To consider

Credentialing pilot studies

Issue

1. In 2011 three pilot studies were launched to look at the feasibility of credentialing discrete areas of medical practice. We need to decide whether we should develop the credentialing concept further and, if so, how.

Recommendations

2.

a. To note the reports of the three credentialing pilots (paragraphs 8 - 9).

b. To invite Council to agree that further developmental work be undertaken towards establishing a regulatory framework for credentialing (paragraphs 10 - 12).

Further information

3. If you require further information about this paper, please contact us by email: gmc@gmc-uk.org or tel. 0161 923 6602.
Background

4. In December 2008 the Department of Health (England) invited PMETB to lead exploratory work on the concept of credentialing. The PMETB Steering Group which was established to take forward this work defined credentialing as:

‘...a process which provides formal accreditation of attainment of competences (which include knowledge, skills and performance) in a defined areas of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice.’

5. In April 2010 the Steering Group published its report. The key conclusions were as follows.

a. Credentialing must be seen to be objective, reproducible, credible, validated and appropriate. It is an umbrella term and need not replace other concepts such preceptorship or certification where appropriate.

b. Pilots should go ahead, particularly in areas of practice with no formal recognition.

c. Clearer articulation of progress within CCT curricula or at other sentinel points within the career pathway. For some areas of practice this could include discrete modules within curricula.

d. Consideration as part of the ongoing development and implementation of revalidation of the need to provide assurance that all doctors providing specialist healthcare are practising to appropriate specialty specific standards.

e. Consideration of longitudinal research as the literature review highlighted the paucity of evidence. Such research should include exploration and identification of reliable outcomes of credentialing.

6. The Postgraduate Board received a copy of the Steering Group report in June 2010. In December 2010 Council agreed that the feasibility of credentialing should be piloted in three areas of practice where there was no formal specialty recognition leading to a CCT or sub-specialty.¹

7. The three areas to be piloted were breast disease management, forensic and legal medicine, and musculoskeletal medicine. They were led, respectively, by the Association of Breast Clinicians, the Faculty of Forensic and Legal Medicine and the British Institute of Musculoskeletal Medicine. These bodies, planned, undertook, resourced and evaluated the pilots in their specialty areas. This paper considers the reports of the three pilot groups.

¹ Council minutes 8 December 2010, paragraph 7.
Discussion

8. The report for forensic and legal medicine is at Annex A, the report for breast disease management is at Annex B and the report for musculoskeletal medicine is at Annex C.2

9. As detailed in their reports, the three pilots followed very different approaches, reflecting the different nature of the specialty areas. Each has identified challenges specific to their disciplines. In forensic and legal medicine, for example, there were issues relating to the sort of security settings in which doctors practice which may affect the assessments carried out. The musculoskeletal medicine pilot reported logistical problems arranging appropriate workplace based assessments (WPBA) and highlighted the potential costs of the process. These, however, seem likely to be surmountable problems. More importantly, the pilots have shown, for the specialties involved, the feasibility of developing credentialing using different methodologies based around the evaluation of an individual’s knowledge, skills and performance.

Recommendation: To note the reports of the three credentialing pilots.

10. Having established that credentialing can be done, the question is whether it should be done, how it should be done and how it might be regulated. Further developmental work will be needed to answer these questions. Among other things, we need to consider:

a. The overarching framework of standards beneath which credentialing in different disciplines could be developed.

b. Agreement about assessment methodology, including the use of WPBAs. The three pilots have followed very different approaches.

c. The criteria for regulatory recognition.

d. The relationship between recognition of credentialing and the existing arrangements for specialty and sub-specialty recognition.

e. The registration and the maintenance of credentialed practice in the context of revalidation.

11. These questions need to be considered alongside other parallel developments such as the introduction of revalidation, the recently launched review of the shape of postgraduate medical training, work on generic outcomes for specialty training and our continued work on assessment. While it might be tempting to put further consideration of credentialing on hold until the outcomes of these various pieces of works are known, it would be more useful to press ahead as our thinking about credentialing may help to inform these other projects.

2 At the time of preparing this paper further work is being undertaken in relation to the breast disease management and musculoskeletal medicine pilots. This may lead to updating of their final reports.
12. This paper does not attempt to address these issues. However, on the basis of the Credentialing Steering Group report and the pilots carried out in the light of that report, we propose that Council be invited to agree that further developmental work be undertaken towards establishing a regulatory framework for credentialing.

**Recommendation:** To invite Council to agree that further developmental work be undertaken towards establishing a regulatory framework for credentialing.

13. We will feedback our thanks and conclusions to the three pilot groups. We will also wish to discuss with them how they might contribute to any further developmental work and what resources (such as GMC staff time) they might require to enable them to do this. Thus far, their contribution has been entirely on the basis of good will.

**Resource implications**

14. At this stage, the main resource implications will be staff time involved in developing our proposals.

**Equality**

15. Credentialing has the potential to provide better recognition of the competences acquired by groups such as staff and associate specialist grade doctors. Within these grades, women and minority groups tend to be over-represented.

**Communications**

16. Our conclusions will be reported to the three pilot groups and to Council.
Faculty of Forensic and Legal Medicine

Report on the credentialing pilot for

The General Medical Council
1. Background to the development of the Faculty

1.1 The Faculty of Forensic and Legal Medicine (FFLM) was established in April 2006 and has been founded to achieve the following objectives:

- To promote for the public benefit the advancement of education and knowledge in the field of forensic and legal medicine;
- To develop and maintain for the public benefit the good practice of forensic and legal medicine by ensuring the highest professional standards of competence and ethical integrity.

1.2 The Faculty includes three different professional groups:
- Forensic practitioners
- Medically qualified coroners
- Medico-legal advisers to the medical defence organisations.

Forensic practitioners include Forensic Physicians, Forensic Pathologists and nurses and paramedics who work in the forensic field.

1.3 There are presently three categories of membership – affiliates, members and fellows. Currently, there are 245 affiliates, 360 members and 135 fellows. Affiliates cannot use post-nominals. Changes to the Faculty’s membership base are shown in the chart below:

1.4 One of the requirements of creating the FFLM was to have a professional membership examination (MFFLM) in place within three years. This was achieved in 2009 and is a two part examination with part 1 being an MCQ common to all forensic practitioners and medico-legal advisers and part 2 being separate written papers and an Objective Structured Clinical Examination (OSCE) for sexual assault medicine (SOM) and general forensic medicine (GFM) and an Objective Structured Practical Examination (OSPE) for medico-legal advisers (MLA). Part 1 was first held in October 2009 and part 2 in April 2010 and they have continued on an annual basis.
1.5 Forensic medical services were traditionally provided by doctors working on an item of service basis directly contracted to police forces. Following the publication of the Audit Commission Report – The Doctor’s Bill – the provision of forensic medical services to the police\(^1\) in 1998, service provision of forensic medical services has changed considerably. Over half of the UK Police Forces now provide forensic medical services via private companies, often with a mixed doctor/nurse/paramedic workforce. Some doctors undertake this work on a part time basis, whilst currently, a minority are employed full time.

1.6 Following the production of the Bradley Report\(^2\), work is ongoing in England and Wales in relation to proposals to transfer the commissioning of forensic medical services from the Home Office to the NHS. In Scotland it is being proposed to transfer the service provision to the NHS.

2. Forensic and Legal Medicine as a specialty

2.1 In May 2007, the Faculty made a first-stage application seeking approval from the Department of Health to create a new specialty of forensic and legal medicine in order to improve the quality and consistency of the forensic assessment and care provided to detainees in police custody and the complainants of sexual assault. In June 2008, the Department informed the Faculty that:

“...the areas of practice that you have defined represent a distinct field that requires a discrete knowledge, set of skills and level of expertise. It was acknowledged there is also an increasing demand for such practitioners.

That said, while we concluded there should be a recognised curriculum, training and qualification in Forensic and Legal Medicine, it was not felt there was necessarily a compelling argument for this to be through a new Certificate of Completion of Training (CCT), and hence a new specialty. Rather, it was felt more appropriate that this expertise should be recognised as a sub-specialty.”

2.2 In the light of this response, and following helpful advice from Postgraduate Medical Education Training Board (PMETB), the Faculty Board identified a number of existing CCT specialties that would best equip doctors with the basic skills to undertake forensic medicine (and thus be the ‘parent’ CCTs to the sub-specialty). Foremost amongst these was general practice, as we considered that forensic medicine is a speciality best practised by generalists, a fact supported by FFLM research, indicating that about 80% of forensic physicians have a background in general practice.

2.3 The Faculty subsequently learnt that general practice was excluded from developing sub-specialities under current legislation. This was an anomaly that we viewed as a major obstacle to the establishment of a successful sub-specialty in forensic medicine as the other parent CCTs we identified were unlikely to provide sufficient numbers of practitioners to meet anticipated service requirements.

3. The concept of credentialing

3.1 Recent years have seen growing interest in the concept of credentialing in UK medicine. As reported in the PMETB Credentialing Steering Group Report\(^3\), during 2007, the GMC Specialist Register Review Group considered this topic and identified potential benefits of credentialing:

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\(^1\) The Doctor’s Bill – provision of forensic medical services to the police. Audit Commission. March 2008.
\(^3\) Postgraduate Medical Education and Training Board. Credentialing Steering Group Report. April 2010.
• Registering specialist credentials would enable recording of competencies acquired throughout a doctor’s specialist careers and not just at the award of a CCT/CESR;
• Specialist credentialing might be used to reflect the increasing modularisation of specialist training and the more flexible training opportunities that will be necessary because of the changing demographics of the medical profession;
• Credentialing would provide a way of giving formal recognition of the additional qualifications acquired by doctors;
• The recording of that additional training would make the expertise of specialists more easily recognised and the register more transparent;
• Specialists credentials would enable the recognition of specialist competencies in the fields of practice for which it is not possible to obtain a CCT and where regulation has been identified as weak;
• Credentialing offers a more agile means of responding to developments in medicine than is possible through the recognition of CCT specialties;
• It should be possible to extend the principles of credentialing to apply to GPs with special interests.

3.2 The debate was given further impetus by Lord Darzi’s 2008 report A High Quality Workforce: NHS Next Stage Review which stated that credentialing ‘gives assurance to patients and employers that professionals have the right skills to deliver high quality care, whilst giving the recognition to professionals themselves.4

3.3 PMETB initially defined a credential as:
“….being a marker of attainment of competences (which include knowledge and skills) in a defined area of practice at a level that would allow the holder of the credential to work with limited direct supervision in that area of practice”.

3.4 Most Forensic Physicians work without direct supervision. Following representation by the Faculty, PMETB agreed to review the definition of a credential.

3.5 For the purposes of the pilot, the PMETB Credentialing Steering Group Report suggested a working definition of medical credentialing as follows:
“Credentialing is a process which provides formal accreditation of attainment of competences (which includes knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice.”

3.6 Four areas of medicine were considered to pilot credentialing: forensic medicine, breast disease management, musculo-skeletal medicine and cosmetic surgery. Ultimately, the first three areas were selected and agreed to take part in a pilot to explore the benefits or otherwise of credentialing.

4. The pilot

4.1 Representatives of the Faculty met with Richard Marchant (Assistant Director, Regulation Policy, GMC) on three occasions - 17 March 2011, 6 July 2011 and 7 October 2011. The first of these

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meetings was also with the representatives of the other two credentialing pilots (Breast Disease Management and Musculoskeletal Medicine) when it was useful to share ideas in relation to the pilots.

4.2 The Faculty established one pilot to encompass a range of service provisions for forensic medicine incorporating the four nations as follows:
   i. A Sexual Assault Referral Centre (SARC) – Treetops in Portsmouth led by Dr Sandy Fielding (who leads the Faculty’s Sexual Offences Forum and represented the Faculty on the DH National Support Team meetings for SARCs);
   ii. Northern Ireland – led by Professor John Farnan – lead Forensic Medical Officer for Northern Ireland and one of our MFFLM examiners;
   iii. An out sourced provider – Reliance Medical – led by Dr Janet Young in South Wales but overseen by Dr Nigel Callaghan, Medical Director;
   iv. Scotland – expanded to include both Lothian and Borders and Central regions jointly led by Dr George Fernie and Dr Alan Grant;
   v. Northamptonshire - a more traditional forensic medical service in England – led by Dr Frank Voeten, Principal Forensic Physician for Northamptonshire Police.

4.3 The Faculty were of the view that to credential by practitioner competence an agreed entry requirement (based on the Faculty’s standards paper) was required which involved a knowledge assessment (the MFFLM examination), followed by work placed based assessments and linked to the Faculty’s proposals appraisal and revalidation.

4.4 Additionally the Faculty considered it essential that those doctors who undertake these assessments should be properly trained to do these assessments. We met with the Royal College of Physicians Director of Education and developed a bespoke course to train assessors to be able to undertake Work Placed Based Assessments (WPBA). This was held on 28 October 2011.

4.5 All those doctors identified in the pilot as well as other key personnel within the Faculty attended the course and have been trained in the relevant assessments. As there was spare capacity on the course additional places were offered to other members of the Faculty and several Members took advantage of this.

4.6 We appointed Dr Jenny Holmes, a member from Merseyside as the Work Placed Based Assessment Lead for the Faculty.

5. Work Place Based Assessments

5.1 In conjunction with the RCP Education Unit we developed assessment guidance and documentation for the following assessments:
   - Direct Observation of Procedural Skills (DOPS)
   - Mini-Clinical Evaluation Exercise (mini-CEX)
   - Case-based Discussion (CbD)
   - 360° colleague feedback
   - Statement Writing.

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5 FFLM. Quality Standards in Forensic Medicine. 2010. www.fflm.ac.uk
7 Norcini J. Workplace-based assessment in clinical training. Association for the Study of Medical Education series.
8 FFLM. Core competencies for revalidation. https://fflm.ac.uk/upload/documents/1225279849.pdf
For the 360⁰ colleague feedback, the Faculty selected the MSF tool validated by the RCP and, following advice from the RCP medical education unit, it would be expected that doctors would circulate the assessment form to at least 20 colleagues to achieve a minimum of 12 and ideally 15 responses. These different assessments and guidance notes are enclosed as appendix 1.

5.2 During the course, Assessment Systems were developed for both General Forensic Medicine (GFM) and Sexual Offence Medicine (SOM) in order to provide a comprehensive global assessment system for each branch of clinical forensic medicine. These are enclosed as appendix 2. Work is on going in consultation with the Forensic Science Regulator (as this was also a piece of work he was planning on exploring) to develop assessment guidance for Court Room Skills. The proposed assessment process has also been mapped to the GMC competency domains for appraisal and revalidation at Appendix 3.

5.3 Following discussion with the GMC in October 2011, it was concluded that:
- possession of the MFFLM;
- completing all of the assessments in either GFM or SOM;
- satisfactory enhanced appraisal;
- revalidation (when in place) being met and revalidation being maintained;
should reach a standard where the award of a “credential” would be appropriate. As the doctors would not be trainees and would be working in a largely unsupervised capacity, it is proposed that the assessments would all be summative, now referred to as Assessments of Performance (AoPs)⁹.

5.4 The doctors who took part in the pilot were asked to undertake some of the assessments and to complete an evaluation form to try and answer the following questions:
- Were the assessments appropriate and of the requisite standard?
- Were there any jurisdictional issues that arose?
- Were there any issues in relation to assessors being allowed to attend a different Force area e.g. security clearances etc?
- What are the resource implications of undertaking assessments?
- Would 4.3 above be appropriate?

5.5 The Faculty’s Academic Committee (AC) was asked to give a view on the following:
- Should all assessments be done by assessors from a different area?
- Should all assessments be done by assessors from the same area?
- Should there be a mixture of some assessments being done by doctors from the same area and some from doctors from another area?
- If a doctor does not give evidence in Court (in the majority of cases the doctor’s written Witness Statement is agreed and the doctor does not give oral evidence) would Statement Writing Skills alone be sufficient?
- Would 4.3 above be appropriate?

5.6 Review of the feedback from the doctors who took part in the pilot was that the assessments were appropriate and 4.3 above would be met. This was also supported by the Academic Committee and finally the Faculty Board.

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6. Specific findings identified in the pilot

6.1 Seven trained assessors undertook 36 different assessments on eight different forensic physicians, some of whom did general forensic medicine, some sexual assault medicine and some both. Of these eight assessees, seven were post MFFLM and very experienced and one was at diploma level i.e. pre MFFLM in experience. Of the assessments of the post MFFLM forensic physicians, 28 assessments were scored at the level expected for completion of a credential post MFFLM and 3 assessments at the level expected on gaining membership. The one doctor at diploma level performed at this level on the one assessment that was carried out.

6.2 Several assessors commented that the tools provided within the Faculty WPBA documentation and guidance were robust enough to arrive at an accurate assessment of an individual’s level of performance.

6.3 In order to treat patients detained in the custodial setting or assess patients who may have been sexually assaulted, security clearance of the doctor is required. This is normally restricted to the police force where the doctor works. In many cases the security clearance is at a very high level, particularly in relation to persons detained under terrorist legislation. Forensic physicians are therefore restricted to working in specific geographical areas where they have security clearance. Thus a forensic physician working in one county may not be able to enter another police force area where he/she does not have security clearance. This may also occur with doctors who might work for private provider companies. Thus it may not be possible to undertake mini-CEX and DOPS WPBA’s outside of an assessor’s normal working area.

6.4 Jurisdictional issues – there are different jurisdictions in the UK and no specific issues were identified in the pilot; this was because doctors in the same country assessed each other. If credentialing were to be implemented, doctors would need to be aware of this potential problem.

6.5 Disclosure – forensic records are potentially subject to disclosure in the criminal justice system and this could be a problem. As an example, if a hospital doctor was undertaking an operative procedure as part of a DOPS and it became apparent to the assessor that it was being done incorrectly or complications were developing, the assessor would be obliged to take over the procedure. In the forensic medicine context, if the assessor identified that the doctor was undertaking a procedure incorrectly, this would need to be corrected and noted and potentially could be disclosable in criminal justice proceedings.

7. Resource implications

7.1 The pilot has, so far, cost £24,200 including 27 days of Officer time.

7.2 These significant resource implications, particularly in relation to the assessor’s time, would need to be addressed. The Faculty is of the opinion that the assessees will be required to meet some of these costs as he/she is ultimately likely to benefit from a credential.

