms Legs Spine) screening examination • All trainees should be able to perform and demonstrate a regional musculoskeletal examination (REMS) 	<ul style="list-style-type: none"> • Respect a patient's dignity and cultural background and other beliefs • <input type="checkbox"/> Recognise importance of patient consent in context of examination • Demonstrate willingness and ability to teach junior and health worker colleagues sound examination technique 		<p>mini-CEX, MSF</p>
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2. History Taking & Clinical Examination: Regional Musculoskeletal Examination - Identifying and Interpreting Abnormalities

Shoulder Pathology:

The trainee should be able to identify:

- Rotator cuff lesions
- Glenohumeral/capsular pathology
- Muscle wasting, proximal myopathy (deltoid)
- S/C joint pathology - synovitis
- A/C joint pathology – synovitis
- Shoulder pain due to pain referred from viscera or neck

Elbow Pathology:

The trainee should be able to identify:

- Olecranon bursitis
- Elbow joint pathology
- Radio-ulnar joint pathology
- Medial or lateral epicondylitis
- Ulnar nerve entrapment

Hand & Wrist Pathology:

The trainee should be able to identify:

- Radiocarpal joint pathology
- Distal radio-ulnar joint pathology
- MCP or IP joint pathology
- Hand deformities
- Muscle wasting
- Flexor or extensor tenosynovitis or tendon nodules
- Rupture or attenuation of flexor or extensor tendons of fingers or thumb
- De Quervain's tenovaginitis
- Carpal tunnel syndrome

Hip/Pelvic Pathology:

The trainee should be able to identify:

- Trochanteric, iliopsoas, gluteal bursitis

- Hip joint pathology including dysplasia
- Real & apparent leg length inequality
- SI joint pathology
- Muscle wasting, proximal myopathy, Trendelenberg sign
- Deformities of the hip, Thomas' test
- Pathology of symphysis pubis
- Pathology of pelvis - fractures
- Hip pain due to pain referred from lumbar region
- Lesions of tendons and entheses

Knee Pathology:

The trainee should be able to identify:

- Knee joint pathology, including internal derangements
- Deformities
- Muscle wasting, myopathy
- Prepatellar, anserine bursitis
- Popliteal cyst
- Damage to collateral ligaments
- Knee pain due to pain referred from hip or lumbar spine
- Lesions of tendons and entheses
- Osgood-Schlatter's disease
- Adolescent anterior knee pain/Patello-femoral syndrome

Ankle & Foot Pathology:

The trainee should be able to identify:

- Ankle (tibiotalar) pathology
- Subtalar/midtarsal joint pathology
- MTP & IP joint pathology
- Lesions of the Achilles tendon, entheses and retrocalcaneal bursa
- Deformities of the ankle and foot
- Foot pain due to pain referred from lumbar spine
- Plantar fasciitis

- Tenosynovitis of tib post and peroneal tendons
- Rupture of tib posterior or Achilles tendon
- Lesions of bone (eg stress fracture)

Spinal Pathology:

The trainee should be able to identify:

- Cervical spine pathology
- Thoracic spine pathology
- Lumbar spine pathology
- Spinal nerve root entrapment syndromes
- Spinal deformities including adolescent scoliosis

Extra-Articular Pathology:

The trainee should be able to identify:

- Raynauds phenomenon
- Vasculitic skin lesions
- Rheumatoid nodules
- Rash – psoriasis, pustular psoriasis, onycholysis, balanitis, lupus rashes, erythema nodosum, calcinosis
- Nail lesions – pitting, onycholysis, splinter haemorrhages, nailfold infarcts
- Scleritis, episcleritis, conjunctivitis, iritis
- Scerodactyly
- Tophi
- Other medical complications of rheumatic disease affecting internal organs

3. For Each of the Following Presentations, the Trainee Will Demonstrate the Skills and Behaviours Identified in the Grid Below:

Patients presenting with:

- A monoarthropathy
- An oligoarthropathy
- A polyarthropathy
- An axial arthropathy
- An inflammatory multi-system disorder
- Muscle weakness
- Regional limb pain
- Spinal musculoskeletal pain disorders
- Unexplained musculoskeletal pain
- Rheumatological emergencies

Skills	Behaviours	GMP	Assessment/Evidence of Competence
On the basis of history and examination, arrives at an appropriate differential diagnosis	Respects the patient; Values the need for careful and accurate clinical assessment	1,3,4	CbD, mini-CEX
Chooses and interprets the appropriate investigations	Respects the need for an accurate diagnosis but also for effective use of scarce and (where relevant) potentially toxic, resources	1,3,4	CbD, mini-CEX
Formulates an appropriate management plan.	Relates theoretical knowledge to patient management. Ensures an evidence-based approach is employed Keeps up to date with published medical evidence	1,2,3,4	CbD, mini-CEX
Communicates the diagnosis, its implications and the treatment options to the patient and facilitates the patient in agreeing a management plan	Respects the patient's perspective and autonomy; appreciates the potential impact on the patient and their family	3,4	mini-CEX, MSF
Involves and refers to the members of the multi-	Values the skills and knowledge of	1,3	CbD, mini-CEX

disciplinary team and other specialists appropriately	colleagues		
Makes appropriate arrangements for follow up and monitoring of the patient	Maintains the patient's interests as paramount; values optimal resource allocation	1,2	CbD, mini-CEX, MSF
Communicates effectively and appropriately with other members of the team, with the patient's GP and with the patient's family or carers; Documents clearly in the patient record	Respects the patient's wishes and needs regarding communication with relatives etc; respects the need for effective communication with the primary care team; respects the need for accurate record keeping	1,3,4	MSF

4. For Each of the Following Conditions, the Trainee Will Demonstrate the Skills and Attitudes Identified in the Grid Below:

Patients with:

- A regional musculoskeletal pain problem
- A spinal musculoskeletal pain problem
- Osteoarthritis
- A crystal arthropathy
- Rheumatoid arthritis
- A spondyloarthropathy
- An autoimmune connective tissue disease
- A bone disorder
- A rheumatological manifestation of a metabolic or endocrine disorder
- An arthritis or rheumatological condition secondary to infection, including septic arthritis
- One of the miscellaneous disorders identified on page 10

Skills	Behaviours	GMP	Assessment/Evidence of Competence
Communicates to the patient the diagnosis, prognosis and treatment options, using patient literature and other media, as appropriate	Respects patients. Appreciates the importance of effective communication by all appropriate means	3,4	CbD, mini-CEX, MSF
Identifies and discusses, the patient's views on causation and management of the patient's condition	Values the patient's perspective	3,4	
Agrees a management plan with the patient, including discussion of the risks and benefits of treatments	Respects the need for a collaborative approach with patients	2,3	
Refers to, and communicates with, other members of the multi-disciplinary team, as appropriate	Respects other members of the team and the need to communicate professionally with them	1,3	

Selects and makes, appropriate arrangements for long term follow up of the patient. This may involve monitoring for treatment- and disease-related complications	Values the importance of appropriate follow up arrangements. Takes responsibility for ensuring adequate follow up and monitoring	1,2	
Performs appropriate follow up medical services. Includes tailoring the approach to the specific needs of a patient in the context of the known impact and complications of the given condition	Respects the individual's autonomy. Keeps up to date with current best practice	1,2	
Refers appropriately to other specialists. This will particularly require a close liaison with orthopaedic surgeons	Values the role of other specialists; respects the importance of effective communication with other specialists	1,3	
Where a patient indicates a desire to, discusses the risks and benefits of complementary or unconventional treatment approaches	Respects the patient's wishes to discuss other approaches	1,3,4	
Identifies and accesses non-NHS agencies, as appropriate, for patients. This may include patient self-help groups, social services, housing departments, Citizens advice bureaus, disablement resettlement officers	Values the need for a holistic approach; respects the role of other agencies; values the need for effective communication with other agencies	2,3	

5. Practical Procedures:

Skills	GMP	Assessment/Evidence of Competence
<p>To be able to:</p> <ul style="list-style-type: none"> • Identify, in a given patient, the need for: <ul style="list-style-type: none"> • Joint aspiration and/or injection with corticosteroid and/or local anaesthetic • Soft tissue injection with corticosteroid and/or local anaesthetic • Aspirate and inject joints competently using the appropriate techniques • Recognise the macroscopic appearance of normal and abnormal synovial fluid (non-inflammatory, inflammatory, haemorrhagic and septic) • Identify synovial fluid crystals on polarised microscopy • Competency is required in all of the following core procedures: <ul style="list-style-type: none"> ○ Hand and wrist: Joint: PIP, MCP, wrist intra-articular injections. Soft tissue: Carpal tunnel, flexor and extensor tendon sheath soft tissue injections ○ Elbow: Joint: Elbow. Soft tissue: Entheses, olecranon bursa . ○ Shoulder: Joint: Glenohumeral joint, ACJ . Soft tissue: Sub-acromial bursa. 	1,2,3	DOPS