7.3 An assessment is likely to cost the individual between £1000 and £1500.
8. Recommendations

8.1 The Academic Committee (AC) recommended that in order to ensure consistency of standards and prevent any collusion, some WPBAs should be done by doctors in the same working area (internal assessors) and a number should be done by external assessors. The AC concluded that it should not be compulsory to provide evidence of Court Room Skills if a court appearance were not made providing that Statement Writing Skills were passed and the doctor has produced suitable evidence of having completed a Court Room Skills course.

8.2 To overcome the problem of access, the AC recommended that DOPS would be done by internal assessors but that some of the mini-CEX and CbDs should be done by external assessors.

8.3 To complete a credential, it is proposed that forensic physicians should complete WPBAs in each of the 16 different categories in the assessment system grids (with the possible exception of Court Room Skills).

8.4 If credentialing were accepted, the overall assessment process would be managed via the Chief Examiner’s Committee who would make a recommendation to the FFLM Board (in just the same way as for MFFLM) for ratification and recommendation to the GMC for the award of a “credential”.

8.5 The AC concluded, and this was endorsed by the Faculty Board, that completion of the relevant Assessments System(s) following attainment of the MFFLM and linked to satisfactory appraisal and revalidation (when in place) being met and revalidation being maintained could lead to the award of a specialist “credential” and the process should be recommended to the GMC.

8.6 As outlined in paragraphs 2.1 to 2.3, the Faculty has spent six years in pursuit of raising standards and initiatives to improve patient safety by trying to develop a speciality of forensic and legal medicine. If the GMC decides not to pursue credentialing as an option, the Faculty would welcome suggestions from the GMC as to how patient safety can be improved and specialty status achieved. Any further delay here would, in the Faculty’s view, be to the detriment of patients and we cannot see the justification for not adopting credentialing as a route to specialist status.

Professor Ian Wall FRCP FRCGP FFFLM MFMLM DMJ
FFLM Credentialing Lead and Past President

April 2012
Appendix 1 – Work Place Based Assessments

Both guidance documentation and pro forma follow for:

- Direct Observation of Procedural Skills (DOPS)
- Mini-Clinical Evaluation Exercise (mini-CEX)
- Case-based Discussion (CbD)
- 360° colleague feedback
- Statement Writing
A DOPS is an assessment tool designed to evaluate the performance of an assessee in undertaking a practical procedure. The assessee should be given an immediate feedback to identify strengths and areas for development. All WPBAs are intended primarily to support learning and best practice so this feedback is very important.

Assessors can be anyone with expertise in the procedure but for Credentialing purposes this should be another doctor with MFFLM or FFFLM.

Not all elements need to be assessed on each occasion. You may explore an assessee’s related knowledge where you feel appropriate.

Please ensure that the detainee/complainant/complainer knows a DOPS is being carried out where appropriate.

The form includes a rating of the level of independent practice the assessee has shown for the procedure, based on what has been observed.

Examples of procedures in Clinical Forensic Medicine in which DOPS might be used:

**SOM**
- Documentation of examination findings, especially with respect to injury
- Harvesting of forensic samples
- Aftercare - sexually transmissible infections - screening and investigation
- Aftercare - contraception - fitting of an IUCD
- Use of the colposcope and photodocumentation

**GFM**
- Road Traffic Medicine - taking of body fluid samples, assessment under S4 Road Traffic Act
- Documentation of examination findings, especially with respect to injury
- Harvesting of forensic samples
Descriptors of competencies demonstrated during CbD:

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Description</th>
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<tbody>
<tr>
<td>Demonstrates understanding of indications including the application of relevant law, relevant anatomy and technique</td>
<td>Does the assessee know the relevant indications, anatomical landmarks, and techniques relevant to the procedure?</td>
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<tr>
<td>Obtains informed consent</td>
<td>Is there a clear explanation of the proposed procedure to the patient, with the patient given an opportunity to ask questions? Where informed consent is sought, is this documented appropriately? Does the assessee avoid giving legal advice during this process?</td>
</tr>
<tr>
<td>Demonstrates appropriate preparation pre-procedure</td>
<td>Does the assessee demonstrate appropriate selection of samples and equipment?</td>
</tr>
<tr>
<td>Minimises risk of cross contamination</td>
<td></td>
</tr>
<tr>
<td>Technical ability</td>
<td>Does the assessee show the requisite technical skills and techniques?</td>
</tr>
<tr>
<td>Aseptic technique</td>
<td>The cleansing of hands and, where relevant, equipment before and after every physical patient episode is mandatory.</td>
</tr>
<tr>
<td>Seeks help where appropriate</td>
<td>Does the assessee recognise his/her limitations and request assistance when appropriate?</td>
</tr>
<tr>
<td>Post procedure management</td>
<td>Does the assessee label and package samples/body charts adequately? Does the assessee maintain the Chain of Continuity?</td>
</tr>
<tr>
<td>Communication skills</td>
<td>Is the assessee polite, and exhibits a sense of self within a team structure? Is he/she able to convey understanding to others?</td>
</tr>
<tr>
<td>Consideration of patient/professionalism</td>
<td>Responds to patients feelings, shows respect, compassion, empathy, establishes trust; attends to patient's needs of comfort, modesty, confidentiality of information.</td>
</tr>
<tr>
<td>Overall ability to perform procedure</td>
<td></td>
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</table>
Date of assessment (DD/MM/YY)  
Assessee’s surname  
Assessee’s forename  
CFM Qualification: DFCASA / MFFLM / Other specify  
Assessee's GMC #  

Assessor’s registration # (e.g. GMC, NMC, GDC)  
Assessor’s name  
Assessor’s email  
Assessor’s position:  
Consultant or post-MFFLM / DFCASA or other diploma specify  
Nurse or paramedic / Other  

Clinical setting (e.g custody, SARC, examination suite, A&E, etc.):  

Procedure:  

Please score the assessee on the scale shown. Please note that your scoring should reflect the performance of the assessee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark ‘Unable to Comment’ if you feel you have not observed the behaviour.

<table>
<thead>
<tr>
<th>Well below expectation for stage of training/level of experience</th>
<th>Below expectation for stage of training/level of experience</th>
<th>Borderline for stage of training/level of experience</th>
<th>Meets expectation for stage of training/level of experience</th>
<th>Above expectation for stage of training/level of experience</th>
<th>Well above expectation for stage of training/level of experience</th>
<th>Unable to comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates understanding of indications, relevant anatomy, technique of procedure</td>
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<tr>
<td>Obtains informed consent</td>
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<td>Demonstrates appropriate preparation pre-procedure</td>
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<tr>
<td>Minimises risk of cross contamination and labels and packages samples correctly</td>
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<td>Technical ability</td>
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<td>Aseptic technique</td>
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<td>Seeks help where appropriate</td>
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<td>Post-procedure management</td>
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<tr>
<td>Communication skills</td>
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</table>
Consideration of patient/professionalism

Overall ability to perform procedure

Based on this observation please now rate the level of independent practice the assessee has shown for this procedure:

<table>
<thead>
<tr>
<th>Level of Independent Practice</th>
<th>Rating</th>
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<tbody>
<tr>
<td>Unable to perform the procedure</td>
<td>☐</td>
</tr>
<tr>
<td>Able to perform the procedure under direct supervision/assistance</td>
<td>☐</td>
</tr>
<tr>
<td>Able to perform the procedure with limited supervision/assistance</td>
<td>☐</td>
</tr>
<tr>
<td>Competent to perform the procedure unsupervised and deal with complications</td>
<td>☐</td>
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</table>

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Assessee’s signature                        Assessor’s signature
Mini-CEX Guidance

This tool evaluates a clinical encounter in forensic medical practice to provide an indication of competence in skills essential for good clinical care in a forensic setting such as history taking, examination, clinical and forensic reasoning. The assessees should be given immediate feedback to identify strengths and areas for development. All WPBAs are intended primarily to support learning and best practice so this feedback is very important.

Each assessment should cover a different clinical or forensic problem so as to sample different areas of the curriculum.

**In SOM this includes:** Consent, capacity and confidentiality

- Safeguarding for children, young people and vulnerable adults
- Process, content and documentation of history taking
- Process and documentation of examination
- Mental health assessment, especially suicide risk
- Aftercare - sexually transmissible infections
- Aftercare - contraception
- Communications

**In GFM this includes:**

- Consent, capacity and confidentiality
- Safeguarding for children, young people and vulnerable adults
- Fitness to detain including management of substance misuse, alcohol dependence, diabetes, head injury
- Fitness to interview
- Preliminary assessment and management of those detained under TACT provisions
- Road Traffic Medicine
- Documentation and interpretation of injuries - findings
- Mental health assessments and mental illness - process
- Scene of suspicious death
- Continuity of care

Assessors can be any doctor with suitable experience but for Credentialing purposes this should be another doctor with MFFLM or FFFLM.
Please ensure that the detainee/complainant/complainer is aware that a mini-CEX is being carried out where appropriate.

**Descriptors of competencies demonstrated during mini-CEX:**

<table>
<thead>
<tr>
<th>Competency</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Interviewing Skills</td>
<td>Active listening skills including facilitating patient's telling of story; effectively using questions/directions to obtain accurate and adequate information; responding appropriately to patients affect and non-verbal cues.</td>
</tr>
<tr>
<td>Physical Examination Skills</td>
<td>Follows efficient, logical sequence; balances screening/diagnostic steps for problem; informs patient; sensitive to patient's comfort, modesty.</td>
</tr>
<tr>
<td>Counselling and Communication Skills</td>
<td>Agrees plan with patient, explains rationale for test/treatment, obtains patient's consent, educates/counsels regarding management.</td>
</tr>
<tr>
<td>Consideration for Patient/Professionalism</td>
<td>Responds to patients feelings, shows respect, compassion, empathy, establishes trust; attends to patient's needs of comfort, modesty, confidentiality of information.</td>
</tr>
<tr>
<td>Clinical Judgement</td>
<td>Selectively orders/performs appropriate diagnostic and forensic investigation, appropriate prescribing including consideration of risks and benefits.</td>
</tr>
<tr>
<td>Organisation/Efficiency</td>
<td>Prioritises; is timely; succinct</td>
</tr>
<tr>
<td>Overall Clinical Competence</td>
<td>Demonstrates judgement, synthesis, caring, effectiveness, and efficiency.</td>
</tr>
</tbody>
</table>
Date of assessment (DD/MM/YY) 

Assessee’s surname 

Assessee’s forename 

CFM Qualification: DFCASA / MFFLM / Other specify 

Assessee’s GMC # 

Assessor’s registration # (e.g. GMC, NMC, GDC) 

Assessor’s name 

Assessor’s email 

Assessor’s position: Consultant or post-MFFLM / DFCASA or other diploma specify 

Nurse or paramedic / Other 

Brief summary of case: 

Setting for Assessment (e.g. custody, SARC, examinations suite, A&E, etc.) 

Please score the assessee on the scale shown. Please note that your scoring should reflect the performance of the assessee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark ‘Unable to Comment’ if you feel you have not observed the behaviour. 

<table>
<thead>
<tr>
<th>Medical record keeping</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Clinical assessment</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Investigation and Referrals</td>
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<tr>
<td></td>
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<tr>
<td>Treatment / Management Plan</td>
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<tr>
<td>Follow-up and Future Planning</td>
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<td></td>
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<tr>
<td>Professionalism</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Overall Clinical Judgement</td>
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<tr>
<td></td>
</tr>
</tbody>
</table>
Based on this observation please rate the level of overall clinical judgement the assesseee has shown:

<table>
<thead>
<tr>
<th>Overall Clinical Judgement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td>Description</td>
</tr>
<tr>
<td>Below level expected during Introductory Training</td>
<td>Demonstrates little knowledge and lacking ability to evaluate issues resulting in only a rudimentary contribution to the management plan</td>
</tr>
<tr>
<td>Performed at the level expected post-introductory training/training for DFCASA/other diplomas</td>
<td>Demonstrates some knowledge and limited evaluation of issues resulting in a limited management plan</td>
</tr>
<tr>
<td>Performed at the level of DFCASA or equivalent in GFM</td>
<td>Demonstrates satisfactory knowledge and logical evaluation of issues resulting in an acceptable management plan consistent with early Higher Training</td>
</tr>
<tr>
<td>Performed at level expected on gaining MFFLM</td>
<td>Demonstrates detailed knowledge and solid evaluation of issues resulting in a sound management plan</td>
</tr>
<tr>
<td>Performed at level expected for completion of Credential post-MFFLM</td>
<td>Demonstrates deep up-to-date knowledge and comprehensive evaluation of issues resulting in an excellent management plan consistent with completion of Higher Training</td>
</tr>
</tbody>
</table>

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Asseesee’s signature                        Assessor’s signature
The CbD assesses the performance of an assessee 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 assessees.

The assessee should be given immediate feedback to identify strengths and areas for development. All workplace-based assessments are intended primarily to support learning so this feedback is very important.

The assessee can suggest cases for discussion but the assessor makes the choice of case for the CbD and leads the discussion. Assessees in post-MFFLM should be able to discuss any case with which they have had significant, recent involvement.

The CbD should focus on a written record (such as written case notes, admission letter, or witness statement). A typical encounter might be when presenting a person detained in custody or under the Mental Health Act, or a complainant of an alleged sexual assault.

Assessors can be any doctor with suitable experience but for Credentialing purposes this should be another doctor with MFFLM or FFFLM.

Examples of the subjects which might be covered by CBD in clinical forensic medicine includes:

**SOM**

- Consent, capacity and confidentiality
- Safeguarding for children, young people and vulnerable adults
- Mental health assessment, especially suicide risk
- Aftercare - sexually transmissible infections
- Aftercare - contraception
- Triage of cases
- Interpretation of findings
- Management/teaching
- Audit

**GFM**

- Consent, capacity and confidentiality
- Safeguarding for children, young people and vulnerable adults
- Fitness to detain - all aspects
- Fitness to interview - all aspects
- Assessment and management of those detained under TACT provisions
- Road Traffic Medicine
- Interpretation of findings
- Mental health assessment and mental illness
- Scene of suspicious death
- Intimate searches
- Management/teaching
- Audit
### Descriptors of competencies demonstrated during CbD:

<table>
<thead>
<tr>
<th>Medical record keeping</th>
<th>Does the assessee:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• produce records in line with GMC standards in <em>Good Medical Practice</em>;</td>
</tr>
<tr>
<td></td>
<td>• show an understanding of Caldicott guardian arrangements;</td>
</tr>
<tr>
<td></td>
<td>• store records securely in line with Caldicott/data protection regulations;</td>
</tr>
<tr>
<td></td>
<td>• produce written care plans legible and populated with sufficient information to be useful to the Custody Staff and another HCP;</td>
</tr>
<tr>
<td></td>
<td>• ensure the detainee understands the limits of confidentiality of the records and what will happen to them.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical and forensic assessment</th>
<th>Does the assessee:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• take a thorough clinical and forensic history;</td>
</tr>
<tr>
<td></td>
<td>• demonstrate a high standard of risk assessment of physical and mental health problems and manage these risks appropriately both in the custodial setting and on release;</td>
</tr>
<tr>
<td></td>
<td>• show an understanding of the forensic implications of the information obtained;</td>
</tr>
<tr>
<td></td>
<td>• make detailed clinical and forensic assessment and recording of injuries;</td>
</tr>
<tr>
<td></td>
<td>• organise information obtained into an effective care plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Investigations and referrals</th>
<th>Does the assessee:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• use the limited tools available for investigation e.g. blood pressure monitors, blood glucose monitors, peak flow meters, urinalysis etc judiciously;</td>
</tr>
<tr>
<td></td>
<td>• understand and use assessment tools such as those for opiate and alcohol withdrawal appropriately;</td>
</tr>
<tr>
<td></td>
<td>• make use of other sources of information e.g. from mandatory drug testing, mental health agencies etc to inform their assessment;</td>
</tr>
<tr>
<td></td>
<td>• make appropriate onward referrals to healthcare partners in their locality and communicate effectively with these agencies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment / Management Plan</th>
<th>Does the assessee:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• maintain as high a degree of confidentiality as possible in communicating with Custody Staff;</td>
</tr>
<tr>
<td></td>
<td>• give written and verbal feedback to the Custody Officer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up and future planning</th>
<th>Does the assessee:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• engage in future planning of care for the detainee’s or complainant’s physical and mental health problems;</td>
</tr>
<tr>
<td></td>
<td>• ensure the detainee or complainant understands what follow up may be useful for their conditions;</td>
</tr>
<tr>
<td></td>
<td>• provide written and verbal information on agencies available to the detainee or complainant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Clinical Judgement</th>
<th>Quality of the assessee’s integrated thinking based on clinical and forensic assessment, investigations and referrals resulting in the detainee/complainant/complainer’s management plan.</th>
</tr>
</thead>
</table>

| Overall Clinical Competence  | Demonstrates judgement, synthesis, caring, effectiveness, and efficiency. |
**Faculty of Forensic and Legal Medicine**

**Case-based Discussion (CbD)**

<table>
<thead>
<tr>
<th>Date of assessment (DD/MM/YY)</th>
<th>Asseesee’s surname</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Assesee’s forename</th>
<th>CFM Qualification: DFCASA / MFFLM / Other specify</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Assesee’s GMC #</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessor’s registration # (e.g. GMC, NMC, GDC)</th>
<th>Assessor’s name</th>
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<tbody>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessor’s email</th>
<th>Assessor’s position: Consultant or post-MFFLM / DFCASA or other diploma specify</th>
<th>Nurse or paramedic / Other</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**Brief summary of case:**

Please score the assessee on the scale shown. Please note that your scoring should reflect the performance of the assessee against that which you would reasonably expect at their stage/year of training and level of experience. Please mark ‘Unable to Comment’ if you feel you have not observed the behaviour.

<table>
<thead>
<tr>
<th>Well below expectation for stage of training/level of experience</th>
<th>Below expectation for stage of training/level of experience</th>
<th>Borderline for expectation for stage of training/level of experience</th>
<th>Meets expectation for stage of training/level of experience</th>
<th>Above expectation for stage of training/level of experience</th>
<th>Well above expectation for stage of training/level of experience</th>
<th>Unable to comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical record keeping</td>
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<td>Clinical assessment</td>
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<td>Investigation and Referrals</td>
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<tr>
<td>Treatment / Management Plan</td>
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<tr>
<td>Follow-up &amp; Future Planning</td>
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<tr>
<td>Professionalism</td>
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<tr>
<td>Overall Clinical Judgement</td>
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</tbody>
</table>
Based on this observation please rate the level of overall clinical judgement the assessee has shown:

### Overall Clinical Judgement

<table>
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<tr>
<th>Rating</th>
<th>Description</th>
</tr>
</thead>
<tbody>
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<td>Demonstrates deep up-to-date knowledge and comprehensive evaluation of issues resulting in an excellent management plan consistent with completion of Higher Training</td>
</tr>
</tbody>
</table>

Which aspects of the encounter were done well?

Any suggested areas for improvement?

Agreed Action:

Assessee’s signature          Assessor’s signature
### Colleague multi-source feedback questionnaire

<table>
<thead>
<tr>
<th></th>
<th>Unacceptable</th>
<th>Below Average</th>
<th>Good</th>
<th>Outstanding</th>
<th>U/C</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reliability:</td>
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<tr>
<td>Conscientious and</td>
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<td>reliable; available</td>
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<td>for advice and help</td>
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<td>when needed; time</td>
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<tr>
<td>management</td>
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<td>2. Professional</td>
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<td>Development:</td>
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<tr>
<td>Commitment to</td>
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<td>improving quality</td>
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<td>of service; keeps</td>
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<td>up-to-date with</td>
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<td>knowledge and skills</td>
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<td>3. Teaching and</td>
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<tr>
<td>Training:</td>
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<td>Contributes to the</td>
<td>☐</td>
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<td>education and</td>
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<td>supervision of</td>
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<td>students and junior</td>
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<td>colleagues</td>
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<td>4. Verbal Communication:</td>
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<td>Spoken English;</td>
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<td>communication with</td>
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<td>colleagues, patients</td>
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<td>and carers</td>
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<td>5. Empathy and</td>
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<td>Respect:</td>
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<td>Is polite, considerate</td>
<td>☐</td>
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<td>and respectful to</td>
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<td>patients and</td>
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<td>colleagues of all</td>
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<td>levels; compassion</td>
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<td>and empathy towards</td>
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<td>patients and</td>
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<td>their relatives</td>
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<td>6. Team Player:</td>
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<tr>
<td>Values the skills</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>and contributions of</td>
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<tr>
<td>multi-disciplinary</td>
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<tr>
<td>team members</td>
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<tr>
<td>7. Leadership:</td>
<td></td>
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<tr>
<td>Takes the leadership</td>
<td>☐</td>
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<td>role when</td>
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<td>circumstances</td>
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<td>require; delegates</td>
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<td>appropriately</td>
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<tr>
<td>8. Do you have any</td>
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<tr>
<td>concerns about the</td>
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<tr>
<td>probity or health</td>
<td>Yes ☐</td>
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<td></td>
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<tr>
<td>(physical or mental)</td>
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<tr>
<td>of this doctor?</td>
<td>No ☐</td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

(If yes, please specify in the text box below)

For statements above with an ‘unacceptable’ or ‘outstanding’ rating, you must give specific examples. This is a very important and useful part of the appraisal process. All your comments will be anonymous but will be reported back verbatim, so there is a risk of your identification from the nature of your comments.

**Scale**
- ‘Unacceptable’ – I have concerns
- ‘Below average’ – Improvement needed
- ‘Good’ – Doing a good job
- ‘Outstanding’ – Excellent performance
- ‘U/C*’ - unable to comment
# Witness Statement and Report Writing Assessment

**Date of assessment (DD/MM/YY)**

[ ] / [ ] / [ ]

**Assessee’s surname**

Click here to enter text.

**Assessee’s forename**

Click here to enter text.

**CFM Qualification: DFCASA / MFFLM / Other specify**

**Assessee’s GMC #**

[ ] [ ] [ ] [ ]

**Assessor’s registration #** (e.g. GMC, NMC, GDC)

[ ] [ ] [ ] [ ]

**Assessor’s name**

Click here to enter text.

**Assessor’s email**

Click here to enter text.

**Assessor’s position:**

Consultant or post-MFFLM / DFCASA or other diploma specify

Nurse or paramedic / Other

**Clinical setting** (e.g. custody, SARC, examination suite, A&E, etc.):

Click here to enter text.

**Specific facts:**

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<td>2</td>
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<td>9</td>
<td>Name of suspect/complainant</td>
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<td>10</td>
<td>Age or DOB of suspect/complainant</td>
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<td>12</td>
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<td>13</td>
<td>Consent</td>
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<td>14</td>
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<td>Conclusion</td>
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### Overall quality:

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<thead>
<tr>
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<th>Unacceptable</th>
<th>Below Average</th>
<th>Good</th>
<th>Outstanding</th>
<th>Unable to comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate format used. Well written and clearly laid out.</td>
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<td>☐</td>
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</table>

<table>
<thead>
<tr>
<th>2. Content &amp; Accuracy</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>3. Adherence to boundaries of expertise</th>
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<tr>
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<table>
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<table>
<thead>
<tr>
<th>5. Professional Standard</th>
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<th>Outstanding</th>
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<tbody>
<tr>
<td>No hearsay, opinion or assumptions. Avoids speculation. Demonstrates impartiality and is ethical</td>
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<table>
<thead>
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<th>6. Expert Opinion</th>
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<th>Below Average</th>
<th>Good</th>
<th>Outstanding</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Overall rating</th>
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<th>Below Average</th>
<th>Good</th>
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<td>☐</td>
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**Which aspects of the statement were done well?**

**Any suggested areas for improvement?**

**Agreed Action:**

---

**Assessee’s signature:**

**Assessor’s signature:**
Appendix 2 – Assessments Systems for General Forensic Medicine (GFM) and Sexual Assault Medicine (SOM)
### General Forensic Medicine

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<thead>
<tr>
<th>Topic</th>
<th>Mini-CEX</th>
<th>DOPS</th>
<th>CbD</th>
<th>MSF</th>
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<tbody>
<tr>
<td>Consent, capacity, confidentiality and disclosure</td>
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<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>Safeguarding for children, young people and vulnerable adults</td>
<td>✔️</td>
<td></td>
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<td>✔️</td>
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<tr>
<td>Fitness to detain including management of substance abuse, alcohol dependence, diabetes, head injury</td>
<td>✔️</td>
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<td>✔️</td>
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<tr>
<td>Fitness to interview</td>
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<tr>
<td>Road Traffic Medicine</td>
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<td>✔️</td>
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<tr>
<td>Documentation and interpretation of injuries - findings</td>
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<td>✔️</td>
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<tr>
<td>Mental Health Assessments and mental illness - Process</td>
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<tr>
<td>Harvesting of forensic samples</td>
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<td>✔️</td>
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<tr>
<td>Scene of suspicious death</td>
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<tr>
<td>Statement writing</td>
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<td>✔️</td>
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<tr>
<td>Giving evidence in Court</td>
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<tr>
<td>Intimate searches</td>
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<tr>
<td>Continuity of care</td>
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<td></td>
<td>✔️</td>
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<tr>
<td>Interpretation of findings</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>Management / teaching</td>
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<td>✔️</td>
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<td>Audit</td>
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## Assessment Systems for FFLM

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<tr>
<td>Consent, capacity, confidentiality and disclosure</td>
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<td>Safeguarding for children, young people and vulnerable adults</td>
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<td>✅</td>
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<tr>
<td>Process, content and documentation of history taking</td>
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<tr>
<td>Process and documentation of examination</td>
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<tr>
<td>Harvesting of forensic samples</td>
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<tr>
<td>Mental health assessment, especially suicide risk</td>
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<tr>
<td>Aftercare – sexually transmissible infections</td>
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<tr>
<td>Aftercare – contraception</td>
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<tr>
<td>Communications</td>
<td>✅</td>
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<td>Statement writing</td>
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<tr>
<td>Giving evidence in Court</td>
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<tr>
<td>Use of colposcope</td>
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<td>✅</td>
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<tr>
<td>Triage of cases</td>
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<tr>
<td>Interpretation of findings</td>
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<tr>
<td>Management / teaching</td>
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<tr>
<td>Audit</td>
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</table>
### Appendix 3 – GMC Domains

#### Domain 1 – Knowledge, Skills and Performance
Numbers following generic standards in this framework refer to paragraph numbers in GMP, except where preceded by MfD which refers to the booklet *Management for Doctors*; or Research which refers to *Research: the role and responsibilities of doctors*

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Generic Standards</th>
<th>Possible sources of evidence</th>
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<tbody>
<tr>
<td>Maintain your professional performance</td>
<td><strong>All doctors</strong></td>
<td>Evidence from WPBA; CPD; Audit; Validated tools for feedback about doctors’ practice</td>
</tr>
<tr>
<td></td>
<td>• Maintain knowledge of the law and other regulation relevant to practice (13)</td>
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<tr>
<td></td>
<td>• Keep knowledge and skills up to date (13)</td>
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<td></td>
<td>• Participate in professional development and educational activities (12).</td>
<td></td>
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<tr>
<td></td>
<td>• Take part in regular and systematic audit (14)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Possible sources of evidence</strong></td>
<td></td>
</tr>
<tr>
<td>Apply knowledge and experience to practice</td>
<td><strong>All doctors</strong></td>
<td>Evidence from training or assessment of skills; CPD; Audit; Validated tools for feedback about doctors’ practice</td>
</tr>
<tr>
<td></td>
<td>• Recognise and work within the limits of your competence (3a)</td>
<td></td>
</tr>
<tr>
<td>Doctors with management, teaching or research roles</td>
<td>• Follow appropriate national research governance guidelines (71)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Apply the skills, attitudes and practice of a competent teacher/trainer (16)</td>
<td></td>
</tr>
<tr>
<td>Doctors with clinical roles</td>
<td>• Work effectively as a manager (MfD 12, 17)</td>
<td></td>
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<tr>
<td></td>
<td>• Adequately assess the patient’s conditions (2a)</td>
<td></td>
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<tr>
<td>Doctors with clinical roles</td>
<td>• Provide or arrange advice, investigations or treatment where necessary (2b)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prescribe drugs or treatment, including repeat prescriptions, safely and appropriately (3b)</td>
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<tr>
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<td>• Provide effective treatments based on the best available evidence (3c)</td>
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<tr>
<td>Doctors with clinical roles</td>
<td>• Take steps to alleviate pain and distress whether or not a cure may be possible (3d)</td>
<td></td>
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<tr>
<td></td>
<td>• Consult colleagues, or refer patients to colleagues, when this is in the patient’s best interests (2c, 3a, 3i, 54,55)</td>
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<tr>
<td></td>
<td>• Support patients in caring for themselves (21e)</td>
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</tr>
<tr>
<td>Keep clear, accurate and legible records</td>
<td><strong>All doctors</strong></td>
<td>Anonymised records viewed at appraisal and WPBA</td>
</tr>
<tr>
<td></td>
<td>• Keep clear, accurate and legible records (3f)</td>
<td></td>
</tr>
<tr>
<td>Doctors with clinical roles</td>
<td>• Make records at the same time as the events you are recording or as soon as possible afterwards (3f)</td>
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</table>
## Domain 2 – Safety and Quality

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Generic Standards</th>
<th>Possible Sources of Evidence</th>
</tr>
</thead>
</table>
| **Put into effect systems to protect patients and improve care** | **All doctors**  
- Respond constructively to the outcome of audit, appraisals and performance reviews (14e)  
- Take part in systems of quality assurance and quality improvement (14)  
- Comply with risk management and clinical governance procedures  
- Co-operate with legitimate requests for information from organisations monitoring public health (14i)  
- Provide information for confidential inquiries, significant event reporting (14g)  

**Doctors with management roles**  
- Make sure that all staff for whose performance you are responsible are properly supervised. (17)  
- Ensure systems are in place for colleagues to raise concerns about risks to patients (45)  

**Doctors with clinical roles**  
- Report suspected adverse drug reactions (14h)  
- Ensure arrangements are made for the continuing care of the patient where necessary (40, 48) | WPBA, appraisal  
Validated tools for feedback about doctors’ practice  
CPD – reflective practice |
| **Respond to risks to safety** | **All doctors**  
- Report risks in the health care environment to your employing or contracting bodies. (6)  
- Safeguard and protect the health and well-being of vulnerable people, including children and the elderly and those with learning disabilities. (26,28)  
- Take action where there is evidence that a colleague’s conduct, performance or health may be putting patients at risk. (43,44)  

**Doctors with clinical roles**  
- Respond promptly to risks posed by patients  
- Follow infection control procedures and regulations | Information collected for folder,  
Evidence of level 3 safeguarding training, BLS training |
| **Protect patients and colleagues from any risk posed by your health** | **All doctors**  
- Make arrangements for accessing independent medical advice when necessary. (77)  
- Be immunised against common serious communicable diseases where vaccines are available (78) | Appraisal Health declaration. |
### Domain 3 – Communication, Partnership and Teamwork

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Generic Standards</th>
<th>Possible Sources of Evidence</th>
</tr>
</thead>
</table>
| Communicate effectively | **All doctors**  
- Communicate effectively with colleagues within and outside the team (41b)  
- Explain to patients when something has gone wrong (30)  
**Doctors with management roles**  
- Encourage colleagues to contribute to discussions and to communicate effectively with each other (MfD 50)  
**Doctors with clinical roles**  
- Listen to patients and respect their views about their health (22 a 27a).  
- Give patients the information they need in order to make decisions about their care in a way they can understand. (22b, 27)  
- Respond to patients’ questions (22c, 27 b)  
- Keep patients informed about the progress of their care (22c)  
- Treat those close to the patient considerately. (29)  
- Pass on information to colleagues involved in, or taking over, your patients’ care (40, 51-53) | WPBA, appraisal, Significant Event Analysis. Validated tools for feedback about doctors’ practice |
| Work constructively with colleagues and delegate effectively | **All doctors**  
- Treat colleagues fairly and with respect (46)  
- Support colleagues who have problems with their performance, conduct or health (41d)  
- Act as a positive role model for colleagues (41)  
- Ensure colleagues to whom you delegate have appropriate qualifications, experience (54)  
**Doctors with management roles**  
- Provide effective leadership ( MfD 50) | Information for folder |
| Establish and maintain partnerships with patients | **Doctors with clinical roles**  
- Encourage patients to take an interest in their health and take action to improve and maintain it (4, 21f)  
- Be satisfied that you have consent or other valid authority before you undertake any examination or investigation, provide treatment or involve patients in teaching or research. (36) | Review of anonymised records, WPBA, appraisal |
**Domain 4 – Maintaining Trust**

<table>
<thead>
<tr>
<th>Attributes</th>
<th>Generic Standards</th>
<th>Possible Sources of Evidence</th>
</tr>
</thead>
</table>
| Show respect for patients                     | **All doctors**  
• Implement and comply with systems to protect patient confidentiality. (37)  
**Doctors with research roles**  
• Respect the rights of patients participating in research. (Research 2, 5)  
**Doctors with clinical roles**  
• Be polite, considerate and honest and respect patients’ dignity and privacy (21a, b, d)  
• Treat each patient fairly and as an individual (38-39, 21 c)                                                                                     | Appraisal, WPBA                               |
| Treat patients and colleagues fairly and without discrimination | **All doctors**  
• Be honest and objective when appraising or assessing colleagues and when writing references (18-19)  
• Respond promptly and fully to complaints. (31)  
**Doctors with clinical roles**  
• Provide care on the basis of the patient’s needs and the likely effect of treatment (7-10)                                                                 | Appraisal, Diversity training, evidence from complaints |
| Act with honesty and integrity                | **All doctors**  
• Ensure you have adequate indemnity or insurance cover for your practice (34)  
• Be honest in financial and commercial dealings (73)  
• Ensure any published information about your services is factual and verifiable (60, 61)  
• Be honest in any formal statement or report, whether written or oral, making clear the limits of you knowledge or competence. (63-65, 67-68)  
**Doctors with research roles**  
• Obtain appropriate ethical approval for research projects (Research 5).  
• Be honest in undertaking research and reporting research results (71 b)  
• Ensure that your research is audited regularly. (research 43)  
**Doctors with clinical roles**  
• Inform patients about any fees and charges before starting treatment (72a)                                                                          | Probit declaration                            |
4 - Credentialing pilot studies - Annex B
A Credential in Breast Disease Management.

Purpose of the Credential

To produce a credential that can be applied, assessed and validated that will be unique to the breast clinician in accordance with the GMC Good Medical Practice guidance and lead to formal accreditation of knowledge and skills in the specialised field of breast disease management, and to be the basis on which on-going performance can to assessed for continued fitness to practice in this field.

Intent of Use of the Credential

This credential is designed specifically for doctors who are defined as “breast clinician’s by the association of breast clinicians and who undertake triple assessment in the field of breast disease management. Elements of the credential may also be used by clinicians working in a limited specific area of breast disease management for the purpose of validating their skills knowledge in the workplace and as a benchmark for measuring their performance for the purpose of appraisal and revalidation.

The Credential

The credential in breast disease management can be applied to clinicians who can show competent skills, knowledge and performance in the field of breast disease management and who can fulfil the following criteria:

- Have a least 5 years prior clinical experience to include equivalent of the current foundation training\(^1\), followed by a period of further clinical experience in a post approved by the GMC as suitable for training or its equivalent
- Undergo a period of training in breast disease management that spans 3 years (Equivalent to current ST3-6 standards)
- Show that the training undertaken could be matched against the criteria set out by the GMC for post-graduate trainings curricula\(^2\) outlined in the “ABC Apprenticeship of the Breast Clinician”
- Show that within that period of training the clinician’s has meet the requirement of the ABC as set out in the “ABC Framework for Knowledge and Skills for Breast Clinicians” and in

accordance with RCR guidance on breast imaging\(^3\) and quality assurance guidelines for radiologists and breast surgeons in breast cancer screening\(^4\).

- Show that following the period of training the skills to work independently in breast disease management have been achieved as outlined in the “ABC Framework for Knowledge and Skills for Breast Clinicians” and that the clinicians can show these skills are equivalent to the standards recommended by other medical clinicians working in the field of breast disease management whose training has been delivered via a recognised GMC approved curricula and validated by a royal college

- Show competency in communication and counselling and breaking bad news as set out in the ABC Framework for Knowledge and Skills for Breast Clinicians and the Royal College of Radiologists(RCR)\(^5\)

- Show that the clinicians interacts professionally with colleagues as part of the multi-disciplinary team\(^6\) and meet published professional guidance

**Core Elements of the Credential**

The individual core elements of the credential are:

- Clinical assessment
- Imaging assessment
- Interventional biopsy
- Communication and counselling

These are detailed in the document ABC Framework of knowledge and skills for Breast Clinicians and are summarised below.