<ul style="list-style-type: none"> ○ Hip: Soft tissue: Bursal injections. ○ Knee: Joint: . Tibio-femoral Soft tissue: Bursal injections. ○ Ankle and foot: Joint: Ankle, MTP Soft tissue: Plantar fascial injections. ● The following procedures are optional <ul style="list-style-type: none"> ○ Injections under X ray guidance: Hip, Sacro-iliac joint, facet joint, sub-talar joint ○ Ultra-sound guided injections ○ Caudal epidural injection ○ Occipital nerve block ○ Suprascapular nerve block ○ Nailfold capillaroscopy ○ Intra-articular injections of Yttrium or osmic acid ○ Punch skin biopsy ○ Needle muscle biopsy 		
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6. Therapeutics and Safe Prescribing:

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Recall range of adverse drug reactions to commonly used drugs, including complementary medicines • Recall drugs requiring therapeutic drug monitoring and interpret results • Outline tools to promote patient safety and prescribing, including IT systems • Undertake regular review of long term medications • Predict and avoid drug interactions, including complementary medicines • Make appropriate dose adjustments following therapeutic drug monitoring, or physiological change (e.g. deteriorating renal function) • Use IT prescribing tools to improve safety • Employ appropriate methods to improve patient concordance with medication • Provide effective explanation for the role of medicines 	<ul style="list-style-type: none"> • Recognise the benefit of minimising number of medications taken by a patient • Appreciate the role of non-medical prescribers • Remain open to advice from other health professionals on medication issues • Recognise the importance of resources when prescribing, including the role of a Drug Formulary and local prescribing guidelines • Ensure prescribing information is shared promptly and accurately between a patient's health providers, including between primary and secondary care • Remain up to date with therapeutic alerts, and respond appropriately 	1,3,4	CbD, mini-CEX, MSF

7. Information Management:

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Outline the local process for clinical coding and the role of coding in health funding • Outline the local systems for information retrieval, including IT systems • Define the provisions of the Data Protection Act and the Freedom of Information Act within the context of patient information • Demonstrate good information management to others • Share written information of a patient's care appropriately by following local procedure • Retrieve investigation results in a timely manner and act upon result appropriately • Use local IT systems appropriately within the context of the data protection act 	<ul style="list-style-type: none"> • Provide leadership for note keeping, referrals, letters and timely discharge summaries written by members of team • Recognise the patient safety and medico-legal impact of poor note keeping 	1,3,4	CbD, mini-CEX, MSF

8. Time Management:

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none">• Outline techniques for improving time management• Recall how time is of use in patient diagnosis and management• Delegate appropriately to ensure critical situations are addressed promptly• Prioritise and re-prioritise own work load and that of members of healthcare team	<ul style="list-style-type: none">• Recognise when you or others are falling behind and take steps to rectify the situation	1,3,4	CbD, mini-CEX, MSF

9. Decision Making and Clinical Reasoning

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • List the drawbacks of commonly used guidelines • Recognise limitations of clinical outcome measures when used in clinical practice • Contribute to the construction, review and updating of local (and national) guidelines of good practice using the principles of evidence based medicine • Appraise retrieved evidence to address a clinical question • Define the steps of diagnostic reasoning: • Develop problem list and action plan • Define the concepts of disease natural history and assessment of risk • Recall methods and associated problems of quantifying risk e.g. cohort studies • Outline the concepts and drawbacks of quantitative assessment of risk or benefit e.g. numbers needed to treat • Describe commonly used statistical methodology • Interpret clinical features and interpret their reliability and relevance to clinical scenario • Generate plausible hypothesis(es) following patient assessment • Construct a concise and applicable problem list using available information 	<ul style="list-style-type: none"> • Keep up to date with national reviews and guidelines of practice (e.g. NICE and SIGN) • Aim for best clinical practice (clinical effectiveness) at all times • Recognise the occasional need to practise outside clinical guidelines • Encourage discussion amongst colleagues on evidence-based practice • Recognise the difficulties in predicting occurrence of future events • Show willingness to discuss intelligibly with a patient the notion and difficulties of prediction of future events, and benefit/risk balance of therapeutic intervention • Be willing to facilitate patient choice • Show willingness to search for evidence to support clinical decision making • Demonstrate ability to identify one's own biases and inconsistencies in clinical reasoning 	1,3,4	CbD, mini-CEX, MSF Evidence of participation in guideline production, evaluation or amendment

<ul style="list-style-type: none">• Define the relevance of an estimated risk of a future event to an individual patient• Use risk calculators appropriately• Apply quantitative data of risks and benefits of therapeutic intervention to an individual patient• Search and comprehend medical literature to guide reasoning			
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10. Lifelong Learning:

Objective: To inculcate the habit of life long learning

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
Life-long learning	Define the principles of Continuing Professional Development.	<ul style="list-style-type: none"> Recognise and use learning opportunities. Use the potential of study leave to keep oneself up to date Identify gaps in knowledge and plan actions to fill them Translate knowledge and new learning into practice Maintain a portfolio of Continuing Professional Development (CPD) Model and promote CPD within the multi-disciplinary team 	Be: <ul style="list-style-type: none"> self motivated eager to learn, Show: <ul style="list-style-type: none"> Willingness to learn from colleagues. Willingness to accept criticism. Strive to enhance professional competence with active involvement in CPD activities Recognise the moral and professional obligation to maintain competence and be accountable Reflect on all aspects of practice	1	CbD, mini-CEX

4.1 Good Quality Care and Patient Safety

1. The Patient as the Central Focus of Care:

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Give adequate time for patients to express ideas, concerns and expectations • Respond to questions honestly and seek advice if unable to answer • Encourage the health care team to respect the philosophy of patient focused care • Develop a self-management plan with the patient • Encourage patients to voice their preferences and personal choices about their care 	<ul style="list-style-type: none"> • Support patient self-management • Recognise the duty of the medical professional to act as patient advocate 	1,3,4	CbD, mini-CEX, MSF, PS

2. Prioritisation of Patient Safety in Clinical Practice:

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Recall principles of risk management • Recall side effects and contraindications of medications prescribed • Outline the hazards of medical equipment in common use • Recognise when a patient is not responding to treatment, reassess the situation, and encourage others to do so • Recognise and respond to the manifestations of a patient's deterioration (symptoms, signs, observations, and laboratory results) and support other members of the team to act similarly • Sensitively counsel a colleague following a significant event, or near incident, to encourage improvement in practice of individual and unit • Improve patients' and colleagues' understanding of the side effects and contraindications of therapeutic intervention • Ensure the correct and safe use of medical equipment, ensuring faulty equipment is reported appropriately 	<ul style="list-style-type: none"> • Continue to maintain a high level of safety awareness and consciousness at all times • Encourage feedback from all members of the team on safety issues • Show willingness to take action when concerns are raised about performance of members of the healthcare team, and act appropriately when these concerns are voiced to you by others • Continue to be aware of one's own limitations, and operate within them competently • Continue to strive for improved practice and patient safety 	1,3,4	CbD, mini-CEX, MSF, PS

3. Principles of Quality and Safety Improvement

Knowledge and Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Define local and national significant event reporting systems • Outline local health and safety protocols (fire, manual handling etc) • Outline the use of patient early warning systems to detect clinical deterioration • Keep abreast of national patient safety initiatives⁵ including National Patient Safety Agency 	<ul style="list-style-type: none"> • Contribute to quality improvement processes (e.g. unit mortality meetings) • Show willingness to participate in safety improvement strategies 	1,3,4	CbD, mini-CEX, MSF

4. Infection Control

Knowledge and Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Outline the principles of infection control defined by the GMC • Outline the principles of infection prevention in high risk groups (e.g. antibiotic use and Clostridium difficile) including antibiotics prescribing policy • List the principle notifiable diseases in the UK • Outline the role of the Consultant in Communicative Disease Control (CCDC) • Counsel patients on matters of infection control • Actively engage in local infection control methods • Prescribe antibiotics according to local antibiotic guidelines 	<ul style="list-style-type: none"> • Encourage other staff to observe infection control principles 	1,3,4	CbD, mini-CEX, MSF