<table>
<thead>
<tr>
<th>Core element</th>
<th>Skills and knowledge</th>
<th>Assessment</th>
</tr>
</thead>
</table>
| Clinical Assessment| **Skills:** Clinical Breast history  
Management of benign breast disease  
Management of malignant breast disease | Completion of relevant post graduate diploma module  
Log book of clinical apprenticeship  
Evidence of meeting quality assurance guidance  
Professional personal portfolio |
### Knowledge:

* The embryology, anatomy, physiology and pathology of both benign and malignant breast disease.

* The signs and symptoms of both benign and malignant breast disease.

* The principles of surgical management of breast cancer

### Skills:

**Principles of Mammography and Mammographic Interpretation**

- Correctly interpret the mammographic appearances of benign lesions
- Correctly interpret and classify abnormal mammographic lesion
- Classify correctly surgical scars and postoperative radiotherapy changes
- Show a systematic approach for breast imaging and further assessment of mammographic abnormalities
- To use skills in mammographic interpretation as a component of triple assessment towards correct diagnosis.

**Knowledge:**

* Breast anatomy and physiology

* Normal anatomical changes

* Benign lesions and malignant changes

* Pathology associated with specific mammographic features

### Logbook of cases and reflections on outcome (100 cases)

**Roller viewer tests (PERFORMS)**

Completion and pass mark for film interpretation and either postgraduate diploma in completion of course in radiation physics and pass in exam in either postgraduate diploma or an equivalent course

Completed a course in IRMA regulations

Personal film reading figures with outcomes that would include cancer detection rate, sensitivity and specificity

Demonstration of outcome of reading 2,500 in training period

Demonstration of outcome of 5000 films read

Report from mentor (QA Radiologist, Clinical Director).

PPP (outlining apprenticeship)

Evidence of meeting national NHSBSP reading figures (5000 per year)
<table>
<thead>
<tr>
<th>The Use of Breast Ultrasound and Ultrasound Interpretation</th>
<th><strong>Skills:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The use of mammographic equipment including imagining and film processing and digital mammography</td>
<td>Evaluate, interpret and report on ultrasound images as part of a triple assessment</td>
</tr>
<tr>
<td>Overview of quality assurance and performance testing mammography</td>
<td>Detect, evaluate and distinguish between benign and malignant breast disease</td>
</tr>
<tr>
<td>To understand the principles required to retrieve high resolution high contrast images</td>
<td>Document normal and abnormal findings</td>
</tr>
<tr>
<td>Production of x-rays and radiation physics</td>
<td>Produce an accurate report in line with local protocols and medico-legal and statutory</td>
</tr>
<tr>
<td>Radiation safety (IRMA and IRR regulations) and the biological effects of radiation</td>
<td>A logbook of cases (100 cases) showing evidence of skill progression e.g. ultrasound observed, performed and reviewed with feedback from mentor’s observation and reflection of outcomes</td>
</tr>
<tr>
<td>The principles of dose reduction techniques</td>
<td>Face to face interview with mentor and feedback</td>
</tr>
<tr>
<td>Factors affecting radiation dose and imaging quality</td>
<td>Pass in the ultrasound module of postgraduate diploma or</td>
</tr>
<tr>
<td>Patient positioning techniques for mammography and specialised views.</td>
<td></td>
</tr>
<tr>
<td>Use of mammography as a screening tool in NHSBSP</td>
<td></td>
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<tr>
<td>Requirements</td>
<td>Knowledge:</td>
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<tr>
<td>--------------</td>
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<tr>
<td>Physics of ultrasound</td>
<td>Physics of ultrasound</td>
</tr>
<tr>
<td>Breast anatomy and pathology pertaining to ultrasound</td>
<td>Breast anatomy and pathology pertaining to ultrasound</td>
</tr>
<tr>
<td>Characteristics of benign and malignant lesions on ultrasound</td>
<td>Characteristics of benign and malignant lesions on ultrasound</td>
</tr>
<tr>
<td>Principles of ultrasound guided biopsy techniques including FNA, core biopsy, vacuum assisted core biopsy and preoperative localisations</td>
<td>Principles of ultrasound guided biopsy techniques including FNA, core biopsy, vacuum assisted core biopsy and preoperative localisations</td>
</tr>
</tbody>
</table>

**Image Guided Interventional Procedures**

**Skills:**
- To use image guided biopsy as the third component of triple assessments
- Be skilled in performing
  - fine needle aspiration
  - core biopsy
  - cyst aspiration
  - preoperative localisations (ultrasound and stereotactic)
  - abscess drainage

- To manage the risks and complications associated with interventional procedures
- To develop the skills to correlate clinical findings, clinical imaging and pathological findings.

**Knowledge:**
- Prerequisite knowledge required of both mammographic and ultrasound interpretation

- Pass in the relevant module of PGD
- Logbook of at least 100 assessed cases with correlation, reflection of results over a 6 month period which is mentor reviewed
- Over a 1 year period should show a minimum of 500 examinations with the outcome of at least 50 interventional procedures presented at the MDT

PPP (reflecting coherence to NHSBSP guidelines and RCR guidance for Breast imaging and biopsy)
| **Communication and Counselling Skills** | **Skills:**  
Effective communication strategies with patients presenting with a range of breast symptoms  
Counselling skills to reduce patient anxiety presenting with breast systems  
Psycho social sequelae of breast cancer  
“Breaking bad news”  
Informed consent | **Knowledge:**  
Appropriate approaches of breaking bad news  
Knowledge of resources and support agencies  
Medico-legal, ethical and statutory considerations.  
Patient confidentiality | **Communications and counselling module of PGD**  
Reflective logbook (50 cases) which show evidence of above skills and knowledge as part of apprenticeship  
Attendance on specialised course for “breaking bad news”, Informed consent  
Video feedback for assessment with actress  
PPP |
The credential should be maintained by continuing medical education (CME) as outlined by ABC Guidance for Breast Clinicians on Continuing Medical Education (which reflects the principles of CME outlined by Academy of Royal Colleges) to demonstrate continuing competency to practice in the field of breast disease management and be an integral part of the appraisal process. This will aid revalidation in this field of clinical practice.
Framework of Skills and Knowledge for Breast Clinicians

1. Introduction

This document defines competency standards for Breast Clinicians which indicate a minimum expected level of knowledge and skill to be achieved during a period of training and clinical apprenticeship to become a competent breast clinician making independent clinical decisions. In addition this framework document can aid the GMC and other professional bodies in benchmarking safe practice for doctors identifying themselves as breast clinicians and aiding the process of credentialing. It is hoped that this framework will also provide the basis of a curriculum for future training and assessment of breast clinicians, and provide guidance to regulatory bodies such as the GMC, NHSBSP and NHS trusts choosing qualified breast clinicians when planning the workforce in breast disease management. This document is providing a framework to be used in conjunction with “medical apprenticeship of the breast clinicians”, and be used as a basis for planning and continual professional development (see CPD and the Breast Clinicians).

The ABC has identified the following categories of expertise in which specific competence should be demonstrated both in medical apprenticeship and in the workplace:

- Clinical assessment
- Imaging assessment
- Interventional biopsy
- Communication and counselling

These are the key areas of competency or will make the basis of the credential for the breast clinician. In addition all Breast clinicians should show competency in the following:

- Organisation of health services within the NHS
- Professional and ethical responsibilities

2. Competency standards and the role of the Breast Clinician

The term breast clinician is now widely used in the UK for a medical practitioner who following a period of training has adopted a holistic approach to the investigation and management of breast disease. The breast clinician has become an expert in triple assessment due to their skills in clinical examination, interpretation of imaging which includes mammography and ultrasound, the use of interventional procedures both within the NHS symptomatic clinic and the NHSBSP, in-depth knowledge of management of benign breast disease, high risk women and is able to work as an independent practitioner administering their own practice. This care is provided by the breast
clinician as part of the multi-disciplinary team and all breast clinicians should comply with the ABC’s standards for working within the multi-disciplinary team.

3. Definition of triple assessment

Triple assessment is the gold standard approach for investigation of palpable or impalpable breast lesions and consists of the following components:

- Medical history and clinical breast examination
- Imaging (mammography +/- ultrasound)
- Breast biopsy (core biopsy, FNA)

Each component of the 3 parts of triple assessment is allocated a score:

1 – normal
2 – benign
3 – indeterminate/probably benign
4 – likely to be malignant
5 – malignant

The outcome of triple assessment is managed within the multi-disciplinary team and all breast clinicians have a responsibility to interpret their findings in the context of the multi-disciplinary team (surgeon, breast clinician, radiologist and pathologist). Where there is a discrepancy in any of the components of triple assessment further investigation is mandatory and all biopsy results should be interpreted in the context of triple assessment.

Using the triple assessment it is aimed to:

- Maximise the diagnostic accuracy in breast disease
- Maximise the preoperative diagnosis of cancer and minimise the proportion of the those diagnosed by excision biopsy
- Minimise the proportion of benign excision biopsies for diagnostic purposes.

4. Learning framework

Many breast clinicians have achieved postgraduate diploma in breast diagnosis or postgraduate diploma in breast disease management, both of which have been based around modular learning. Other clinicians have used some of the modular learning workplace skills and knowledge acquisition. Trained breast clinicians currently working independently will need to retrospectively attempt to record and validate the areas of learning and how this compliment the newly proposed framework and should record this in a personal professional portfolio (PPP) outlined in the medical
apprenticeship of the breast clinicians document. The following learning framework is based around the previous modular learning in the postgraduate diplomas with the addition of other areas that would be relevant to the practice of breast clinicians and should be used to retrospectively as the basis for information collection for the PPP. This learning framework used as the basis of any recognised curriculum in the future and the ABC has also suggested relevant assessment of the clinician could undertake in the future. The ABC suggests that all medical practitioners which undertake the work of the breast clinician should now use this framework to base their learning of the acquisition of the knowledge and skills within the workplace. The areas of learning defined as important by the ABC are as follows:

1. Clinical skills which should include a in depth knowledge of benign breast disease and malignant breast disease
2. The principles of mammography and mammographic interpretation
3. Breast ultrasound and its interpretations
4. Interventional procedures.
6. Communication and counselling skills
7. Population screening and epidemiology
8. Breast cancer genetics, family history and management of high risk groups
9. Breast pathology
10. Developing in new technologies in breast disease management

5. The Personal Professional Portfolio and the Breast Clinician

The ABC has produced advice on compiling the personal professional portfolio. This is an essential tool to show the apprenticeship of the breast clinician, current training they are undergoing and their ongoing CPD. The ABC suggests that this tool is used and is particularly relevant in the process of credentialing.

6. Clinical assessment and the management and benign and malignant breast disease

6.1 Skills
- To take a competent breast history and understand its relevance to the investigation of breast symptoms.
- To be skilled in clinical breast examination and to use this skill appropriately in the management of breast symptoms and signs.
- To use this skill as a component of triple assessment to aid diagnosis.
- To manage benign breast disease including the appropriate use of imaging and interventional techniques for diagnosis.
- To use a holistic approach to the care of patients with breast cancer as part of a multi-
disciplinary team.
- To classify breast cancers and be skilled in the discussing the significance of prognostic indicators for the individual patient.
- To be able to discuss all the areas of breast cancer management which would include surgery, radiotherapy, chemotherapy, endocrine therapy, follow up regime and the role of complimentary therapies and other members of the multi-disciplinary team.

6.2 Knowledge

- The embryology, anatomy, physiology and pathology of both benign and malignant breast disease.
- The signs and symptoms of both benign and malignant breast disease.
- Hormonal interactions which affect breast structure and function.

6.21 Knowledge required of benign breast disease

- Congenital abnormalities of the breast e.g. amastia.
- Benign proliferative breast conditions:
  - Papilloma (solitary or multiple)
  - Sclerosing adenosis
  - Radial scar
  - Papillomatosis
  - Fibroadenoma and hamartoma
  - Tubular adenoma
  - Nipple adenoma
  - Phyllodes (benign – malignant)

- Benign proliferative breast conditions with atypia:
  - Atypical ductal hyperplasia (ADH)
  - Atypical lobular hyperplasia (ALH)
  - Lobular carcinoma in-situ (LCIS)
- Reactive and inflammatory conditions:
  - Duct ectasia
  - Periductal mastitis
  - Breast abscess
- Haematoma
- Fat necrosis
- Mondor’s syndrome
- Granulomatous mastitis
- Gynaecomastia
  - Physiological
  - Systemic disease related
  - Drug related.
- Nipple discharge
  - Physiological
Pathological

- Mastalgia
  - Hormonal
  - Non hormonal

6.22 Knowledge of malignant breast disease

- Epidemiology of breast cancer including all histological subtypes
- The clinical presentation in features in-situ breast cancer
- The clinical presentation and imaging features of invasive breast cancer
- Cancer cell biology which includes the characteristics of cancer cells, biopsy of tumour cell growth, the mechanisms of invasion and metastases and ductal carcinoma in-situ
- An understanding of prognostic and predictive factors relating to management and treatment planning of breast cancer
- An understanding of the psychological, ethical and legal aspects of breast cancer management

6.23 The principles of surgical management of breast cancer

- Mastectomy and wide local excision
- Staging of the axilla, including sentinel node biopsy, axillary node clearance (ANC) and axillary node sample (ANS).
- Reconstructive techniques
- The use of the TNM classification of cancers
- The role of radiotherapy
- The role of chemotherapy
- The role of other therapies e.g. antibody therapy
- The role of hormonal therapies
- Management of special groups of breast cancer including young women and pregnant women.

6.3 Assessment

6.31 A logbook
The completion of a logbook with a past grade of those who have taken the postgraduate diploma in breast diagnosis or the postgraduate certificate in breast diagnosis or the postgraduate diploma in breast disease management and show that the criteria of skills and knowledge in these areas have been achieved. Practitioners who have not undergone this formulated training that wish to show a period of training with (apprentice in the workplace) may be required to produce retrospective logbooks of cases of alternative evidence to show how this has been achieved. The logbook should show a range of benign and malignant cases reflecting the areas of knowledge discussed above.

6.32. OSCE examination
6.33. Presentation of logbook. (As part of formal assessment in diploma or review by mentor)
6.34. MCQ exam

7. Principles of Mammography and Mammographic Interpretation

7.1 Skills
The Breast clinician should develop and maintain skills in the interpretation of mammographic images. This would include the following:

- Appearances of normal and anatomical structures and parenchymal patterns including the effects of endogenous and exogenous hormones
- To correctly interpret the mammographic appearances of benign lesions
- To correctly interpret and classify abnormal mammographic features which would include stellate lesion, density changes, masses, asymmetries, architectural distortions and the classification of calcifications
- To identify changes occurring in augmented breasts
- To identify and classify correctly surgical scars and postoperative radiotherapy changes
- To appropriately manage and order further investigations of abnormal mammographic findings including the need for additional mammographic views, ultrasound and MRI
- To correlate clinical and imaging findings
- To overall develop a systematic approach for breast imaging and further assessment of mammographic abnormalities
- To use skills in mammographic interpretation as a component of triple assessment towards correct diagnosis.

7.2 Knowledge

- Breast anatomy and physiology
- Normal anatomical changes
- Benign lesions and malignant changes
- Pathology
- Pathology associated with specific mammographic features
- The use of mammographic equipment including imagining and film processing and digital mammography
- Overview of quality assurance and performance testing mammography
- To understand the principles required to retrieve high resolution high contrast images
- Production of x-rays and radiation physics
- Radiation safety (IRMA and IRR regulations) and the biological effects of radiation
- The principles of dose reduction techniques
- Factors affecting radiation dose and imaging quality
- Patient positioning techniques for mammography and specialised views.

7.3 Assessment

- Logbook of cases and reflections on outcome
- Roller viewer tests (PERFORMS)
• Completion and pass mark for film interpretation and either postgraduate diploma in completion of course in radiation physics and pass in exam in either postgraduate diploma or an equivalent course
• Completed a course in IRMA regulations
• Personal film reading figures with outcomes that would include cancer detection rate, sensitivity and specificity
• Report from mentor (QA Radiologist, Clinical Director).

8. The Use of Breast Ultrasound and Ultrasound Interpretation

8.1 Skills
• To evaluate, interpret and report on ultrasound images as part of a triple assessment
• To correlate ultrasound findings with the other components of triple assessment
• To interpret normal from abnormal ultrasound appearances and be able to detect, evaluate and distinguish between benign and malignant breast disease in real time examination
• To recognise artefact and their diagnostic implication
• To recognise the variations of physiological changes of the breast tissue including those in pregnancy and lactation
• To accurately document normal and abnormal findings
• To produce an accurate report in line with local protocols and medico-legal and statutory requirements

8.2 Knowledge
• Physics of ultrasound; production of sound waves, transducers reflection of sound waves at tissue interface
• Breast anatomy and pathology pertaining to ultrasound
• Basic principles of image formation including pulse echo and Doppler techniques
• Indication for breast ultrasound
• Breast anatomy relating to normal and abnormal ultrasound appearances including physiological variations of breast tissue
• Typical characteristics of benign and malignant lesions on ultrasound
• Basic principles of operation of imaging and recording equipment
• Knowledge of the principles of ultrasound guided biopsy techniques including FNA, core biopsy, vacuum assisted core biopsy and preoperative localisations
• The limitations of ultrasound

8.3 Assessment
• A logbook of cases (100 cases) showing evidence of skill progression e.g. ultrasound observed, performed and reviewed with feedback from mentor’s observation and reflection of outcomes
• OSCE exam
• Short answer and question exam
• Face to face interview with mentor and feedback (pass in the ultrasound module of postgraduate diploma or equivalent validated course)
9. Image Guided Interventional Procedures

9.1 Skills
- To use image guided biopsy as the third component of triple assessments
- Be skilled in performing
  - fine needle aspiration
  - core biopsy
  - cyst aspiration
  - preoperative localisations (ultrasound and stereotactic)
  - abscess drainage
- To manage the risks and complications associated with interventional procedures
- To develop the skills to correlate clinical findings, clinical imaging and pathological findings.

9.2 Knowledge
- Prerequisite knowledge required of both mammographic and ultrasound interpretation
- The indications and protocols for interventional breast biopsy
- Understanding breast cytopathology and histopathology and interpreting pathological reports
- Knowledge of vacuum assisted techniques and other emerging image guided techniques and localisations e.g. microbubbles, elastography.