4.2 Team working

Skills	Behaviours	GMP	Assessment/Evidence of Competence
<ul style="list-style-type: none"> • Outline the components of effective collaboration • Describe the roles and responsibilities of members of the healthcare team • Demonstrate leadership and management in the following areas: • Education and training • Deteriorating performance of colleagues (e.g. stress, fatigue) • High quality care • Effective handover of care between shifts and teams • Participate in interdisciplinary team meetings • Provide appropriate supervision to less experienced colleagues 	<ul style="list-style-type: none"> • Encourage an open environment to foster concerns and issues about the functioning and safety of team working • Recognise and respect the request for a second opinion • Recognise the importance of induction for new members of a team • Recognise the importance of prompt and accurate information sharing with Primary Care team following hospital discharge 	1,3,4	CbD, mini-CEX, MSF

4.3 Professional Behaviour

Objective: To ensure that the trainee has the knowledge, skills and attitudes to act in a professional manner at all times

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
(i) Continuity of care	Understand the relevance of continuity of care.	Ensure satisfactory completion of reasonable tasks at the end of the shift/day with appropriate handover Documentation of/for handover. Make adequate arrangements to cover leave.	Recognise the importance of: <ul style="list-style-type: none"> punctuality attention to detail. 	2,3	CbD, mini-CEX, MSF
(ii) Doctor-patient relationship	Define the concept of modern medical professionalism Understand all aspects of a professional relationship such as the need to: <ul style="list-style-type: none"> Deal with inappropriate patient and family behaviour e.g. aggression, violence, racism and sexual harassment. Respect the rights of children, elderly, people with physical, mental, learning or 	Help the patient appreciate the importance of cooperation between patient and doctor. Develop a relationship that facilitates solutions to patient's problems. Deal appropriately with behaviour falling outside the boundary of the agreed doctor patient relationship in patients, e.g. aggression, violence, sexual harassment	Adopt a non-discriminatory attitude to all patients and recognise their needs as individuals. Seek to identify the health care belief of the patient. Acknowledge patient rights to accept or reject advice. Secure equity of access to health care resources for minority groups. Act with compassion at all times	3,4	mini-CEX, MSF, PS

	<p>communication difficulties</p> <ul style="list-style-type: none"> • Adopt a non-discriminatory approach • Place needs of patients above own convenience • Behave with honesty and probity • Act with honesty and sensitivity in a non-confrontational manner <p>Establish the limiting boundaries surrounding the consultation.</p>				
(iii) Recognises own limitations	Know the extent of one's own limitations and know when to ask for advice.	Reflection on individual practice	Be willing to consult and to admit mistakes.	1	CbD, mini-CEX
(iv) Stress	Know the effects of stress Have knowledge of support facilities for doctors.	Develop appropriate coping mechanisms for stress and ability to seek help if appropriate.	Recognise the manifestations of stress on self & others.	2	
(v) Relevance of outside bodies	Have an understanding of the relevance to professional life of: The Royal Colleges GMC Postgraduate Dean Rheumatology Specialty Advisory Committee Defence unions	Recognise situations when appropriate to involve these bodies/individuals.	Be open to constructive criticism. Accept professional regulation. Respect the views of patient representation groups.	2	CbD, mini-CEX, SCE

	British Society for Rheumatology BMA Patient representation groups				
(vi) Personal health	Know about occupational health services. Know about one's responsibilities to the public. Know not to treat oneself or one's family.	Recognise when personal health takes priority over work pressures and to be able to take the necessary time off.	Recognise personal health as an important issue.	2	

4.4 Medical Ethics and Legal Issues

Objective: To ensure the trainee has the knowledge and skills to deal appropriately with ethical and legal issues that arise during the management of patients with rheumatological and other medical disorders.

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
(i) Informed consent	<p>Recall the principles of informed consent</p> <p>Outline the guidance given by the GMC on consent</p> <p>Outline the principles of who is able to obtain consent</p> <p>Outline the situation of providing care without consent in an emergency</p> <p>Recall the concept of capacity including:</p> <ul style="list-style-type: none"> o Principles of consent where capacity is fluctuating o Proceeding with treatment in the event of mental incapacity, including the role of the courts and the relevant mental health legislation <p>Outline the principles of advance directives</p>	<p>Appropriate use of written material</p> <p>Seek a formal assessment of decision making capacity when appropriate</p> <p>Present all information to patients in a format they understand, allowing time for reflection on the decision to give consent</p> <p>Provide a balanced view of care options</p> <p>Obtain a second opinion on treatment options and explanations to patients when appropriate</p> <p>Inform a patient and seek alternative care where personal, moral or religious belief prevents a usual professional action</p>	<p>Respect a patient's rights of autonomy, even in situations where their decision might put themselves at risk of harm</p> <p>Avoid exceeding the scope of authority given by a patient</p> <p>Avoid withholding information relevant to proposed care or treatment in a competent adult</p> <p>Respect a patient's withdrawal of consent</p> <p>Show willingness to seek advance directives</p> <p>Show willingness to obtain a second opinion, senior opinion, and legal advice in difficult situations of consent or capacity</p>	3,4	mini-CEX, MSF, PS

	<p>List the factors to be considered when acting in a patient's 'best interests', including previous expression of preferences by the patient and views of patient's wishes provided by a third party</p> <p>List situations in which consent for treatment is not needed under common law</p> <p>List the factors that must be considered when obtaining consent for screening</p> <p>Understand process of consent for tissue/sample storage and use.</p> <p>How to gain consent for a research project</p> <p>Outline situations where patient consent, while desirable, is not required for disclosure e.g. communicable diseases, public interest</p>				
(ii) Confidentiality	<p>Outline and follow the guidance given by the GMC on confidentiality</p> <p>Define the role of the Caldicott Guardian within an institution, and outline the process of attaining</p>	<p>Use and share all information appropriately</p> <p>Avoid discussing one patient in front of another</p> <p>Be prepared to seek patients wishes before disclosing information</p>	<p>Respect the right to confidentiality.</p> <p>Respect patients' requests for information not to be shared, unless this puts the patients or others at risk of harm</p>	4	CbD, MSF, PS

	<p>Caldicott approval for audit or research</p> <p>Outline the procedures for seeking a patient's consent for disclosure of identifiable information</p> <p>Recall the obligations for confidentiality following a patient's death</p> <p>Be aware of relevant strategies to ensure confidentiality.</p> <p>Be aware of situations when confidentiality might be broken</p>		<p>Show willingness to share information about their care with patients, unless they have expressed a wish not to receive such information</p>		
(iii) Legal issues relating to criminal matters	<p>Know where to seek advice relating to responsibilities in serious criminal matters.</p>	<p>Be able to obtain suitable evidence or know whom to consult if in doubt.</p>	<p>Recognise the importance of legal issues in medical practice and always be ready to seek advice.</p>	1	CbD, SCE
iv) Ethical issues	<p>Demonstrate a knowledge of the principles of medical ethics</p> <p>Be aware of professional guidelines published by the GMC, BSR and other bodies related to clinical rheumatology</p>	<p>Recognise the factors influencing ethical decision making: religion, moral beliefs, cultural practices</p> <p>Be able to communicate ethical issues with patients, colleagues and the public, surrounding:</p> <p>Confidentiality</p> <p>Informed consent</p>	<p>Encourage ethical reflection in others</p> <p>Show willingness to seek advice of peers, legal bodies, and the GMC in the event of ethical dilemmas over disclosure and confidentiality</p> <p>Respect opinions of patients.</p> <p>Respect the opinion of colleagues.</p> <p>Be willing to refer on to a</p>	1,4	MSF, PS, SCE

			colleague if conflict exists between personal values and those of the patient.		
v) Do not resuscitate	Define the standards of practice defined by the GMC when deciding to withhold or withdraw life-prolonging treatment	Counsel patients, family, carers and advocates tactfully and effectively when making decisions about resuscitation status, and withholding or withdrawing treatment	Show willingness to seek the opinion of others when making decisions about resuscitation status, and withholding or withdrawing treatment	1,4	CbD, MSF, SCE
vi) Legal framework for practice	Outline the principles of the following medico-legal areas: Child protection relevant to adolescent and adult practice Mental health legislation: the powers to detain a patient and giving emergency treatment against patient's will under common law Death certification and role of coroner / procurator fiscal Advance directives and living wills Surrogate decision making such as Power of Attorney Organ donation and retention and awareness of local procedures Communicable disease	Prepare a medico-legal statement for submission to the Coroner's Court and other legal proceedings Incorporate legal principles into day to day practice Practise and promote accurate documentation within clinical practice	Show willingness to seek advice from the Healthcare Trust, legal bodies (including defence unions), and the GMC on medico-legal matters Promote reflection on legal issues by members of the team	1,4	CbD, MSF, SCE

	<p>notification Medical risk and driving. Conditions to be reported by patients to the DVLA and responsibilities of doctors if patients do not Data Protection and Freedom of Information Acts Provision of continuing care and community nursing care by local authorities, including Section 47 National Assistance act Outline sources of medico- legal information Outline the process of discipline in the event of medical malpractice Outline the procedure to be followed when abuse is suspected</p>				
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4.5 Patient Education and Disease Prevention

Objective: To ensure that the trainee has the knowledge, skills and attitudes to be able to educate patients effectively about rheumatological disease.