9.3 Assessment
- Logbook of at least 100 assessed cases with correlation, reflection of results over a 6 month period to be reviewed by a mentor or alternatively as pass in ultrasound model and film interpretation and practical collaborations of assessment techniques module from the postgraduate diploma or relevant modules from the diploma in Breast Disease Management
- Over a 1 year period should show a minimum of 500 examinations with the outcome of at least 50 interventional procedures presented at the MDT.

10. Communication and Counselling Skills

10.1 Skills
- To develop effective communication strategies with patients presenting with a range of breast symptoms
- Develop and consolidate counselling skills to reduce patient anxiety presenting with breast systems
- Recognise the psycho social sequelae of breast cancer diagnosis and have methods to assist patient coping skills
- Develop the skill of “breaking bad news”
- To undertake informed consent whether for initial investigations, further management or clinical trials etc.
10.2 Knowledge

- Appropriate approaches of breaking bad news
- Knowledge of resources and support agencies available to patients and other health professionals involved
- Providing information and how to involve women in decision making
- Addressing cultural diversity and non-English speaking backgrounds.
- Medico-legal, ethical and statutory considerations.
- Patient confidentiality

10.3 Assessment

- Pass in communication and counselling module of PGD
- Reflective logbook (50 cases) which show evidence of above skills and knowledge
- 3,000 word essay
- Attendance on specialised course for “breaking bad news”, Informed consent
- Video feedback for assessment with actress
Report by British Institute of Musculoskeletal Medicine on the credentialing pilot of Musculoskeletal Medicine for the GMC

Background

Musculoskeletal Medicine [MSM] is not a recognised specialty but has a history that is relevant to any consideration of its practice being recognised for use within the NHS.

Over the last twenty years rapid developments have transformed the field of healthcare devoted to musculoskeletal pain and impairment: advances in investigation methods, anti-inflammatory pharmacology and reconstructive surgery have had a major impact on formerly crippling conditions. However, as a result, the specialties providing these treatments, Rheumatology and Orthopaedic Surgery, have had to focus on the needs of a more clearly delineated responsive section of sufferers and those who cannot benefit have consequently been seen as having less priority or even as inappropriate candidates for these specialties' attention.

These developments have resulted in the bulk of musculoskeletal presentations that cannot be managed by general practitioners having no obvious specialist medical referral pathway. Physiotherapy, osteopathy and chiropractic professions have been increasingly recruited, often taking on referrals directly and found in many cases to be as effective as medical referrals.

Pertinent to this however is the concurrent acceptance of a bio-psychosocial model as essential to the understanding and management of most musculoskeletal patients, and expectations that care will engage with all aspects of this model. However the training of the three professions mentioned above has not been designed to ensure full competence in assessment and management of the three entailed areas: [i] structural pathological processes; [ii] impairments of function; and [iii] the psychological factors involved. Recognition of these professional limitations has resulted in the multidisciplinary team [MDT] being advanced as the optimal model of care by sharing necessary competences: medical assessment of structural pathology, a physical therapy professional assessing function and a clinical psychologist engaging with psychological factors. This model uses considerable resources in duplication and communication so that the MDT is more frequently an aspiration than a reality in marginally resourced services. Whereas for doctors, already trained and experienced in managing disease and its psychosocial impact on people, acquiring additional competence in managing impairments of musculoskeletal function has enabled them to engage with the challenges of the bio-psychosocial model.

Prior to the twenty years of this analysis, many doctors found that enhancing their competence dealing with musculoskeletal maladies led to a brisk demand for these abilities both in the health service and independently. Training in specific diagnosis and manipulation was provided by several disciplines and was practised in the NHS by general practitioners and doctors in established specialties but also some were appointed to full consultant status in Musculoskeletal Medicine despite having no recognition in any official specialty (several had taken post-graduate training in osteopathy). With the introduction of GP fund-holding in 1992 most doctors with extended musculoskeletal skills were quickly recruited into work that
would now be considered to be at the interface between primary and secondary care. With the closure of GP fund-holding many of them continued in a variety of NHS clinics set up in response to local needs and this movement was boosted by the 2006 Musculoskeletal Framework [MSF] document which urged PCTs to encourage establishment of musculoskeletal interface services using a variety of professionals including “musculoskeletal physicians”.

This description, implying a doctor practising MSM, had a provenance: the Clinical Standards Advisory Group Report on Back Pain in 1994 makes frequent mention of MSM suggesting that those developing its competencies may be ideal to provide a second opinion service. The term musculoskeletal physician had been used in 2002, in the DoH and RCGP report 'Implementing a scheme for General Practitioners with Special Interests', to describe the work of general practitioners who had acquired specific expertise. A Diploma of Musculoskeletal Medicine under the Society of Apothecaries of London had been set up in 1992 and the various groups representing those working in it had unified as the British Institute of Musculoskeletal Medicine [BIMM] in that year and established training including an eight module course involving 170 hours of contact time.

The majority of doctors with such training currently find posts as GPSIs in musculoskeletal interface clinics while some have worked in the NHS without any oversight by a recognised specialist and others have had contracts with PCTs to provide care independently. With the recent increased need for accreditation of all doctors these situations have been seen to be anomalous and some independent musculoskeletal physicians have had contracts terminated because there is no mechanism within the incoming regulations under which a doctor not accredited as a specialist or principal in general practice can take full clinical responsibility. It was this situation of the NHS losing people providing valued services and those doctors losing part of their livelihoods that prompted BIMM officials in 2009 to approach the Department of Health again. Prior to that BIMM had negotiated with the 18 week team in 2007 who clarified the MSF document's description of MSM practitioners acknowledging that “we are aware of the valuable training your organisation delivers . . . . your members seem ideally equipped to undertake this work . . . we are working to promote the development of new roles that could support the delivery of an 18 week pathway and the training offered by the British Institute for Musculoskeletal Medicine will play an important part in this.”

In early 2009 Ben Bradshaw, Under Secretary for Health, after visiting the Plymouth back pain service conducted by two musculoskeletal physicians and an osteopath, said that such a model should be rolled out more widely. BIMM let him know that quite the other situation prevailed and doctors practising MSM were losing ground in medical practice due to increasing discrimination against competence acquired outside officially recognised specialist training. The reply from his successor, Ann Keen, acknowledged that “. . . it does seem anomalous that the skills of doctors undertaking this work are not formally recognised. At the same time I understand that discrete areas of practice such as this would not necessarily be appropriate for recognition as a specialty or sub-specialty in their own right.” She went on to invite BIMM to consider credentialing as an option and suggested liaising with the Department's Education, Training and Development Branch with whom contact was made late in the Summer of 2009.

At the end of that November the BIMM President had a meeting with Patricia Le Rolland, Director of Quality at the PMETB, leading to her and colleagues meeting a group from
BIMM in February 2010 to discuss the Institute carrying out a pilot of credentialing MSM. BIMM's proposition at that time is summarised in Appendix 1. Confirmation that the pilots would go ahead but without any funding was received in November and, at a meeting at the GMC in January 2011, BIMM committed to develop a plan for a pilot of credentialing MSM and then carry that out with the aim of completing and reporting on the process in January 2012: this is that report.

**Development.**

Relevant medical groups, the Primary Care Rheumatology Society, Society of Orthopaedic Medicine, Royal College of General Practitioners and Association for Medical Osteopathy were consulted and invited to take part in the pilot. A representative of the latter organisation subsequently joined three BIMM members in an initial working party.

The working party produced a draft plan for the pilot [Appendix 2] which was presented at a meeting, at the GMC on 17th March 2011, of the three clinical groups who were to pilot credentialing of their practice. Following that meeting BIMM was asked to proceed with the pilot process beginning in April and provide an interim report by August.

At subsequent meetings of the working party, elements of the plan were developed in detail but the only departure from the draft was that a telephone interview after consideration of the Personal Profile and Portfolio, between two assessors and the assesse, would occur in all cases.

Up till this point the syllabus and competencies listed for the Diploma in M-S medicine developed at a stakeholder meeting in Keele under Prof Elaine Hay in 2006 were the reference for GPSI level competency. Initially we worked on revisiting this document and related training programmes to define a new ‘curriculum’ which we have re named Competencies after discussions and feedback from Prof. Rowley. (Appendix 3)

**The Competencies in MSK medicine** is our new reference document which helps define a level of knowledge, skills and attitudes required in any specific role. The doctor’s specific role will be mapped to the Competencies document in advance of the assessment.

The following tools (of which all are linked to the GMC competency framework for appraisal and revalidation except the first) were developed and adapted for this task. (Appendix 4)

**An initial invitation to participate – letter in Form 1**

**A Personal Professional Profile** (PPP blank email Form 2) used originally by osteopaths in their registration process for the GOSc was adapted to describe the role of the MSK physician from a matrix of possibilities ranging from triage of referrals to a MSK service within the NHS under supervision, or to full independent practice as a specialist using the fullest repertoire of diagnostic and treatment techniques.
The assessee then completed the remainder of the template with qualifications, formal and informal training from initiation of MSK involvement to current status, experience in terms of cases seen, case mix, working relationships as part of the team, and description of current working practice.

This PPP was then assessed by 2 of the initial 4 assessors and a summary form (Form 3) extracted from which further clarification of training, experience, or current work could be sought during a telephone interview by two assessors lasting 30-60 minutes. This form is also used to summarise the PPP and the final conclusion as to whether the candidate is competent to work at the indicated level.

From this interview the assessors decided what aspects of the assessee’s work was to be observed at the Workplace Based Assessment (WPBA)

Two assessors then visited the doctor for a day at their workplace to observe their work.

The tools used for this part of the credentialing exercise were adapted from the RCGP tools used for a WPBA which are informed by the GMC guide to Good Medical Practice.

The Direct Observation of Procedural Skills (DOPS) (Form 6) was used to assess specific practical skills including physical examination of a specific region, joint or soft tissue injection, manual treatment, injections under fluoroscopy or other procedure and recorded on this form by the two assessors.

Case Based Discussion (CBD): The assessee had prepared in advance 2 case histories which were read either in advance or during the day by the assessors to form part of a 30 minute case based discussion. The tool used for this assessment is found in Form 5.

WPBA summary form (Form 4) collates and summarises the findings of the visit together with additional information sought at the time. This includes:

Review of any recent clinical audits

Multi source feedback

Patient satisfaction questionnaires

Record of untoward events, complications or complaints

Form 4 of the doctor’s last Appraisal

The opinion of both assessors was recorded in the comments section and used to decide whether the doctor was:

Excellent and working well in line or above clinical level indicated

Competent for required role
Requiring further training or experience to be ‘fit for role’

This is presented in the box on the Summary Form 3.

Forms 1-6 are found in Appendix 4

The Assesees

MSK service provision is currently provided in a number of different ways both inside and outside the NHS;

1) As sole independent practitioner

2) As independent practitioner within a multidisciplinary team

3) Employee of a private treatment provider commissioned by PCT

4) As part of a community based interface clinic contracted by PCT

5) As a GPSI or MSK practitioner (SAS grade) within secondary care in Rheumatology/Orthopaedics, Rehabilitation medicine

6) From within primary care as a GPwSI

There may be other types of practice, and often a MSK doctor works in more than two or more of these capacities.

The first 7 doctors to complete this process represented a variety of these settings:

1. An independently practising Musculoskeletal and Sports physician working in a large private clinic with many allied practitioners in a MDT and utilising fluoroscopically guided injection techniques.

2. An independent orthopaedic physician employed by a private treatment provider in Pain Management procedures in a hospital and also working part time from his own private practice.

3. A GP with Special interest working part time in general practice and part time in private practice with links in a multidisciplinary team

4. An independent sports and orthopaedic physician with previous osteopathic training working from his own clinic and local private hospital.

5. An orthopaedic physician with previous rheumatology training working for the MOD in a Rehab Unit and as sessional GPSI in a health centre.
6. An orthopaedic and Sports Physician working in an NHS Orthopaedic Hospital Musculoskeletal unit and using fluoroscopically guided injection techniques, also in an NHS GP MSK clinic and privately.


Feedback and discussion of credentialing process

Over the last 6 months small amendments to the documentation were made to improve their utility and ease of use.

To enhance the robustness of the overall process it was decided early on to draw on some of the documentation that a doctor needs to collect for their Appraisal process since that provides a more comprehensive and in depth picture of their overall performance over time.

It quickly became clear that one of the biggest drawbacks was coordinating a WPBA visit for 2 assessors on a suitable day to observe the required working practices of the physician. (One of our team fortunately has recently retired making this process easier due to his flexibility).

The other three however found themselves so busy with their own working commitments that clearing a day to make such a visit was either not achievable or led to serious limitations on the process. (Eg only being able to be free on a Monday). Consequently the process of coordinating a telephone interview, a WPBA visit, the CBD sometimes needing to be held on a separate occasion from the day visit by telephone, was spread out over weeks or months in some individual cases. Furthermore these visits have involved travelling considerable distances across the country and 3 overnight stays.

Soon after the first two assessees had been ‘passed’ they were recruited for the credentialing process and have subsequently been involved in assessing some of the 4th, 5th, 6th and 7th doctors volunteering for the credentialing process.

Another difficulty arises from the choice of day for the WPBA assessment which tended to be influenced more by the practical logistics of getting three doctors to meet on one day than selection of type of work and case mix one would ideally wish to observe. Part of this difficulty arises from the variety of locations and settings that comprises one doctor’s working week.

For example the was observed treating his MSK patients within the context of a ‘normal’ morning GP surgery although the case mix was accented deliberately towards booking returning MSK patients. This meant that one was observing patients who may already have been ‘worked up’ with a particular problem and were simply returning for review or the injection. The same doctor worked in his own private practice on another day of the week where one might have observed more of the clinical processes involved with a patient in a complete episode but that would have meant another day visit.
Similarly the doctor worked with a physiotherapist on the day chosen to do the WPBA but she had requested that only one assessor might come because the presence of four experts observing one patient might be understandably intimidating for that patient. Furthermore to get a fuller picture of her practice required a further visit on a separate day to see how she works in the NHS MSK clinic. This was done by a different assessor.

To summarise the above it is not always easy to see all aspects of a doctor’s practice on a one day visit. At present this has not proved too great a problem because the assessors have tended to have known the assesseee over a long period of time and are familiar with most of their methods and practice and so may wish to observe only some aspects of their work to be satisfied. However with a doctor who is not at all well-known or relatively new in the field it may be important to see many aspects of their work at the WPBA. The practicalities of arranging this may have logistic and resource implications both in time and costs in future assessments.

There is a tension between the extra robustness of having two assessors at each stage of the process, and the practicalities (and cost) of requiring 3 doctors to devote many hours to a single credentialing event. Comparison of the independent scores of each assessor has so far not shown any significant disagreement regarding competence: this suggests that a way forward after the pilot would be to use a single assessor supported by a second assessor who could become involved in the following circumstance:

- To advise the first assessor if uncertain
- To share the burden of the process (for practical reasons)
- At the request of the assesseee

Assessors will need training (with reference to GMC guidance on WPBAs 2010) before working singly and be able to access mentoring at any point during the process from an assessor colleague.

**Mapping of role to Competencies Document**

It has taken longer than anticipated to get overall agreement and feedback on the Competencies Document. As a consequence the first 6 credentialing assessments were undertaken without direct reference to this. We are going to attempt some mapping of these doctors role to the Document retrospectively with the help of the doctors concerned.

Moving forward we intend to send new credentialles the PPP and Competencies Document at the same time. They will be asked to read through the latter and highlight

1. **In red** those specific competences they *either* do not have *or* believe are not relevant or required in their current work.
2. **In green** add any additional competences they both possess and employ as an addendum which are not covered in the Document.

The assessors will utilise this information for further questioning and discussion during the interview. The assessors will also be able to pick up any obvious deficiencies and discrepancies between the job(s) as described, the assessors’ own interpretation of the required competencies for that doctor’s work, and what the doctor claims he/she is competent to do. This in turn serves to direct the Assessor(s) to specific competency observations at the WPBA.

This process provides the flexibility to individualise the WPBA to the doctor’s specific role with his/her collaboration in advance. The alternative is to attempt to categorise each ‘box’ of the matrix in
the PPP (page1) with a rigid set of competencies. This is unlikely to reflect the reality of the many varied roles in which MSM doctors are employed.

**Current status**

We have at least 5 more PPPs in process, with needs to arrange interviews by phone and complete WPBAs. We have not been short of doctors willing to volunteer for this process. There is clearly a perceived need for this by the individual and some organisations (eg Commissioners of services, BUPA and others). In the future it is anticipated this may have relevance to the Revalidation process.

John Tanner - Musculoskeletal and Sports Physician and Osteopath
Rod MacDonald - Musculoskeletal Physician and Medical osteopath
Garth Robertson - Musculoskeletal Physician and registered osteopath
Richard Ellis - Consultant Rheumatology and Rehabilitation (retired)
Andrew Watson - Musculoskeletal Physician
Simon Petrides - Musculoskeletal and Sports Physician and Osteopath

**Costs**

Each credentialing assessment involves approximately 2 and 1/2 days of work plus travel and occasionally overnight accommodation.

3rd March 2012

**Appendices**
I. Credentialing musculoskeletal practitioners – An Outline
II. The pilot process
III. The Competencies for Musculoskeletal Medicine
IV. Forms 1-6 used by the Assessors
CREDENTIALING
MUSCULOSKELETAL MEDICINE
PRACTITIONERS

An Outline

March 2010

British Institute of
Musculoskeletal Medicine
1. Introduction

1.1 Doctors with advanced competence in managing musculoskeletal problems, in contract with or as employees of the NHS, are providing care for its patients but may have no recognition with the GMC as a specialist or a general practitioner. Notwithstanding their informal status such doctors are successfully providing care for musculoskeletal pain and disability at all levels of clinical responsibility from clinical assistant and GPSI, to NHS consultant or independent provider with no clinical oversight.

1.2 With no immediate prospect of a recognised specialty of Musculoskeletal Medicine [MSM], as employers or commissioners, local health bodies need to have official criteria to guide their recruitment and employment of practitioners. The current need is greatest in the interface musculoskeletal Clinical Assessment and Treatment Centres [CATs] that PCTs are required to set up. A means of credentialing practitioners could go a long way to remedy the present deficiency, provided a robust process can be developed.

1.3 The British Institute of Musculoskeletal Medicine [BIMM] has been invited to put forward a proposal to pilot the credentialing of MSM practitioners.