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
(i) Educating patients about: Disease Investigations Management	Know disease course and manifestations. Know investigation procedures including possible alternatives / choices. Be aware of management strategies for rheumatological disease.	Give information to patients clearly in a manner that they can understand including written information. Encourage questions. Discuss management plans and follow up arrangements	Consider involving patients in developing mutually acceptable investigation plans. Encourage patients to access: Further information Patient support groups	1,3	mini-CEX, MSF, PS, SCE
(ii) Environmental & lifestyle risk factors	Understand the risk factors that may influence certain rheumatological diseases, including; Life style Smoking Alcohol Medication	Advise on lifestyle changes. Advise on teratogenic potential of medication. Involve other health care workers as appropriate.	Do not display prejudice	1,3	Cbd, mini-CEX, SCE

(iii) Epidemiology & screening	<p>Know the methods of data collection and their limitations.</p> <p>Know principles of 1° & 2° prevention & screening.</p> <p>Outline current UK screening programmes</p>	<p>Assess an individual patient's risk factors.</p> <p>Encourage participation in appropriate disease prevention or screening programmes.</p>	<p>Encourage appropriate screening to facilitate early intervention</p> <p>Encourage effective team working in health promotion</p> <p>Show willingness to remain well briefed in local or national outbreaks</p> <p>Consider the: positive & negative aspects of prevention importance of patient confidentiality Respect patient choice.</p>	1,4	mini-CEX, PS, SCE
(iv)	<p>Outline the concept of patient self-care</p>	<p>Develop and agree a management plan with the patient ensuring comprehension to maximise self-care</p> <p>Provide effective patient education, with support of the multi-disciplinary team</p> <p>Promote and encourage involvement of patients in appropriate support networks, both to receive support and to give support to others</p> <p>Encourage and support patients in accessing appropriate information</p>	<p>Show willingness to facilitate access to the appropriate training and skills in order to develop the patient's confidence and competence to self care</p> <p>Ensure appropriate equipment and devices are discussed:</p> <ul style="list-style-type: none"> o Put patients in touch with the relevant agency from where they can procure the items as appropriate o Provide the relevant tools and devices when possible 		

4.6 Relationships with Patients and Communication:

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
(i) Within the consultation	<p>A comprehensive understanding of:</p> <ul style="list-style-type: none"> • Interview structure • Effective listening • Need to clarify information given by patient • Use of comprehensible language tailored to patient • Use open and closed questions appropriately • Ability to gauge patients' ideas, concerns, expectations and comprehension • Appropriate use of written materials and interpreters • Importance of acting in a courteous, polite and professional manner 	<p>Demonstrate good communication skills to others in the team</p> <p>Manage patient follow-up effectively</p> <p>Accurately record details of discussions with the patient over care</p> <p>Identify and manage communication barriers while respecting confidentiality: language, cultural, hearing impairment, poor literacy etc</p>	<p>Show willingness to provide patients with a second opinion</p> <p>Show willingness to identify other sources of information for patients (printed literature, support societies etc)</p> <p>Ensure the patient is well informed and central to the decision making process</p> <p>Be aware of significant others and recognise their role in the management of the patient with a long term condition</p>	3	mini-CEX, MSF, PS
(ii) Breaking Bad News	<p>A thorough understanding of:</p> <ul style="list-style-type: none"> • Interview structure 	<p>Demonstrate to others good practice in breaking bad news</p> <p>Counsel families on issues of:</p>	<p>Take leadership in breaking bad news</p>	3	mini-CEX, MSF, PS

	<ul style="list-style-type: none"> • Normal bereavement process • Understand and respect cultural differences in end of life care and bereavement • Select appropriate setting • Encourage questioning and ensure comprehension • Avoid undue optimism or pessimism • Act with empathy, honesty and sensitivity 	<ul style="list-style-type: none"> • Death and dying • Withdrawing and withholding life-prolonging treatment • Incapacity (such as follows disabling stroke) • ○ Transplantation 	Respect the different ways people react to bad news		
(iii) Complaints and Medical Error	<p>Develop comprehensive awareness of:</p> <ul style="list-style-type: none"> • Local complaints procedure • Factors likely to lead to complaints (poor communication, dishonesty etc) • Need to adopt behaviour likely to prevent complaints • Ability to deal with dissatisfied patients or relatives • Need to recognise when something has gone 	<p>Contribute to processes whereby complaints are reviewed and learned from</p> <p>Explain comprehensibly to the patient the events leading up to a medical error</p> <p>Deliver an appropriate apology</p> <p>Distinguish between system and individual errors</p>	<p>Take leadership over complaint issues</p> <p>Recognise the impact of complaints and medical error on staff, patients, and the National Health Service</p> <p>Contribute to a fair and transparent culture around complaints and errors</p> <p>Recognise the rights of patients, family members and carers to make a complaint</p>	3,4	CbD, mini-CEX, MSF, PS

	<p>wrong and identify appropriate staff to communicate this with</p> <ul style="list-style-type: none"> • Act with honesty and sensitivity in a non-confrontational manner <p>Outline the principles of an effective apology. Define the local complaints procedure Identify sources of help and support when a complaint is made about yourself or a colleague</p>				
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4.7 Working with Colleagues:

Objective: to demonstrate good working relationships with colleagues

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
Interactions between: •Hospital & GP •Hospital & other agencies e.g. social services •Medical and surgical specialties	Know the roles and responsibilities of team members. Know how a team works effectively. Know the roles of other clinical specialties and their limitations. Know the role of multidisciplinary management in rheumatological disorders. Outline features of good team dynamics Outline the principles of effective inter-professional collaboration to optimise patient, or population, care	Establish effective communication with relevant teams by means appropriate to the urgency of a situation e.g. accurate written consultation letter Delegate to members of the medical team and members of the multi-disciplinary team whilst maintaining appropriate supervision Be able to communicate effectively. Handover safely. Seek advice if unsure. Recognise when input from another specialty is required for individual patients.	Show respect for others opinions. Be conscientious and work co-operatively. Recognise own limitations. Foster a supportive and respectful environment where there is open and transparent communication Respect opinions and encourage open communication with all members of the multidisciplinary team to improve learning and patient care Encourage an atmosphere of open communication within teams to improve patient	3	CbD, MSF

		<p>Be able to work effectively with GPs, other medical and surgical specialists and other health care professionals.</p> <p>Employ collaborative negotiation to prevent and resolve conflict</p>	<p>care and learning</p> <p>Show willingness to participate in multi-disciplinary and multi-specialty team meetings</p>		
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4.8 Team Working

Objective: To demonstrate the ability to work in clinical teams

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
Clinical teams. Respect others opinion Effective leadership skills	Roles & responsibilities of team members. How a team works. Ensuring colleagues understand the individual roles and responsibilities of each team member. Own professional status and specialty A knowledge of the field. The capacity to perceive the need for action and initiate that action	Respect skills and contribution of colleagues to be conscientious and work constructively. Respect for others opinion. To recognise your own limitations Objective setting; Lateral thinking; Planning; Motivating; Organising; Setting example; Negotiation skills.	Recognise own limitations. Enthusiasm; integrity; courage of convictions; imagination; determination; energy; and professional credibility.	3	CbD, MSF

4.9 Leadership:

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
Personal qualities	Identify own strengths, limitations and the impact of their behaviour; is able to change their behaviour in light of feedback and reflection				
	Identify different methods of obtaining feedback Recognises the importance of best practice transparency and consistency	Maintain and routinely practice critical self awareness, including being able to discuss strengths and weaknesses with supervisor and recognising external influences and changing behaviour accordingly. Use assessment, appraisal, complaints and other feedback to discuss and develop an understanding of own development needs	Recognise and show respect for, diversity and differences in others Show commitment to continuing professional development which involves seeking training and self development opportunities, learning from colleagues and accepting criticism	3	MSF, PS
Working with others	Adopt a team approach, acknowledging and appreciating efforts, contributions and compromises. Continue to recognise the common purpose of the team and respect their decisions				
	Recognise a wide range of leadership styles and approaches and the applicability to different situations and people	Enable individuals, groups and agencies to implement plans and make decisions	Show recognition of a team approach, respecting colleagues, including non-medical professionals	3	MSF
Managing services	Support team members to develop their roles and responsibilities and continue to review performance of the team members to ensure that planned service outcomes are met				