The term Musculoskeletal Medicine has several components:

1.4 An approach that:

[a] incorporates conventional diagnosis of traumatic, degenerative and pathological causes of pain and impairment;

[b] includes those factors into a biopsychosocial model of illness;

[c] and, unique to medical specialties, brings into this multifactorial synthesis an understanding of abnormal function of the neuromusculoskeletal [somatic] system of the body;

1.5 assessment that uses:

[a] the skills of an experienced medical practitioner;
distinct skills such as palpation and pattern recognition, acquired by guided experience; [These skills are not part of the competences of any other medical specialist training. Clinical experience needs to be informed by an awareness that changes in function cannot be assumed to be fluctuant secondary effects of underlying pathological processes but require assessment as an independent factor.]

1.6 and treatment that uses:

Standard medical treatment methods in a holistic approach but particularly addressing abnormal function, that will include educating subjects in all aspects of their physical activity, augmented where appropriate by special skills such as manipulation, acupuncture, or injection aimed at specific pain-generating structures.

2. Principles.

2.1 The present state that the credentialing process will address is of a variety of practitioners, with varying training, practising at all levels of clinical responsibility and using a variety of techniques. This situation is an inevitable consequence of the absence of a prescribed training programme for these doctors. The services in which they work are often in a state of development with roles evolving according to local circumstances.

2.2 This current diverse situation prevents the use of the usual practice within established medical specialties of defining a national list of required competencies that once assessed and certified for an individual would provide a standard to allow local commissioners to accredit her/him to take up any post in that specialty. Decisions on such a set national competency list for MSM would be arbitrary and not address the prevailing variety of situations and individuals.

2.3 We recommend a process designed for the present situation. This process will assess both the range of activities and the level of responsibility that can be taken on by the practitioner. A grid plotting these ranges and levels, as in the Table, could be used to represent both the requirements of a post and also the
competencies of the practitioner. Congruence of the two plots would be required for an appointment to take place. For each locus on the grid the required competence would be laid down as would the elements of required training and/or assessment. [See appendices]. The bedrock of the assessment will be the generic features of Musculoskeletal Medicine which will be required by all practitioners, relating primarily to knowledge, attitude and clinical examination skills.

<table>
<thead>
<tr>
<th>Level of Responsibility</th>
<th>Supervised MSM practice</th>
<th>Off-site supervised MSM practice</th>
<th>Unsupervised NHS MSM practice</th>
<th>Independent MSM practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic assessment and triage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuing MSk management</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>MSk management Using special skills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Application.

3.1 Levels of responsibility:

[a] Independent specialist MSM practice – undertakes clinical activity without any supervision beyond standard audit and appraisal. Criteria and protocols discussed with other clinicians and commissioners but finally self-determined. Provides and manages practice organisation and setting.

[b] Unsupervised MSM practice in NHS setting – as [a] but without responsibility for organisation and setting.
[c] Off-site supervised MSM practice – Criteria and protocols discussed with a consultant colleague not necessarily on site who has the final decision and provides supervision on overall performance and may be involved with exceptional cases and events.

[d] Supervised MSM practice – as [c] but the consultant colleague is available close to work site and may give further opinions on individual cases or be consulted routinely on specified categories of patients.

3.2 Range of activities:

[a] Basic assessment and triage – Assesses, investigates, and triages patients with [i] spinal pain; [ii] limb pain; [iii] undifferentiated musculoskeletal referrals; [iv] sports injuries;

[b] Continuing musculoskeletal management – Manages patients with general advice on causation, prognosis, activities of daily living [ADL], work and exercise(s). [i] short intervention prior to referral for treatment; [ii] until discharge or referral to another specialty.


4. Assessment.

4.1 To accommodate the variety of formal and informal trainings that MSM practitioners have had, each will require an initial assessment to consider the extent of their capabilities and the posts for which they wish to be eligible. An appropriate locus on the grid will be agreed which will define the standards to be achieved. The initial assessment will determine which criteria have been met and prescribe what methods will be necessary to assess any outstanding. Where possible assessment tools will be chosen that have established validity.
4.2 The design of the initial process will be a validated paper-based Professional Profile and Portfolio [PPP] which could lead on to interview and/or clinical assessment. It will be written specifically for MSM practitioners following a format developed by the General Osteopathic Council [GOsC] when initially set up and used after validation for fifteen hundred practitioners. [See appendix]

4.3 Evaluation of the PPP, and interview if required, will be followed by a prescription of the further assessments the applicant should have. While specific training leading to a professional qualification could be required, it will be more likely that assessment, especially for practitioners already in post, would be by workplace–based assessment [WPBA] to provide the most direct demonstration of safe competent practice. For the WBPA we will used validated tools developed by the Royal College of General Practitioners [RCGP] that will translate comfortably into the assessment of MSM practitioners, particularly Case–Based Discussions [CBD] and Direct Observation of Procedural Skills [DOPS]. It will be an initial task of the assessment team, once appointed, to populate the competency areas assessed in WPBA tools with descriptors specific to the MSM situation.

4.4 The clinical abilities mentioned in 1.4 – 1.6 and 3.2 will be classified into individual competencies with unique identifiers thus allowing the assessment prescription to be defined concisely. Each locus on the grid will have its specified competencies that will only vary with choices of patient group or technique employed [see 3.2]

5.0 Establishing a credentialing board:

5.1 While BIMM has its origin in the aspiration to build standards in practice and education and can show considerable achievements, it is a special interest group of practitioners from which a credentialing board should have independence. Consequently invitations to be represented on the board will go to organisations that have expertise and a legitimate interest in maintaining MSM standards. Invitations will set out the board’s terms of reference but, once set up, it will decide on the specific actions to be taken to meet its objectives.
5.2 The initial task of a board would be to recruit a panel of assessors and with them develop the criteria for prescription of assessment tools in individual cases and undertake procedures for establishing the validity and calibration of those tools. Assessors would need to meet for this initial programme of development tasks but, when this is complete and the credentialing process is established, its updating and the induction of new assessors would take place in a regular programme. The terms of reference would set a period for the initial programme of four months.

5.3 To maintain and raise quality in MSM, BIMM has decided to look for partners to establish a faculty of Musculoskeletal Medicine. Representatives would be enlisted from the specialties of Rheumatology, Rehabilitation, Orthopaedics, Sport & Exercise, Pain and relevant organisations such as the Primary Care Rheumatology Society and Society of Orthopaedic Medicine. In the specialties mentioned, MSM credentialing could highlight specific areas to which training and service-delivery by their members could extend. The timetable envisaged for establishing a faculty could mean that it would be available, by the time a pilot process could be commissioned, to support a credentialing board or even subsume that function.
Credentialing Musculoskeletal Medicine. March 2011

Pilot planning document prepared by the British Institute of Musculoskeletal Medicine.

Introduction:

Musculoskeletal Medicine [MSM] encompasses an amalgam of competencies, addressing a variably defined area of clinical need and is delivered, at varying levels of clinical responsibility, as clinicians work recognising their levels of ability. While progress in education has been rapid over the last decade, there is at present no overall accepted model for training and most practitioners undergo self-selected portfolios of learning, experience and assessment. Course curricula and assessments vary with none attempting to attest to the ability to practice safely and independently across the whole range of musculoskeletal medical competencies.

In the absence of a unified training programme, there is no one curriculum from which to derive a credentialing process and it must therefore, in each case, assess performance congruent with the specific responsibilities of the post held and the individual competencies of the practitioner.

At a later stage in the development of MSM, possibly following the formation of a faculty, credentialing may be more closely informed by an overall curriculum and become more standardized but for the pilot and any initial subsequent phase it must be adapted to the practitioner and whatever role they occupy. For that reason the outcome of the process cannot be an unqualified approval but will have to state the range and level of practice credentialed in a Credentialing Report.

Presumably, should credentialing become more widely used and applied in recognised specialties [possibly as part of re-validation] it will be directed at many areas of performance not covered by a CCT or practised by all in the specialty, so necessarily credentialing will always have a qualified and categorized outcome.
Credentialing prescription:

Credentialing for an individual will be tailored to the range of clinical situations they will encounter and the level of responsibility at which they will perform. The elements of the process to be followed will depend on what competence can be assured by prior assessed learning and experience, and what levels of performance have been achieved for which evidence is presented.

Assessment of achieved learning, experience and performance will be by means of a Professional Profile and Portfolio [PPP] document submitted by the applicant. The outcome of the PPP submission, following independent consideration by two assessors, will be a statement of what further assessments will be required in order that credentialing for the proposed clinical role can be definitively carried out. Where the two assessors cannot come to a consensus a third assessor will consider the PPP.

Further assessments will have elements of workplace-based performance assessment [WPBA], case-based discussion [CBD] and directly observed procedures [DOPS].

Occasionally the PPP assessors will not feel able to decide on necessary further assessments in the workplace without eliciting more information. They may decide to interview the applicant and they may go on to a clinical skills assessment [CSA]. It will be open to them at the stage of PPP, interview or following CSA to decide not to proceed further but recommend re-submission of a PPP following further training.

Progression to an expanded range of modalities of treatment or higher level of clinical autonomy may require a Revision Credentialing which would follow the same overall process. Relatively small changes may be assessed following submission of an addendum to the PPP on record and may or may not require additional assessment. For example, if a new technique has been acquired and the level of
achieved performance assessed robustly, its use may be added to the Credentialing Report without any WPBA.

Flow Chart

Appendices:

Professional Profile and Portfolio
THE COMPETENCIES FOR MUSCULOSKELETAL MEDICINE PRACTICE

Draft of March 2012 prepared for the Working Party for a Faculty of Musculoskeletal Medicine
c/o The British Institute of Musculoskeletal Medicine,
PO Box 1116, Bushey, Herts WD23 9BY

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10 Equality and Diversity
Musculoskeletal Medicine is succinctly defined as the assessment and treatment of musculoskeletal pain and impairment. Within the scope of this broad definition, certain areas of practice have become established as medical specialties, most notably Rheumatology for inflammatory diseases and Orthopaedic Surgery for major trauma and those requiring structural revision. Rehabilitation, Pain Medicine and Sport & Exercise Medicine also have parts of their musculoskeletal practice that are exclusive to their specialties.

However, outside these distinct areas of expertise, the established specialties practise to a varying extent a common range of competencies that they share not just with each other but with those who address the full range of musculoskeletal problems that present to general practice but are beyond its usual expertise. For the purposes of this document it is practice in this common area that will be referred to as Musculoskeletal Medicine (MSM). Only a minority of these presentations meet the strict criteria for referral to the established specialties, so that the bulk of their care is undertaken by Musculoskeletal Physicians, General Practitioners with a Special Interest, and Physiotherapists.

2 Rationale
2.1 The Purpose of the Competencies Document: The purpose of this document is to define elements of training and practice for Musculoskeletal Medicine. Originally the Working Party’s objective, determined at its meeting in April 2011, was to develop a curriculum. The purpose of a curriculum is to provide a guide for training for a specific clinical role, and for an established specialty will define the competences required to allow independent specialist practice in its area of medical expertise. However at present, and increasingly in the future, the practice of MSM will be (i) by a variety of specialists using it alongside their exclusive specialist skills, (ii) by those who may practise only MSM with considerable clinical independence and (iii) by General Practitioners with a Special Interest or others who work under clinical direction. They may work in secondary care and at the interface in services that may become configured differently from current models.

With this variability of career pathways, practice roles and uncertainty about future deployment, this document must be both prospective and adaptable to accommodate change. It will not apply solely to training for any one specialist practice and so the title “Competencies for Musculoskeletal Medicine” has been adopted. However, despite these qualifications, it should be a guide that is robust in ensuring that the contained elements will have currency for a variety of applications in MSM training and assessment and be incorporated into curricula developed for training for roles that arise to meet clinical need in this area. The increasingly used performance-based assessments of clinicians should be mapped to explicit criteria of which this document could be an authoritative source.

2.2 The Development of the Document.
The Working Party for a Faculty of Musculoskeletal Medicine, convened from the range of organisations involved in musculoskeletal medical practice, decided in April 2011 that this project was its major priority. It derives from the curriculum for the Diploma of Musculoskeletal Medicine, inaugurated by the Society of Apothecaries of London in 1992 and now administered by the British Institute of Musculoskeletal Medicine; the Competencies Framework for general practitioners with a special interest in musculoskeletal medicine developed through Keele University (Hay E, et al. Rheumatology, 2007), and the training recommendations of the International Federation for Manual and Musculoskeletal Medicine (FIMM, 2001). The process has been greatly helped by comparison with other specialties’ work, notably rheumatology. This document is designed to meet the General Medical Council’s standards for Curricula and Assessment, and to incorporate leadership, health inequality and common competencies. This draft follows consultation on the initial version, with stakeholders and Prof David Rowley, nominated by the GMC. A further round of consultation on this draft will take place prior to submitting a final draft to the second meeting of the Working Party in Spring 2012. Prior to this acceptance the draft document has been used in the credentialing pilot of MSM practitioners that BIMM is carrying out for the GMC.
2.3 Training Pathway
Specialist practice in Musculoskeletal Medicine will require both core and advanced 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. The advanced speciality training then builds on these core skills to develop the specific competencies required to practise independently in Musculoskeletal Medicine.

Progression to independent MSM practice will be most readily achieved by the completion of training in one of the five established specialties, i.e., Orthopaedics, Rheumatology, Rehabilitation Medicine, Sport & Exercise Medicine, and Pain Medicine. In these disciplines, under current regulations, one or more of the higher training years could be dedicated to MSM training, attaining elements laid down in later parts of this document selected according to the doctor’s chosen role in MSM practice. There are movements in some of these specialties that could lead to an increasing number of doctors taking this route.

In addition to the situations above, demonstrating competences defined in this document may be used for those doctors working in MSM without specialist status, towards establishing their ability to occupy clinical roles. Decisions as to which competences are necessary for each role and also the extent of core medical training required will be determined by evolving regulations that are outside the function of this document. So such regulations, as well as prescribing future training requirements, will need to apply to those already in established roles with considerable or even full clinical independence. In the latter situation, where there is evidence of safe effective practice over a significant period, it may be decided that criteria should be established, if only to operate temporarily, to confirm acceptable standards of performance to commissioners of care. This would be decisions for commissioners of care and not the authors of this document.

The Department of Health, under the scrutiny of the GMC, has asked the British Institute of Musculoskeletal Medicine to carry out a pilot of credentialing practitioners’ performance in MSM. The impetus for the pilot is the anomalous situation that the community makes significant use of the services of MSM practitioners who have no recognised specialist who can oversee their work. One purpose of this document is for the assessments used in the credentialing pilot to be mapped to it.

GPs with Special Interest in most specialties come under the clinical supervision of a consultant in that specialty. In MSM clinics there is often no consultant available whose specialist competence extends to the range of work being done. An issue for future regulatory development may be whether a doctor licensed as a GP who can meet agreed competences from this document may work in MSM with full clinical independence.

There are common competences 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 Core Medical Training and then developed further. This document supports 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.
At present, 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. For pre-1998 practitioners of MSM the process of ‘credentialling’ may apply.

In the past, doctors providing specialist expertise in Musculoskeletal Medicine have been in disparate environments including rehabilitation medicine, rheumatology, orthopaedics, and primary care, and their training pathway has been obtained in a less than full time (LTFT) manner by attending appropriate teaching and practice environments. It is expected that competences will continue to be obtained in a variety of opportunities and time scales for the next few years.

2.4 Duration of Training
Although this document 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. Those who are training in MSM and who are already in a training post for an established specialty will spend a significant period in posts targeted to supervised acquisition of MSM competences. In MSM there is currently no established specialty training programme, so that the flexible LTFT pathway is most appropriate.

2.5 Less Than Full Time Training (LTFT)
Trainees who are unable to work full-time are entitled to opt for less than full time training programmes. EC Directive 2005/36/EC requires that:

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

3 Content of Learning

3.1 Programme Content and Objectives
The generic skills required for specialist practice in Musculoskeletal Medicine relate to 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. The learning content described below uses the following framework:

A general outline of the objectives of specialist medical training in Musculoskeletal Medicine.
The knowledge, skills and attitudes required needed for practice in Musculoskeletal Medicine, and their methods of assessment.
The generic standards outlined in ‘Good Medical Practice’ (GMC 2008) are identified in appropriate parts of the document.
Generic qualities of good practice for any doctor, and especially those undertaking a specialised practice, are outlined in the latter parts of the document, but are not significantly different from curricula for other specialist practice.
Appropriate to the clinical role undertaken elements from the document will be specified to enable trainees to be competent in the:

Establishment of a differential diagnosis for patients presenting with musculoskeletal pain or disability by appropriate use of history, clinical examination and investigation.
Use of investigations required for musculoskeletal disorders.
Development of holistic management plans for the 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 a 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 Musculoskeletal Medicine.
Management of time and other resources to the benefit of patients and colleagues.
Facilitation of effective learning by other healthcare 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 document defines which of the four domains of the Good Medical Practice Framework for Appraisal and Assessment is 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 musculoskeletal disorders and the basic scientific principles and evidence base underpinning the current practice of Musculoskeletal Medicine. This knowledge base will be applied to ensure safe and competent clinical practice.
Basic science essential to understanding of the musculoskeletal system (GMP Domain 1)
The doctor will know:
i. Structure and function of cartilage, synovium, joint capsule, menisci, ligaments and intervertebral discs; pathology and repair processes.

ii. Structure and function of muscle, tendon, enthesis; control of posture, proprioception and muscular activity; pathology and repair processes.

iii. Structure and function of bone, control of bone growth and mass and its disorders (osteoporosis, osteomalacia and Paget’s disease); pathology and repair processes.

iv. Structure and function of the spinal cord and nerves including the nerve roots, the dorsal horn, spinal pathways and the autonomic nervous system; response to injury of nerve roots and peripheral nerves and their repair processes; referred pain.

v. The neuromuscular functions of motor and proprioceptive control.

vi. The neurophysiology of acute and chronic pain, types of pain and their clinical manifestations.

vii. The biopsychosocial model and its relevance to spinal pain disorders.

viii. Musculoskeletal functional anatomy. Sufficient knowledge of spinal and regional disorders, diagnosis and management to work at an advanced level.

ix. Principles of diagnosis, history taking, physical examination (including segmental examination of spine), use of investigations and imaging.

x. Aetiology and pathology of musculoskeletal disorders, including osteoarthritis and degenerative changes in soft tissue, inflammatory arthritis, seronegative arthropathies, the common connective tissue diseases, and crystal arthropathy, their diagnosis and management, and these conditions’ potential impact (functional, physical and psychological) on the individual, the potential impact on carers and on society.

xi. Clinical methods to assess dysfunction of neuro-musculoskeletal (somatic) structures where this is not apparently an appropriate response, proportional to the severity of injury or one of the pathological processes in (x) above.

xii. The effects of pain and impairment on cognition, affect and behaviour and strategies to ameliorate their impact on occupation and relationships with family and society.

xiii. ‘Red flag’ conditions (serious pathology) and musculoskeletal emergencies to be able to take appropriate action in management and referral.