	Be aware of relevant legislation and HR policies, including the duties, rights and responsibilities of an employer and co-worker. Describe individual performance review	Continue to contribute towards staff development and training, including mentoring, supervision and appraisal	Demonstrate commitment to good communication whilst also inspiring confidence and trust	3	MSF, SCE
Improving services	Ensure patient safety at all times, continue to encourage innovation and facilitate transformation			2, 3	
	Identify how healthcare governance influences patient care. Recognise a variety of methodologies for developing creative solutions to improving services	Monitor the quality of equipment and safety of the environment relevant to the specialty. Question existing practice in order to improve the services	Seek advice and/or assistance whenever concerned about patient safety Support colleagues to voice new ideas and be open minded to new thoughts.		MSF, PS
Setting direction	Is able to identify the contexts for change and is able to make decisions			3	
	Identify the functions and responsibilities of national bodies, College and faculties, representatives, regulatory bodies. recognises effective communication strategies within organisations	Can discuss the local, national and UK health priorities and how they impact on the delivery of health care relevant to the specialty Can contribute to committee meetings and work collegiately and collaboratively with a wide range of people outside the immediate clinical setting	Is willing to articulate strategic ideas and use effective influencing skills Is willing to participate in decision making processes beyond the immediate clinical care setting		MSF, SCE

4.10 Teaching and Educational Supervision

Objective: To demonstrate the knowledge, skills and attitudes to provide appropriate teaching, learning and assessment opportunities in clinical rheumatology for varied groups (medical, other health professional and lay groups)

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
(i) To have the skills, attitudes and practices of a competent teacher	<p>The goals and objectives of undergraduate medical education as set out by the GMC.</p> <p>Identify adult learning principles.</p> <p>Identify learner needs.</p> <p>Identify learning styles.</p> <p>Structure teaching activities for large audiences, small groups and clinic based teaching.</p> <p>Principles of evaluation.</p> <p>Outline the workplace-based assessments in use</p> <p>Outline the appropriate local course of action to assist the failing trainee</p>	<p>Facilitate learning process.</p> <p>Identify learning outcomes.</p> <p>Construct educational objectives.</p> <p>Communicate effectively with the learners.</p> <p>Use effective questioning techniques.</p> <p>Teach large and small groups effectively.</p> <p>Select and use appropriate teaching resources.</p> <p>Evaluate programmes and events</p> <p>Be able to chair an educational event.</p> <p>Vary teaching format and stimulus, appropriate to situation and subject</p> <p>Provide effective feedback after teaching, and promote learner reflection</p> <p>Design and deliver effective lecture, presentation, small</p>	<p>Demonstrate a willingness, enthusiasm and commitment to teach.</p> <p>Show respect for the learner.</p> <p>Demonstrate a professional attitude towards teaching.</p> <p>Demonstrate a learner centred approach to teaching.</p> <p>Seek feedback and demonstrate a willingness to change methods in response to constructive feedback.</p> <p>Recognise the importance of the role of the physician as an educator</p> <p>Encourage discussions in the clinical settings to colleagues to share knowledge and understanding</p> <p>Show willingness to participate in workplace-</p>	1	MSF, TO, Formal qualifications (eg Cert Med Ed)

		group and bed side teaching sessions Provide appropriate career advice, or refer trainee to an alternative effective source of career information Participate in strategies aimed at improving patient education e.g. talking at support group meetings Recognise the failing trainee	based assessments Show willingness to take up formal tuition in medical education Recognise the importance of personal development as a role model to guide trainees in aspects of good professional behaviour		
(ii) Assessment	Know the principles of assessment Know different assessment methods Define formative and summative assessment	Use appropriate assessment methods Give constructive, effective feedback	Maintain honesty and objectivity during appraisal and assessment	1	MSF, TO
(iii) Appraisal	Know the principles of appraisal Know the structure of the appraisal interview	Participate in effective appraisal	Show respect for those participating in appraisal.	1,2	MSF

4.11 Research

GMP 1,2,4

Understanding rheumatology research.

Trainees should become generally conversant with several of the scientific methods which are used in rheumatological research.

These include:

- epidemiology - principles and techniques; study design
- genetics – association and linkage studies, whole genome approaches, SNPs etc, statistical techniques
- cell biology – signalling, genetic manipulation – transfection, use of siRNA, protein and RNA analysis techniques, gene profiling, stem cell research
- immunology – animal models, including gene knockout/knock-in mice, flow cytometry, cytokine measurement, characterisation of autoantibodies
- pharmacology – drug development, assessment, trial design, pharmacogenetics
- behavioural and psychological studies – methods of assessment, models; pain research
- bio-engineering – design, modelling, testing; tissue engineering

The list is not exhaustive, and it is not envisaged that trainees will be familiar with more than 3 or 4 areas; of these they would commonly be very familiar with only one and competent to understand research carried out in 2 or 3 others.

4.12 Conducting Rheumatology Research

Section 5.4 below defines requirements for participation in research

Trainees are encouraged to undertake a period of full time research and have a good knowledge of research methodology. There should be active involvement with research projects throughout the training period.

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/ Evidence of Competence
To be able to plan and analyse a research project.	Be able to set up a hypothesis and test it. Know how to design a research study. Know how to use appropriate statistical methods. Know the principles of research ethics and the role of research ethics committees (CoREC LREC, MREC). Know how to write a scientific paper. How to identify sources of research funding.	Develop critical appraisal skills and apply these when reading literature Ability to frame questions to be answered by a research project. Develop protocols and methods for research. Obtain ethical committee approval for a research proposal. Participate in collaborative research with clinical/scientific colleagues. Be able to use databases. Be able to accurately analyse data. Write and submit a case report or scientific paper. Have good written and verbal presentation skills.	Demonstrate curiosity and a critical spirit of enquiry. Demonstrate the persistence needed to follow a project from inception to completion. . Humility and the acknowledgement of the contribution of others.	1,4	SCE Completed audits. Completed projects. Research proposals and grant applications. Formal qualifications.
Participation in clinical research	Outline the GMC guidance on good practice in	Demonstrate the ability to write a scientific paper	Ensure patient confidentiality. Demonstrate knowledge of the	1,4	mini-CEX, PS

	<p>research11 Outline the differences between audit and research Describe how clinical guidelines are produced Demonstrate a knowledge of research principles Outline the principles of formulating a research question and designing a project Comprehend principal qualitative, quantitative, bio-statistical and epidemiological research methods Outline sources of research funding Describe a patient's rights with respect to participation in a research study, informed consent, patient confidentiality, data protection.</p>	<p>Apply for appropriate ethical research approval Demonstrate the use of literature databases Demonstrate good verbal and written presentations skills Explain a clinical research study to a potential patient participant Take informed consent Assess patients for the efficacy (response and side effects) of interventions in terms of current clinical practice</p>	<p>importance of ethical approval and patient consent for clinical research Recognise the ethical responsibilities to conduct research with honesty and integrity, safeguarding the interests of the patient and obtaining ethical approval when appropriate Follow guidelines on ethical conduct in research and consent for research12,13 Show willingness to the promotion of involvement in research</p>		
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4.13 Clinical Governance

Objective: Demonstrate an understanding of the context, the meaning and the implementation of Clinical Governance.