3.3.1 Investigations used in Musculoskeletal Medicine practice (GMP 1,2, 3)

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/report in the context of the given patient

Blood tests in routine use in non-specialist practice, both haematolological, biochemical, and immunological.
Laboratory tests in routine use in non-specialist practice, both microbiological, serological, histological and cytological.
Imaging including x-rays, isotope scans, bone density tests, ultrasound scans, CT scans and MRI scans
Neurophysiological tests including nerve conduction tests and electromyographic studies.

3.3.2 The role and activities of possible members of a multi-disciplinary team (GMP 1,2,3)
Musculoskeletal Medicine is often carried out as part of a team, including physiotherapists, occupational therapists, nurses, podiatrists, orthotists and clinical psychologists.

The doctor in specialist musculoskeletal medicine practice is able to:
- Describe these professionals’ roles
- Describe, in principle, their activities
- Identify how and which patients may benefit from their input
- Recognise effective ways of communication with them and between members of the team

3.3 Drug therapy underpinning Musculoskeletal Medicine practice (GMP 1,2)

The doctor will possess:
- Knowledge of the pharmacology of all drugs used in Musculoskeletal Medicine practice, including analgesics, non-steroidal anti-inflammatory drugs, corticosteroids, drugs used in treating patients with metabolic bone diseases, gout, and in the management of patients with chronic pain. In addition, an outline of the rationale and features of disease-modifying anti-rheumatic drugs and biological agents used for inflammatory arthritis.
  - the ability to identify and evaluate, information on new drugs
  - the ability to identify, evaluate and notify appropriate authorities of, potential adverse drug effects noticed within their clinical practice

3.3.3 Rehabilitation techniques in Musculoskeletal Medicine practice (GMP 1,2,3)

The doctor will possess knowledge of:
- The evidence base for efficacy of manual therapies
- The principles of manual therapies and schools of thought
- The relative importance of motor control, joint and muscle dysfunction
- Indications and contraindications for mobilisation and manipulation

3.3.4 Injection therapy used in Musculoskeletal Medicine practice (GMP 1,2)

The doctor will be able to:
- Describe the theory of musculoskeletal injection
- Describe the evidence base for the use of injections of corticosteroids and other agents, including the side effects and hazards of injection
- Describe the full range of joint and soft tissue injections commonly carried out in musculoskeletal medicine practice
- Describe the indications and contraindications for spinal injections
- Describe evidence for acupuncture and dry needling, and appropriate use of these techniques

3.3.5 Injection therapy used in Musculoskeletal Medicine practice (GMP 1,2)

The doctor will be able to:
- Describe the theory of musculoskeletal injection
- Describe the evidence base for the use of injections of corticosteroids and other agents, including the side effects and hazards of injection
- Describe the full range of joint and soft tissue injections commonly carried out in musculoskeletal medicine practice
- Describe the indications and contraindications for spinal injections
- Describe evidence for acupuncture and dry needling, and appropriate use of these techniques

3.3.6 Rehabilitation techniques in Musculoskeletal Medicine practice (GMP 1,2,3)
The doctor knows:
- The general principles of musculoskeletal rehabilitation and specific exercise programmes relevant to particular conditions
- The principles and practice of rehabilitation to counteract the psychological aspects of musculoskeletal disorders and pain
- The principles of returning individuals to work, including the place of vocational rehabilitation, and their importance to the individual, family and society

3.3.7 Orthopaedic surgery in the context of Musculoskeletal Medicine practice  GMP (1,2,3)

Musculoskeletal Medicine has a close interface with orthopaedic surgery: patients with the same conditions are often seen by practitioners from both specialties.
The doctor knows:
- The circumstances in which orthopaedic referral is appropriate
- The indications for, principles of and complications of, those orthopaedic procedures suitable for patients commonly presenting to a musculoskeletal specialist. These include joint replacements, arthrodeses, nerve decompressions, spinal decompression procedures, and arthroscopic procedures.
- Effective ways of communicating with orthopaedic surgeons.

3.3.8 Rheumatology and Pain Medicine in the context of Musculoskeletal Medicine practice (GMP 1,2,3)

The doctor knows:
- The circumstances in which referral to other specialists is appropriate
- The principles of the specialist help provided by other specialists
- The ways of communicating effectively with other specialists

3.3.9 Complementary therapy and unconventional treatment approaches     (GMP 1,2,3)

A significant proportion of patients with musculoskeletal diseases consult alternative practitioners, including chiropractors, osteopaths and homeopaths.
The doctor knows:
- In principle, the main activities of these treatment approaches
- How to evaluate the evidence base underlying these approaches
- In principle, the potential advantages and disadvantages of these approaches

Assessment of achievement of knowledge objectives:
Relevant knowledge is assessed by case-based discussion.
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.

“GMP” defines which of the four domains of the Good Medical Practice Framework for Appraisal and Assessment are addressed by each competency. Abbreviations used are: AA audit assessment; ACAT acute care assessment tool; CbD case-based discussion; CCF common competences framework of the Academy of Medical Royal Colleges; CMT core medical training; DOPS direct observation of procedural skills; GMP good medical practice; PS patient survey; TO teaching observation.

The overall aim is to develop the ability to perform a clinical assessment of patients with musculoskeletal 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

(i) History Taking & Clinical Examination - Overview

History:

<table>
<thead>
<tr>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be able to elicit and correctly interpret a history of:</td>
<td>• Fully address patients’ concerns, ideas and expectations</td>
<td>1,3,4</td>
<td>mini-CEX, PS</td>
</tr>
<tr>
<td>• The presenting symptoms of musculoskeletal disorder i.e. pain,</td>
<td>• Respect patient confidentiality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stiffness, weakness, loss of function</td>
<td>• Maintain cultural awareness and identity</td>
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</tr>
<tr>
<td>• The impact on the individual of the disorder</td>
<td>• Value patient comprehension</td>
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<td></td>
</tr>
<tr>
<td>• The psychosocial problems associated with musculoskeletal disorders</td>
<td>• Recognise importance of a collateral history in certain situations e.g. unreliable history</td>
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<tr>
<td>• Other general medical problems</td>
<td></td>
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<tr>
<td>• Identify and record risk factors for conditions relevant to mode</td>
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</tbody>
</table>
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

Examination:

<table>
<thead>
<tr>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Perform an examination relevant to the presentation and risk factors that is valid, targeted and time efficient</td>
<td>• Respect a patient’s dignity and cultural background and other beliefs</td>
<td>1,3,4</td>
<td>mini-CEX, MSF</td>
</tr>
<tr>
<td>• Perform a valid examination in more challenging situations (e.g. distracting environment)</td>
<td>• Recognise importance of patient consent in context of examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assess mood and cognitive function as appropriate and apply this to interpretation of history</td>
<td>• Demonstrate willingness and ability to teach junior and health worker colleagues sound examination technique</td>
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<tr>
<td>To carry out an examination recognising and assessing:</td>
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<td></td>
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<tr>
<td>• The musculoskeletal system and its variations with age</td>
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<tr>
<td>• The anatomical features of the spine, shoulder girdle, elbow, , hand/wrist, hip/pelvis, knee, ankle/foot ,</td>
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<td></td>
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<tr>
<td>• The normal range of movement</td>
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</tbody>
</table>
(active and passive) of these joints
• The actions of muscles and their tendons
• The clinical signs associated with dysfunction of the spine or limb joints
• Non-articular, systemic and other features of rheumatic disease
• General medical complications of musculoskeletal disease
• Diffuse or regional pain disorders or somatisation disorders

(ii) Musculoskeletal Medicine practice for Spinal & Regional Disorders: Identifying and Interpreting Abnormalities and undertaking Management. The doctor can demonstrate the Knowledge, Skills and Behaviours identified below in addition to the general ones above:

Patients presenting with:

(ii)a. All musculoskeletal conditions

<table>
<thead>
<tr>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• On the basis of relevant history and examination reaches an appropriate differential diagnosis</td>
<td>• Respects the patient</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td>• Chooses and interprets any appropriate investigations</td>
<td>• Values the need for a careful and accurate clinical assessment</td>
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<tr>
<td>• Makes an appropriate management plan</td>
<td>• Shows effective use of scarce, expensive or potentially harmful investigations</td>
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<tr>
<td>• Communicates the diagnosis, its implications and the treatment options to the patient and helps the patient to decide on a management</td>
<td>• Uses an evidence-based approach</td>
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<tr>
<td></td>
<td>• Respects the patient’s perspective and autonomy; appreciates the potential impact on the patient and the family</td>
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<tr>
<td></td>
<td>• Values the skills and knowledge of colleagues</td>
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<tr>
<td></td>
<td>• Maintains the patient’s wishes and needs as paramount, including for communication with relatives and others.</td>
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<tr>
<td></td>
<td>• Respects the need for effective communication with the primary care team</td>
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</tbody>
</table>
plan
- Refers to other members of the team or other specialists appropriately
- Makes appropriate arrangements for follow up if required
- Communicates appropriately with the team, with the general practitioner, the family and or carers
- Documents accurately in the patient record

- Respects the need for accurate record keeping
- Values optimal resource allocation

(ii)b. All spinal conditions

<table>
<thead>
<tr>
<th>Knowledge for MSM training and assessment</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The structure of the spine, and its muscle, fascia and ligamentous support.</td>
<td>• A history and physical examination, including assessment of posture, gait and movement patterns, and of segmental dysfunction to achieve an appropriate differential diagnosis</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td>• The structure of the spinal cord and nerves including the peripheral autonomic system.</td>
<td>• Makes appropriate use of investigations and imaging and interpretation of reports</td>
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<tr>
<td>• The physiological and biomechanical bases on which the axial skeleton functions.</td>
<td>• Recognition of adverse factors in cognition, affect, behaviour and interpersonal and societal maladaptation</td>
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<tr>
<td>• Awareness of neuromuscular functions of motor and proprioceptive control.</td>
<td>• Makes an assessment of regional and overall disability</td>
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<tr>
<td>• Neurophysiology of acute and chronic pain, types of pain, and their clinical manifestations.</td>
<td>• Makes appropriate use of exercise, therapies and/or drugs</td>
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<tr>
<td>• The clinical features of spinal pain and diseases of the spine.</td>
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<tr>
<td>• The biopsychosocial model and its relevance to spinal pain disorders.</td>
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<tr>
<td>• Management: evidence-based treatment</td>
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</table>
including recent evidence and current guidelines

- Communicates effectively securing concordance in treatment plans such as pain management techniques
- Makes appropriate referral for specialist care

(ii)c. Various spinal conditions

<table>
<thead>
<tr>
<th>Spinal Condition</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Red flag conditions</td>
<td>Clinical features of:</td>
<td>How to diagnose and arrange appropriate urgent referral</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD</td>
</tr>
<tr>
<td></td>
<td>- Infection of bone or disc space</td>
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<td></td>
<td>- Tumour - primary and secondary</td>
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<td></td>
<td>- Trauma</td>
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<td></td>
<td>- Cauda equina syndrome</td>
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<tr>
<td>Other important diagnoses</td>
<td>Clinical features of:</td>
<td>Appropriate investigation and referral (e.g. secondary or severe osteoporosis, spondylarthropathies)</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td></td>
<td>- Osteoporotic fracture</td>
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<tr>
<td></td>
<td>- Inflammatory spinal disorders</td>
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<tr>
<td>Lumbar and cervical disc</td>
<td>Clinical features</td>
<td>Assessment</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Natural History</td>
<td>Initial Investigation</td>
<td>Treatments Available</td>
<td>Relevant Codes</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Prolapse</td>
<td>Natural history</td>
<td>Initial investigation</td>
<td>Treatments available</td>
<td>CEX</td>
<td></td>
</tr>
<tr>
<td>Degenerative disc disease, osteoarthritis, spondylosis, non-specific back</td>
<td>Clinical features including significance of potential red flag symptoms (e.g. thoracic pain)</td>
<td>Managing the patient with reassurance and advice recognising fears, misconceptions, harmful health beliefs. Assessment and appropriate use and interpretation of imaging. Management strategies: appropriate use of medication, providing and/or referring for exercise and education. Use of counselling using basic cognitive behavioural approaches where suitable.</td>
<td>As in 3a</td>
<td>1,2,3,4 CBD, mini-CEX</td>
<td></td>
</tr>
<tr>
<td>syndrome including spinal somatic dysfunction, sacroiliac dysfunction and facet syndrome</td>
<td>Natural history, epidemiology; relevance or lack of relevance to imaging to clinical presentations Treatments available</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Spondylolysis and Spondylolisthesis</td>
<td>Types, causes, and relevance at different ages The significance in relation to sport participation Understanding of fears, expectations, role of parents and sports coaching</td>
<td>As in 3a</td>
<td>1,2,3,4 CBD</td>
<td></td>
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</tbody>
</table>
(ii)d. All limb conditions

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional anatomy including joints, ligaments, muscles, nerve supply</td>
<td>Use of a problem-oriented approach in history in examination</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td>The range of conditions that can give rise to limb problems at different ages</td>
<td>Use of investigations where suitable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The natural history and epidemiology of conditions</td>
<td>• Radiology: use as per Royal College of Radiologists guidelines, and ability to interpret reports for x-rays, ultrasound, CT, MRI and bone scans</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Red flags (e.g. of malignancy, infection, trauma, and inflammatory disease)</td>
<td>• Blood tests</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>The presenting features of inflammatory arthritis</td>
<td>Early recognition of inflammatory arthritis and referral for specialist care</td>
<td></td>
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</tr>
<tr>
<td>Impact of conditions of individuals’ lives and occupations</td>
<td>Injection techniques</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The role of allied health professionals</td>
<td>Appropriate referral for further therapy or investigation</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Risk factors for disorders, e.g. genetic, occupational, hypermobility</td>
<td>How to access other services, including orthotics, aids, occupational health services and social services</td>
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<td></td>
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</tr>
<tr>
<td>Management options, including non-drug treatment including exercises, drug therapy, injections, manual therapies, complementary therapies and their current evidence base. Knowledge of other resources such as patients’ organisations and charities such as Arthritis Care</td>
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</table>

(ii)e. Upper limb conditions

<table>
<thead>
<tr>
<th>Upper limb area</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shoulder</td>
<td>Clinical features of articular and periarticular problems</td>
<td>Ability to make a differential diagnosis</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td></td>
<td>Red flags, e.g. referred pain, bony pain, septic arthritis, polymyalgia,</td>
<td>Assess function and disability</td>
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<tr>
<td></td>
<td></td>
<td>Injection skills, e.g. to acromioclavicular joint, subacromial space, glenohumeral joint. Ability to explain and educate regarding self-help</td>
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</tbody>
</table>


<table>
<thead>
<tr>
<th>Location</th>
<th>Indications and contraindications for injections</th>
<th>Ability to make a differential diagnosis</th>
<th>As in</th>
<th>1,2,3,4</th>
<th>CBD, mini-CEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elbow &amp; Forearm</td>
<td>Recognition of capsular and periarticular soft tissue problems Functional anatomy and pathophysiology, including work-related upper limb disorder and hypermobility Function of orthotics, e.g. epicondylitis splint</td>
<td>Injection of medial and lateral elbow epicondyles Aspiration of olecranon bursa and elbow joint Recognition of precipitating causes and advice on adjustment of activity Ergonomic advice</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Wrist</td>
<td>Carpal tunnel: clinical features, investigation, awareness of associated conditions Appropriate use of investigations including radiology, ultrasound and nerve conduction tests Awareness of notifiable work related conditions</td>
<td>Ability to make a differential diagnosis Injection of the carpal tunnel, wrist joint and de Quervain’s tendon sheath</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td>Hand</td>
<td>Pattern of joint involvement in inflammatory conditions and osteoarthritis Recognition of evidence of neurological deficit, e.g. thenar wasting and sensory change Awareness of deformities such as Dupuytren’s contracture</td>
<td>Ability to make a differential diagnosis Early recognition and referral for inflammatory arthritis Injection of trigger finger, trigger thumb, CMC joint and flexor tenosynovitis Aspirate ganglions</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
</tbody>
</table>
and delayed effects of trauma

(ii) Lower limb conditions

<table>
<thead>
<tr>
<th>Lower limb area</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip</td>
<td>Functional anatomy of the hip area including the musculoskeletal components in the groin and pelvic girdle. The range of conditions that can give rise to pain in the hip at different ages. The clinical features and natural history of: Osteoarthritis of the hip joint. Referred pain from the back or to the knee. Soft tissue disorders, e.g. trochanteric pain. Biomechanical hip pain, e.g. from leg length inequality or foot disorders. Polymyalgia, septic arthritis, inflammatory arthritis. Myofascial and soft tissue disorders and hypermobility.</td>
<td>Appropriate history and examination to allow differentiation between true hip pain and referred pain from the back and referred pain to the knee. To identify local myofascial and soft tissue disorders and periarticular conditions such as labral pathology. Appropriate referral for surgery and ability to institute and/or coordinate non-surgical management for hip osteoarthritis. Injection for soft tissue conditions such as trochanteric pain.</td>
<td>As in 3a</td>
<td>1,2,3,4</td>
<td>CBD, mini-CEX</td>
</tr>
<tr>
<td>Knee</td>
<td>The anatomy of the knee.</td>
<td>Use of analgesia, appropriate exercise therapy.</td>
<td>As in 1,2,3,4</td>
<td>CBD, mini-CEX</td>
<td></td>
</tr>
<tr>
<td>Ankle &amp; Foot</td>
<td>Joint and adjacent areas of the lower leg</td>
<td>Injections to the knee joint, anserine bursa, and collateral ligaments</td>
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<tr>
<td></td>
<td>The range of conditions that can give rise to pain at the knee</td>
<td>To coordinate the non-surgical management of knee osteoarthritis</td>
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<tr>
<td></td>
<td>The clinical features and course of:</td>
<td>Appropriate referral for further investigation, physiotherapy or surgery</td>
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<tr>
<td></td>
<td>Pain from other sources, e.g. hip and spine</td>
<td>Early recognition and referral of inflammatory arthritis</td>
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<tr>
<td></td>
<td>Anterior knee pain and biomechanical problems of the knee</td>
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<td>Osteoarthritis of the knee</td>
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<td>Inflammatory and crystal arthropathies, septic arthritis</td>
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<td></td>
<td>Internal derangements</td>
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<td></td>
<td>Bursae</td>
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<td>Hypermobility</td>
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<tr>
<td></td>
<td>Soft tissue strains and sprains, tendinopathy</td>
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<tr>
<td>Ankle &amp; Foot</td>
<td>Appropriate examination skills leading to differential diagnosis and assessment of function.</td>
<td>As in 3a</td>
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<tr>
<td></td>
<td>Recognition of red flags for onward referral.</td>
<td>1,2,3,4 CBD, mini-CEX</td>
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<td></td>
<td>Early referral of possible inflammatory arthritis</td>
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<td></td>
<td>Appropriate use of simple / shock absorbing appliances and advice on suitable footwear</td>
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<td></td>
<td>Use of further investigations</td>
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<td></td>
<td>Appropriate referral to podiatrist, orthotist, orthopaedics, rheumatology</td>
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<td></td>
<td>Injection for plantar fasciitis, intermetatarsal neuroma and MCP joint of the great toe</td>
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<tr>
<td>Tendinopathy/myopathy</td>
<td>Plantar fasciitis</td>
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<tr>
<td>Tarsal Tunnel Syndrome</td>
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<td>Hallux valgus/rigidus</td>
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<td>Intermetatarsal</td>
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<td>neuroma/bursa</td>
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<td>Tibialis posterior tendon</td>
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<tr>
<td>dysfunction.</td>
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<tr>
<td>Septic, inflammatory</td>
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<td>and crystal arthritis</td>
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</table>