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
<p>(i) The organisational framework for Clinical Governance at local, health authority and national levels. Understanding of the benefits a patient might reasonably expect from Clinical Governance. Creating an environment where mistakes and mismanagement of patients can be openly discussed and learned from</p>	<p>Define the important aspects of Clinical Governance. Explain medical and clinical audit. Research and Development. Integrated care pathways. Evidenced based practice. Clinical effectiveness. Clinical risk systems. To define the procedures and the effective action when things go wrong in own practice or that of others. Complaints procedures.</p>	<p>Be an active partaker in clinical governance. Be able to undertake medical and clinical audit. Be actively involved in audit cycles. Be active in research and development. Critically appraise medical data research. Practice evidence based medicine. Aim for clinical effectiveness (best practice) at all times. Educate self, colleagues and other health care professionals. Be able to handle and deal with complaints in a focused and constructive manner. Learn from complaints. Develop and institute clinical guidelines and integrated care pathways. Be aware of advantages and disadvantages of guidelines. Report and investigate critical</p>	<p>Make the care of your patient your first concern. Respect patient's privacy, dignity and confidentiality. Be prepared to learn from mistakes, errors and complaints. Recognise the importance of team work. Share best practice with others. Willingness to cultivate a questioning approach to current practice of rheumatology and motivation to make improvements.</p>	<p>1,2,4</p>	<p>SCE Audit Assessment tool. Evidence of effective participation in governance procedures, audit designs and implementation</p>

		incidents. Regular review of adverse events and modify practice accordingly. Take appropriate action if you suspect you or a colleague may not be fit to practice.			
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(ii) Risk management	Knowledge of such matters as H&S policy, policies on needle stick injuries, note keeping, communications and staffing numbers. Knowledge of risk assessment, perception and relative risk Know the complications and side effects of treatments.	Confidently and authoritatively discuss risks with patients and to obtain informed consent. Able to balance risks and benefits with patients.	Willingness to respect and accept patients views and choices Willingness to be truthful and to admit error to patients, relatives and colleagues.	1,2,3	CbD, PS, SCE
(iii) Evidence	Know & understand: the principles of evidence based medicine the types of evidence	Able to critically appraise evidence. Ability to be competent in the use of databases, libraries and the internet. Able to discuss the relevance of evidence with individual patients	Display a keenness to use evidence in the support of patient care and own decisions therein.	1	
(iv) Audit	Recall the role of audit (developing patient care, risk management etc) Recall the steps involved in completing the audit cycle	To be able to design, plan and carry out an audit project on a relevant clinical topic. To achieve this the trainee will be required to - <ul style="list-style-type: none"> Specify an appropriate standard of practice for auditing, 	Consider the relevance of audit to: benefit patient care clinical governance	1,2,4	SCE Audit Assessment. Evidence of effective participation in governance procedures, audit designs

		<ul style="list-style-type: none"> • Identify suitable outcome measures • Apply appropriate statistical methods to achieve a robust study design and analysis of results <p>complete the audit 'loop' to demonstrate whether change in practice has occurred Contribute to local and national audit projects as appropriate (e.g. NCEPOD17) Support audit within the multi-disciplinary team</p>			and implementation
(v) Guidelines	Know the advantages and disadvantages of guidelines Methods of determining best practice	Ability to utilise guidelines Be involved in guideline generation, evaluation and review	Show regard for individual patient needs when using guidelines Willingness to use guidelines as appropriate		

4.14 Structure of the NHS and the Principles of Management

Objective: To display knowledge of the structure and organisation of the NHS nationally and locally.

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/ Evidence of Competence
Structure of the NHS and the principles of management	<p>Know the structure of the NHS, primary care groups, Trusts and Hospital Trusts.</p> <p>Know the local Trusts structure including Chief Executives, Medical Directors, Clinical Directors and others.</p> <p>Know the role of postgraduate deaneries, specialist societies, the royal colleges and the general medical council.</p> <p>Know the appointments procedures and the importance of equal</p>	<p>Develop skills in managing change and managing people.</p> <p>Develop leadership skills to play a leading role in developing local rheumatological services.</p> <p>Develop interviewing techniques and those required for performance reviews.</p> <p>Be able to build a business plan.</p> <p>To acquire the management skills relevant to participation in and leadership of a rheumatology team. To achieve this the trainee will be required to demonstrate -</p> <ul style="list-style-type: none"> • Effective time management • Negotiating skills • Participation in staff organisation • Effective supervision of junior medical staff 	<p>Show an awareness of equity in health care access and delivery.</p> <p>Demonstrate an understanding of the importance of a health service for the population.</p> <p>Show respect for others, ensuring equal opportunities.</p> <p>Demonstrate a willingness to assume managerial responsibilities.</p> <p>Recognise the importance of just allocation of healthcare resources</p> <p>Recognise the role of physicians as active participants in healthcare systems</p> <p>Show willingness to improve managerial skills (e.g. management courses) and engage in</p>	1,2	SCE, MSF, Evidence of management experience

	<p>opportunities.</p> <p>Outline the guidance given on Management and Doctors by the GMC</p> <p>Outline the principles of:</p> <ul style="list-style-type: none"> • Clinical coding • European Working Time Directive • National Service Frameworks • Health regulatory agencies (e.g. CHI, NICE, Scottish Executive) • NHS Structure and relationships • NHS finance and budgeting • Consultant contract and the contracting process • Resource allocation • The potential role 	<ul style="list-style-type: none"> • Effective team leadership <p>Employ new technologies appropriately, including information technology</p>	<p>management of the service</p>		
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	<p>of the Independent sector as providers of healthcare</p> <p>Describe the structure and function of the healthcare system as it applies to Rheumatology</p>				
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4.15 Information Technology, Computer Assisted Learning and Information Management

Objective: Demonstrate competence in the use and management of health information

Subject	Knowledge	Skills	Behaviours	GMP	Assessment/Evidence of Competence
To demonstrate good use of information technology for patient care and for own personal development.	<p>Define how to retrieve and utilize data recorded in clinical systems.</p> <p>Define main local and national projects and initiatives in information technology relevant to clinical rheumatology.</p> <p>To understand the implications of the Data Protection Act for patient confidentiality.</p>	<p>Demonstrate competent use of database, word processing and statistics programmes.</p> <p>Undertake effective literature searches.</p> <p>Access relevant web sites and specialist databases to undertake searches.</p> <p>To appraise available software.</p> <p>To apply the principles of confidentiality and their implementation in terms of clinical practice in the context of information technology.</p> <p>Produce effective computer assisted presentations.</p>	<p>Demonstrate the acquisition of new attitudes in patient consultations in order to make maximum use of information technology.</p> <p>Be willing to offer advice to lay person on access to appropriate Internet sources and support groups.</p> <p>Adopt proactive and enquiring attitude to new technology.</p>	1,2	CbD, Presentations

5 Teaching and Learning

5.1 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 Rheumatology in each deanery is, therefore, the remit of the regional Rheumatology 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.

The core learning method for training in Rheumatology will be work-based experiential learning supported by independent self-directed learning and by a formal education programme run regionally or sub-regionally for rheumatology trainees. Key to the success of the work-based learning will be appropriate clinical and educational supervision. This will be overseen by the named educational supervisor but will also involve other consultants and clinicians with appropriate expertise.

Clinical skills acquisition will be predominantly by supervised work-based learning, supported where appropriate by skills laboratory activities (e.g. when initially learning joint injections). Skills competence will be assessed by means of directly observed, on-the-job activities, using the workplace-based assessments. Trainees will keep a portfolio of their activities, including assessments, which will inform both their appraisals and their ARCP.

The formal education programme will generally be away from the clinical site. It will allow the opportunity for collaborative learning between trainees and trainers. Such sessions will be mapped to the rheumatology curriculum. Additionally, in some cases, trainees may embark upon a relevant formal Masters programme to develop aspects of their knowledge and skills, both clinical and otherwise (e.g. research methods, literature searching). Trainees will also attend other off-site educational activities, in agreement with their educational supervisor. Such activities will include attendance at certain specialist meetings (e.g. the British Society for Rheumatology annual meeting) as well as relevant education courses. Attitudinal development will be fostered by appropriate behaviours in the workplace, in addition to individual (with and without the educational supervisor) and group reflections (e.g. on training days) on aspects of practice. Again this may be supported by attendance at relevant courses, e.g., on communication, on ethical aspects of practice. Professionalism will be assessed in the workplace by means of multi-source feedback.

Acting up as a consultant (AUC)

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

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

5.2 Clinical Placements

The programme to which the trainee is appointed will be based in a region with a Programme Director answerable to the Postgraduate Dean via the Regional Rheumatology lead. The trainee will be based in different centres within the region, typically for periods of 12-18 months. In each centre the trainee will have a named consultant educational supervisors. In each centre, there is a minimum of one consultant per trainee. The Deanery is responsible for local quality assurance of training and ensuring that training programmes meet the GMC standards for postgraduate medical education.

Placements in the different training centres will be allocated to ensure that the trainee is exposed to the case mix of patients and experiences relevant to covering the learning outcomes of the programme. Thus specific opportunities in a given clinical centre will be mapped against the curriculum learning outcomes. Programme directors will then allocate trainees in a blueprinting exercise so that there is opportunity to cover all core learning outcomes during the trainee's individual programme. Where the learning outcome is relatively more specialised, e.g. the diagnosis and management of patients with the rarer inflammatory autoimmune conditions seen by the rheumatologist, trainees will spend time at those centres dealing with such patients in the latter half of their training. This is because more experienced trainees will be better placed to maximise such a learning opportunity and will also be more prepared to deal with patients with such complex conditions. In some circumstances, trainees may spend time in a department outside of their own region. This will be by agreement with the programme director and will have a clear purpose in terms of developing defined learning objectives.

5.3 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.

For trainees to maximise their experiential learning opportunities it is important that they work in a 'good learning environment'. This includes encouragement for self-directed learning as well as recognising the learning potential in aspects of day to day work (e.g. what three things have I learnt from this ward round?) and generally adopting a positive attitude to training.

Learning from peers should also be encouraged. Active involvement in group discussion is an important way for doctors to share their understanding and experiences. Lectures and formal educational sessions make up only a small part of the postgraduate training in rheumatology. The bulk of learning occurs as a result of clinical experience (Experiential learning) and self-directed study. The degree of self-direct learning will increase as trainees become more experienced. A supportive open atmosphere should be cultivated and questions welcomed.

The list of learning opportunities below offers guidance only, there are other opportunities for learning that are not listed here. Trainees will learn in different ways according to their level of experience.

A. Experiential Learning Opportunities

1. 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 around clinical problems.
2. Every time a trainee observes another doctor, consultant or fellow trainee, seeing a patient or their relatives there is an opportunity for learning.
3. Ward-based learning including ward rounds. Ward rounds, including those post-take, should be led by a consultant and include feed-back on clinical and decision making skills.
4. Supervised consultations in outpatient clinics. Trainees should have the opportunity to assess both new and follow-up patients and discuss each case with the supervisor so as to allow feedback on diagnostic skills and gain the ability to plan investigations.
5. Trainees need to learn to make increasingly independent decisions on diagnosis, investigations and treatment consistent with their level of experience and competence and with maintaining patient safety. These decisions should be reviewed with their supervising consultant.
6. There are many situations where clinical problems are discussed with clinicians in other disciplines, such as radiology, pathology and multidisciplinary meetings. These provide excellent opportunities for observation of clinical reasoning.

B. Small Group Learning Opportunities

1. Case presentations and small group discussion, particularly of difficult cases, including presentations at clinical and academic meetings. This should include critical incident analysis.
2. Small group bedside teaching, particularly covering problem areas identified by the trainees.
3. Small group sessions of data interpretation, particularly covering problem areas identified by trainees.
4. Local resuscitation skills review by a resuscitation training officer including simulation with manikins.
5. Participation in audit meetings, journal clubs and research presentations etc.
6. Video consultation with subsequent small group discussion.

C. One-to-One Teaching

1. Review of out-patients, ward referrals or in-patients with supervising consultant.
2. Review/case presentations with educational supervisor including selected notes, letters and summaries.
3. Critical incident analysis.
4. Discussion between trainee and trainer of knowledge of local protocols.
5. Video consultation with subsequent individual discussion with trainer.
6. Feedback following a mini-CEX assessment provides an excellent teaching opportunity.

D. Regular Teaching and External Courses etc

1. Lectures and small group teaching as part of regional teaching sessions for trainees.
2. Educational courses such as the British Society for Rheumatology (BSR) Core and Advanced courses.
3. Formal training in communication skills and in teaching skills.

E. Personal Study

1. Personal study including computer-based learning.
2. Practise examination questions and subsequent reading.
3. Reading journals and books.
4. Writing reviews and other teaching material.

F. Teaching Others

1. Teaching undergraduate medical students and students in allied health professions and postgraduate doctors provides excellent learning opportunities for the teacher.
2. Presenting cases at grand rounds or similar clinical meetings provides the opportunity to review the literature relating to the clinical case. This provides the opportunity for in depth study of one clinical problem as well as learning important critical thinking skills.
3. Journal club presentations allow development of critical thinking and in depth study of particular areas.

G. Research

1. Research provides the opportunity to develop critical thinking and the ability to review medical literature. This is an essential skill for effective clinical practice as well as for the pursuit of more academic research.
2. Clinical research allows development of particular expertise in one area of rheumatology allowing more in depth knowledge and skills and helping to focus long term career aims and interests.

H. Audit and Guidelines

1. Participation in audit: trainees should be directly involved and expect, after understanding the rationale and methodology, to undertake a minimum of one in-depth audit every two-years of training.
2. Guideline generation/review.

5.4 Research

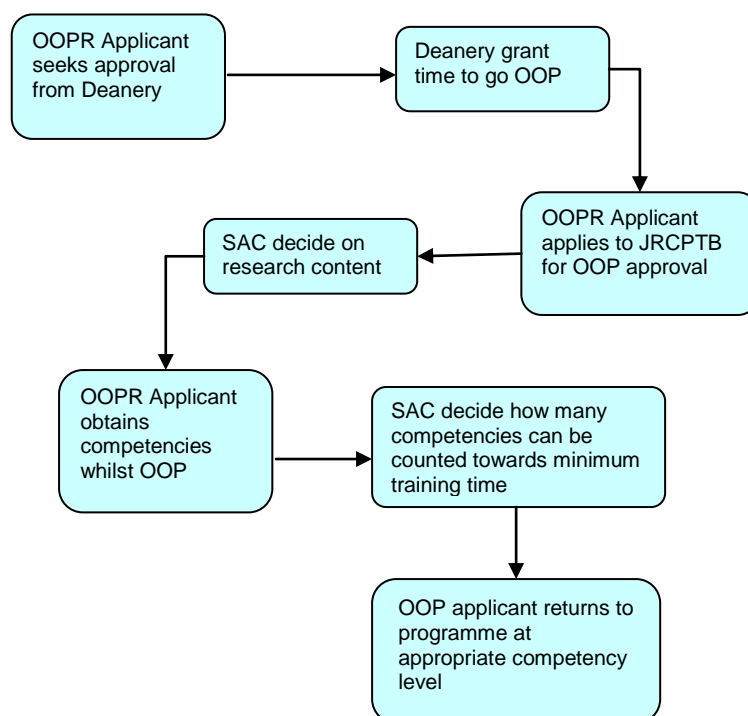
Full time research (one year fellowships and additional years out of programme leading to a higher degree) is strongly encouraged but optional since this is usually dependent on funding.

All trainees are required to carry out *some research*, starting with *audit* and continuing with "*post-audit*" research questions which are often thrown up by audits. Case reports and case series should be written up as *short papers* and presented, often as *posters* at national or regional meetings. Participation in *clinical trials* is encouraged, particularly as co-investigators to gain experience of trial design, LREC/MREC functions, recruitment and analysis of results. *Clinical collaboration* with local laboratory or epidemiological research should be undertaken whenever possible, e.g. assembling patient databases. *Short laboratory projects* can sometimes be arranged in local research units, similar to those undertaken by BSc/MSc students, and not requiring full-time work.

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.

6 Assessment

6.1 Assessment System

The purpose of the assessment system is to:

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

The integrated assessment system comprises workplace-based assessments and knowledge – 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.

6.2 Assessment Methods

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

Examinations and Certificates

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

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

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

Workplace-Based Assessments

- Multi-Source Feedback (MSF)
- mini-Clinical Evaluation Exercise (mini-CEX)
- Direct Observation of Procedural Skills (DOPS)
- Case-Based Discussion (CbD)
- Patient Survey (PS)
- 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.

Direct Observation of Procedural Skills (DOPS)

A DOPS is an assessment tool designed to assess the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

Case based Discussion (CbD)

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

Patient Survey (PS)

Patient Survey address issues, including behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and

professionalism by concentrating solely on their performance during one consultation.

Audit Assessment 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 (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).

6.3 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 6.4, giving details of the evidence required of trainees for submission to the ARCP panels.

6.4 ARCP Decision Aid

Assessment / Evidence	ARCP year 3 (End of ST3)	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5 = PYA)	ARCP year 6 (End of ST6 = CCT)
Expected competence	<p>Trainees should be competent in the initial assessment of patients presenting with a common rheumatological problem.</p> <p>They should be competent in the management of a patient presenting with an acute “hot” joint.</p> <p>Trainees must demonstrate appropriate professional behaviours throughout</p>	<p>Trainees should be competent in the assessment of patients presenting with any of the common rheumatological conditions</p> <p>Trainees should be competent in the assessment and management of all common rheumatological emergencies.</p> <p>Trainees must demonstrate appropriate professional behaviours throughout</p>	<p>Trainees should be autonomously competent in the assessment and management of patients presenting with all common rheumatological conditions.</p> <p>Trainees must demonstrate appropriate professional behaviours throughout</p>	<p>Trainees should be autonomously competent in the assessment and management of patients presenting with all core rheumatological conditions – ie, those that are common but also those that a non sub-specialised rheumatologist would expect to see in a typical year’s practice.</p> <p>Trainees must demonstrate appropriate professional behaviours throughout</p>
Rheumatology Specialty Clinical Examination		Opportunity to attempt at this stage	Must have attempted	Must have passed to obtain CCT
MSF	Satisfactory	Satisfactory	Satisfactory	Satisfactory
DOPS	Have demonstrated competence by DOPS in 2 core techniques	Have demonstrated competence by DOPS in 3 further core techniques	Have demonstrated competence by DOPS in 3 further core techniques (+/- specialist techniques)	Competence should have been demonstrated in the full spectrum of core techniques, covering all types of core injection, but not necessarily every site.
Patient Survey		Satisfactory*	Satisfactory*	
mini-CEX	<p>2 mini-CEX in which the emphasis is on history/exam in common conditions.</p> <p>1 mini-CEX or CBD must be on</p>	4 mini-CEX where the emphasis is on the assessment and management of patients with common rheumatological conditions	4 mini-CEX on the assessment and management of patients with common conditions and the assessment of patients with more	4 mini-CEX on the assessment and management of patients with all core rheumatological conditions, with the emphasis on complex

Assessment / Evidence	ARCP year 3 (End of ST3)	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5 = PYA)	ARCP year 6 (End of ST6 = CCT)
	acute hot joint.		complex rheumatological conditions	conditions
CbD	2 CBD in which the emphasis is on history/exam in common conditions. 1 CbD or mini-CEX must be on acute hot joint	4 CbD where the emphasis is on the assessment and management of patients with common rheumatological conditions	4 CbD on the assessment and management of patients with common conditions and the assessment of patients with more complex rheumatological conditions	4 CbDs on the assessment and management of patients with all core rheumatological conditions, with the emphasis on complex conditions
ALS	Must have valid ALS	Must have valid ALS	Must have valid ALS	Must have valid ALS
Audit		Evidence of participation in an audit. Indicative evidence would include an audit proposal, audit report, evidence of involvement in the design and/or implementation of an audit.	Evidence of completion of an audit – with major involvement in design, implementation, analysis and presentation of results and recommendations. Such evidence may be publication or presentation at formal meetings. Evidence may also include audit assessment tool.	Satisfactory portfolio of audit involvement,
Research		Evidence of critical thinking around relevant clinical questions. Such evidence might be via a formal research proposal, formal written work, participation within an existing research group.	Evidence of developing research awareness and competence – participation in research studies, completion of “Good Clinical Practice” module, critical reviews, presentation at relevant research meetings or participation in (assessed) courses.	Satisfactory academic portfolio with evidence of research awareness and competence. Evidence might include a completed study with presentations/publication, a completed higher degree with research component (e.g. Masters) or a research degree (MD or PhD). Trainees should have completed a recognised “Good Clinical Practice” module.
Teaching		Evidence of participation in teaching of medical students, junior doctors	Evidence of participation in teaching with results of students’ evaluation	Portfolio evidence of ongoing

Assessment / Evidence	ARCP year 3 (End of ST3)	ARCP year 4 (End of ST4)	ARCP year 5 (End of ST5 = PYA)	ARCP year 6 (End of ST6 = CCT)
		and other AHPs	of that teaching and teaching observations Evidence may include teaching observation tool Evidence of understanding of the principles of adult education. Evidence might include attendance at relevant courses, accredited qualifications in medical education	evaluated participation in teaching Evidence of implementation of the principles of adult education Evidence may include teaching observation tool
Management		Evidence of participation in, and awareness of, some aspect of management – examples might include responsibility for organising rotas, teaching sessions or journal clubs	Evidence of awareness of managerial structures and functions within the NHS. Such evidence might include attendance at relevant courses, participation in relevant local management meetings with defined responsibilities.	Evidence of understanding of managerial structures e.g. by reflective portfolio entries around relevant NHS management activities.
Structured Educational Supervisor's report	Satisfactory report	Satisfactory report	Satisfactory report	Satisfactory report

The precise interpretation of the ARCP decision aid must take into account the structure of the individual trainee's programme. For example, where trainees are dual training in GIM supervisors will have to adjust the detail of requirements to allow for the extra training time. Similarly, for trainees spending some time out of programme e.g. in research, interpretation of the decision aid is required to take this into account.

* It is recommended that the patient surveys are performed early in year 4 and just prior to PYA in year 5

6.5 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.

6.6 Complaints and Appeals

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

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.

7 Supervision and Feedback

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.

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.

Clinical supervision in rheumatology involves discussion about referrals, supervision of patient management including confirmation of diagnosis, discussion about

appropriate management and investigation. There are opportunities for clinical observation during clinic appointments as well as discussion following the appointment. Clinical supervision can be provided by all members of the multi-disciplinary team with appropriate expertise and the opportunity to discuss clinical problems in a multi-disciplinary setting should be provided on a regular basis. The trainee must be aware of his/her own limitations and be able to seek advice and receive help at all times.

The educational supervisor will ensure that appropriate clinical supervision of the trainee occurs by discussing with the trainee issues of clinical governance, risk management and the report of any untoward clinical incidents involving the trainee. The educational supervisor is part of the rheumatology team and can address any identified concerns about the performance of the trainee or identified issues concerning patient or doctor safety.

The feedback from analysis of the GMC trainee questionnaire and local Deanery quality assurance of training should also identify any concerns about appropriate educational and clinical supervision.

Ensuring Feedback

The educational supervisor meets with the trainee at regular intervals to undertake appraisal, set educational objectives, review progress against the curriculum, give both formative and summative feedback from work based assessments as well as countersigning the training portfolio and preparing the evidence for the annual supra regional ARCP process. These regular opportunities to feedback on performance ensure that the trainee identifies progress and future development needs. Areas of concern will be identified and discussed. Identified weaknesses will be suitably addressed. Appraisals will be informed by the results of the assessments that the trainee undergoes, including multi-source feedback and patient satisfaction questionnaires (the trainee will undergo at least two of each during the period of their higher medical training).

Rheumatology is a multi disciplinary specialty and there will be opportunities for constructive feedback in both formal and informal settings from supervising consultant specialists, specialist nurses and therapists, as well as service users.

7.1 Appraisal

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

Induction Appraisal

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

Mid-point Review

This meeting between trainee and educational supervisor is 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.

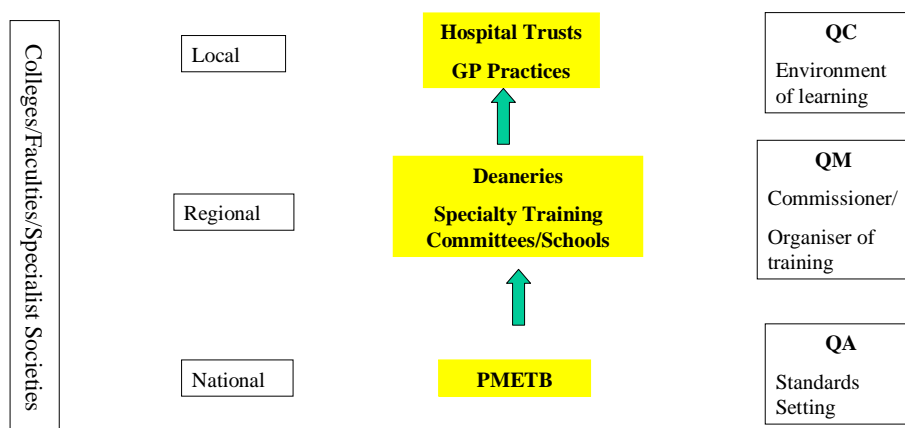
End of Attachment Appraisal

Trainees should review the PDP and curriculum progress with their educational or clinical supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed.

8 Managing Curriculum Implementation

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.

The Organisation and Quality Assurance of PG Training



8.1 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.

8.2 Recording Progress

On enrolling with JRCPTB trainees will be given access to the ePortfolio for Rheumatology. 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.

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

JRCPTB will use summarised, anonymous ePortfolio data to support its work in quality assurance.

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

Reflections, assessments and other ePortfolio content should be linked to curriculum competencies in order to provide evidence towards acquisition of these competencies. Trainees can add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

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

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

9 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, British Rheumatology Society, 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.

10 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.