(ii)g. Chronic Widespread Musculoskeletal Pain & Fibromyalgia Syndrome

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
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<tbody>
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</tbody>
</table>
Understands bio-psychosocial aspects of pain perception. 
Pain pathways
Understands the ACR 1990 criteria for the diagnosis of 
fibromyalgia syndrome and its limitations
WHO analgesic ladder in relation to non-cancer pain and 
pharmacology of drugs commonly used in pain relief
Understands the chronic pain/deconditioning cycle
Knows the evidence for treatment interventions, 
antidepressants, exercise programmes, cognitive 
behavioural therapy
Local knowledge of voluntary sector resources, self-
management programmes and health service professional 
networks for referral

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Higher level communication skills</td>
<td></td>
</tr>
<tr>
<td>Educational and motivational skills for patients and Primary Health Care Teams</td>
<td></td>
</tr>
<tr>
<td>Diagnostic skills to recognise this syndrome as distinct from arthritis or connective tissue disorder (or concomitantly)</td>
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<tr>
<td>Diagnostic skills to recognise specific cognitive factors and peripheral pain generators which may drive the condition</td>
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<tr>
<td>Utilises the team approach and patient self-management skills to best effect</td>
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</tbody>
</table>

As in 3a
1,2,3,4
CBD, mini-CEX

(ii)h. Certain Rheumatic diseases
Crystal arthropathy | The clinical features and course of gout and pseudogout
The causative factors and associated morbidity of gout and pseudogout

| Recognise characteristics of crystal arthropathy
Ability to diagnose
Interpret blood tests and x rays (inc. chondrocalcinosis)
Treatment of acute phase and prevention
Aspirate and inject large joints (issues re analysis of aspirate)
Ability to educate patients appropriately

| As in 3a | 1,2,3,4 | CBD, mini-CEX

Polymyalgia rheumatica | Recognise characteristics of typical and atypical presentations and differential diagnoses (e.g. myeloma, polymyositis, TA, early rheumatoid)
Awareness of need for appropriate steroid therapy
Awareness of adverse effects of therapy
Awareness of current best practice

| Assessment using history and examination
Education of patient re long term steroid use
Appropriate use of bone protection and drug monitoring
Appropriate referral to secondary care

| As in 3a | 1,2,3,4 | CBD

(iii). Practical Procedures:

(iii)a. Injection procedures
<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The evidence base for injections of drugs in musculoskeletal practice</td>
<td>Performance of joint and soft tissue injections carried out in musculoskeletal practice</td>
<td>Minimises the use of injections compatible with best care</td>
<td>1,3</td>
<td>CBD, mini-CEX, DOPS</td>
</tr>
<tr>
<td>The evidence base for acupuncture and dry-needling</td>
<td>Determines the possible benefit of injection in the individual’s case</td>
<td>Appreciates the patient’s wishes if disinclined for injection therapy</td>
<td></td>
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</tr>
<tr>
<td>Indications and contra-indications for joint and soft tissue injections carried out in musculoskeletal practice</td>
<td>Anticipates the potential side effects of any proposed injection</td>
<td>Takes care to allay the patient’s unreasonable fears and beliefs concerning injections</td>
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<tr>
<td>Indications and contra-indications of spinal injections carried out in musculoskeletal practice</td>
<td>Informs the patient impartially potential benefits and disadvantages of the procedure</td>
<td>Takes care to ensure the patient's comfort during the injection and to minimise the discomfort of the injection itself</td>
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</tr>
<tr>
<td>Indications, contraindications, side effects, drug interactions and dosage of commonly used drugs for musculoskeletal injection</td>
<td>Obtains the patient’s consent for the procedure</td>
<td>Remains open to advice from other healthcare professionals about injections and medications used</td>
<td></td>
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<tr>
<td>Define effects of age, body size, organ dysfunction and concurrent illness on drug effects, metabolism and suitable dosage</td>
<td>Carries out the procedure with techniques to ensure accuracy and minimum possibility of infection</td>
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<tr>
<td>Understand the roles of regulatory agencies involved in drug use, monitoring and licensing</td>
<td>Advises patients and carers (where relevant) about important after effects of injection including interactions, and the possibility of infection</td>
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<tr>
<td>Understand the importance of non-medication based therapeutic interventions including the legitimate role of placebos</td>
<td>Makes appropriate drug dose adjustments</td>
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<tr>
<td>The anatomical hazards of injection at each injection site</td>
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</table>
The side effects of musculoskeletal injections including infection, bleeding and tendon integrity

(iii)b. Manipulation and other manual therapies

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<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
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<th>Assessment of Competence</th>
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<tr>
<td>The evidence base for efficacy of manual therapies</td>
<td>Assessment of suitability of manual treatments in individual cases</td>
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<tr>
<td>The principles of manual therapies and schools of thought</td>
<td>Anticipates any potential side effects of a proposed procedure</td>
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<tr>
<td>The relative importance of motor control, joint and muscle dysfunction</td>
<td>Informs the patient impartially on the potential benefits and disadvantages of the procedure</td>
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<tr>
<td>The anatomical features of manipulation sites</td>
<td>To advise patients on their suitability for manual therapy, whether carried out by the doctor or by another health professional</td>
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<tr>
<td>The biomechanics of the spine and peripheral articulations</td>
<td>If the doctor personally carries out the manual treatment:</td>
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<tr>
<td>The hazards of manual techniques, whether anatomical, neurological, vascular or biomechanical</td>
<td>• Obtains the patient’s consent for the procedure</td>
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<tr>
<td>Indications and contraindications for mobilisation and manipulation techniques</td>
<td>• Carries out the procedure with appropriate technique</td>
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<tr>
<td></td>
<td>• Advises the patient and carer (where relevant) about important possible after effects</td>
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<td></td>
<td>Appreciates the patient’s wishes if disinclined for manipulation or other manual therapy</td>
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<td></td>
<td>Takes care to allay the patient’s unreasonable fears and beliefs concerning manual treatments</td>
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<td></td>
<td>Takes the patient’s wishes into account when referring for manual treatment</td>
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<td></td>
<td>If carrying out the procedure personally:</td>
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<tr>
<td></td>
<td>• Minimises the use of manipulation, mobilisation and other manual therapy compatible with best care</td>
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<td></td>
<td>• Takes care to ensure the patient’s comfort during the procedure and to</td>
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</table>

1,3 for MSM training and assessment

CBD, mini-CEX, DOPS
Remains open to advice from other healthcare professionals about the use and best techniques of manipulation and other manual therapy to minimise the discomfort of the procedure itself.

(iii)c. Therapeutics and Safe Prescribing:

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
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<th>Assessment of Competence</th>
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</table>
Recall range of adverse drug reactions to commonly used drugs, including complementary medicines

Understand the roles of regulatory agencies involved in drug use, monitoring and licensing

• Recall drugs requiring monitoring and interpret results
• Outline tools to promote patient safety in 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)
• Employ appropriate methods to improve patient concordance with medication
• Remain up to date with therapeutic alerts, and respond appropriately

• 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
• Provide effective explanation for the role of medicines

1,3,4  

CbD, mini-CEX, MSF

(iii)d. Further generic items relating to Integrated Clinical Practice and patient safety (as detailed in the Common Competences Framework for Doctors, Academy of Medical Royal Colleges, 2009 and in Good Medical Practice, General Medical Council 2006)
<table>
<thead>
<tr>
<th>Item</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GM</th>
<th>Assessment of Competence</th>
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</thead>
</table>
| Information Management   | • 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 | • 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       |
| Time Management | • 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 | • Recognise when you or others are falling behind and take steps to rectify the situation | 1,3,4  
CbD, mini-CEX, MSF |
|------------------|---------------------------------------------------------------|---------------------------------------------------------------|------------------|
| Decision Making and Clinical Reasoning | • List the drawbacks of commonly used guidelines  
• Recognise limitations of clinical outcome measures when used in clinical practice  
• Contribute to the construction, review and 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  
• Define the relevance of an estimated risk of a future event to an individual patient  
• Use risk calculators appropriately | • 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 | 1,3,4  
CbD, mini-CEX, MSF |
<table>
<thead>
<tr>
<th>Lifelong Learning</th>
<th>Knowledge: Define the principles of Continuing Professional Development</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Apply quantitative data of risks and benefits of therapeutic intervention to an individual patient</td>
<td>• Be willing to facilitate patient choice</td>
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<tr>
<td>• Search and comprehend medical literature to guide reasoning</td>
<td>• Show willingness to search for evidence to support clinical decision making</td>
</tr>
<tr>
<td>• Demonstrate ability to identify one’s own biases and inconsistencies in clinical reasoning</td>
<td>• Demonstrate ability to identify one’s own biases and inconsistencies in clinical reasoning</td>
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</table>

| Be: self-motivated eager to learn |
| Show: Willingness to learn from colleagues, and willingness to accept criticism. Strive to enhance professional competence with active involvement in CPD activities |
| Recognise the 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. These generic qualities of practice are no less relevant to doctors undertaking specialist practice are described in detail in Common Competences Framework for Doctors, Academy of Medical Royal Colleges, 2009 and in Good Medical Practice, General Medical Council 2006
<table>
<thead>
<tr>
<th>The Patient as the Central Focus of Care</th>
<th>Prioritisation of Patient Safety in Clinical Practice</th>
</tr>
</thead>
</table>
| **•** 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 | **•** 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  
  • Sensitive 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 | **•** Support patient self-management  
  • Recognise the duty of the medical professional to act as patient advocate  
  • 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 | 1,3,4 | CbD, mini-CEX, MSF, PS |
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

| Principles of Quality and Safety Improvement | • 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 initiatives including National Patient Safety Agency | • 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 |
| Infection Control | • 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 principal 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 | • Encourage other staff to observe infection control principles | 1,3,4 | CbD, mini-CEX, MSF |
| Team working | • 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  
    • Participate in interdisciplinary team meetings  
    • Provide appropriate supervision to less experienced colleagues | Establish effective communication with colleagues and members of the team  
  • Delegate appropriately to colleagues  
  • Recognise when input from another specialty is required  
  • Be able to work effectively with GPs, other doctors and health professionals | • 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 | 1,3,4 | CbD, mini-CEX, MSF |

4.3 Professional Behaviour
<table>
<thead>
<tr>
<th>Item</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
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</thead>
<tbody>
<tr>
<td>(i) Continuity of care</td>
<td>Understand the relevance of continuity of care.</td>
<td>Ensure satisfactory completion of reasonable tasks at the end of session with appropriate handover. Documentation of/for handover. Make adequate arrangements to cover leave.</td>
<td>Recognise the importance of • punctuality • attention to detail.</td>
<td>2,3</td>
<td>Cbd, mini-CEX, MSF</td>
</tr>
<tr>
<td>(ii) Doctor-patient relationship</td>
<td>Define the concept of modern medical professionalism Understand all aspects of a professional relationship such as the need to: Deal with inappropriate patient and family behaviour, e.g. aggression, violence, racism and sexual harassment Respect the rights of children, elderly, people with disabilities 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 Establish the boundaries surrounding the consultation</td>
<td>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, etc.</td>
<td>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.</td>
<td>3,4</td>
<td>mini-CEX, MSF, PS</td>
</tr>
<tr>
<td>(iii) Recognition of own limitations</td>
<td>Know the extent of one’s own limitations and know when to ask for advice.</td>
<td>Reflection on individual practice</td>
<td>Be willing to consult and to admit mistakes.</td>
<td>1</td>
<td>CbD, mini-CEX</td>
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<tr>
<td>(iv) Stress</td>
<td>Know the effects of stress Have knowledge of support facilities for doctors.</td>
<td>Develop appropriate coping mechanisms for stress and ability to seek help if appropriate.</td>
<td>Recognise the manifestations of stress on self &amp; others.</td>
<td>2</td>
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</tbody>
</table>
### 4.4 Medical Ethics and Legal Issues

<table>
<thead>
<tr>
<th>(v) Relevance of outside bodies</th>
<th>Have an understanding of the relevance to professional life of medical bodies and patient representation groups</th>
<th>Recognise situations when appropriate to involve these bodies/individuals.</th>
<th>Be open to constructive criticism. Accept professional regulation. Respect the views of patient representation groups.</th>
<th>2</th>
<th>CbD, mini-CEX, SCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(vi) Personal health</td>
<td>Know about occupational health services. Know about one's responsibilities to the public. Know not to treat oneself or one's family.</td>
<td>Recognise when personal health takes priority over work pressures and to be able to take the necessary time off.</td>
<td>Recognise personal health as an important issue.</td>
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<tr>
<td>Item</td>
<td>Knowledge</td>
<td>Skills</td>
<td>Behaviours</td>
<td>GMP</td>
<td>Assessment of Competence</td>
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</table>
| (i) Informed | Recall the principles of informed consent  
Outline the guidance given by the GMC on consent  
Outline the principles of who is able to obtain consent  
Outline the situation of providing care without consent in an emergency  
Recall the concept of capacity including where capacity is fluctuating or inadequate and the role of the courts  
Outline the principles of advance directives  
List factors to be considered when acting in a patient’s ‘best interests’  
List situation in which consent for treatment is not needed in common law | Appropriate use of written material  
Seek a formal assessment of decision making capacity when appropriate  
Present all information to patients in a format they understand, allowing time for reflection on the decision to give consent  
Provide a balanced view of care options  
Obtain a second opinion on treatment options where appropriate  
Inform a patient and seek alternative care where personal, moral or religious belief prevents a usual professional action | Respect a patient’s rights of autonomy, even in situations where their decision might put themselves at risk of harm  
Avoid exceeding the scope of authority given by a patient  
Avoid withholding information relevant to proposed care or treatment in a competent adult  
Respect a patient’s withdrawal of consent | 3,4 | mini-CEX, MSF, PS |
| (ii) Confidentiality | Outline and follow the guidance given by the GMC on confidentiality  
| Define the role of the Caldicott Guardian within an institution, and outline the process of attaining Caldicott approval for audit or research  
| Outline the procedures for seeking a patient’s consent for disclosure of identifiable information  
| Recall the obligations for confidentiality following a patient’s death  
| Be aware of relevant strategies to ensure confidentiality.  
| Be aware of situations when confidentiality might be broken | Use and share all information appropriately  
| Avoid discussing one patient in front of another  
| Be prepared to seek patients’ wishes before disclosing information | Respect the right to confidentiality  
| Respect patients’ requests for information not to be shared, unless this puts the patients or others at risk of harm  
| Show willingness to share information about their care with patients, unless they have expressed a wish not to receive such information | Show willingness to seek advance directives  
| Show willingness to obtain a second opinion, senior opinion and legal advice in difficult situations of consent or capacity | 4 | Cbd, MS, PS |
| (III) Legal issues relating to criminal matters | Know where to seek advice relating to responsibilities in serious criminal matters | Be able to obtain suitable evidence or know whom to consult if in doubt | Recognise the importance of legal issues in medical practice | 1 | CbD |
| (iv) Ethical issues | Demonstrate a knowledge of the principles of medical ethics  
Be aware of professional guidelines published by the GMC and other bodies | Recognise the factors influencing ethical decision making; religion, moral beliefs, cultural practices  
Be able to communicate ethical issues with patients, colleagues and the public | Encourage ethical reflection in others  
Show willingness to seek advice in ethical dilemmas  
Respect the opinion of patients and colleagues  
Be willing to refer on to a colleague if conflict exists between personal values and those of the patient | 1,4 | MSF, PS |
<table>
<thead>
<tr>
<th>(v) Do not resuscitate</th>
<th>Define the standards of practice defined by GMC</th>
<th>Counsel patients, family, carers and advocates tactfully when making decisions</th>
<th>Show willingness to seek the opinion of others</th>
<th>1,4</th>
<th>CdD, MSF</th>
</tr>
</thead>
<tbody>
<tr>
<td>(vi) Legal framework for practice</td>
<td>Outline the medico-legal principles relating to: child protection, mental health legislation, death certification, advance directives, surrogate decision making, organ donation, communicable disease notification, medical risk in driving, Data Protection and Freedom of Information Acts, provision of continuing care by local authorities, and procedure to be followed when abuse is suspected.</td>
<td>Prepare a medico-legal statement for submission to the Coroner’s Court and other legal proceedings Incorporate legal principles into day to day practice, and keep accurate documentation</td>
<td>Show willingness to seek advice from legal bodies and the GMC Promote reflection on legal issues by members of the team</td>
<td>1,4</td>
<td>CdD, MSF</td>
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4.5 Patient Education and Disease Prevention
<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
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</thead>
<tbody>
<tr>
<td>Course of each condition</td>
<td>Give clear information to patients, including written information</td>
<td>Encourage patients to access further information and support groups</td>
<td>1,4</td>
<td>mii-CEX, PS</td>
</tr>
<tr>
<td>Risk factors for conditions</td>
<td>Encourage questions</td>
<td>Show willingness to access skills to develop the patient’s confidence and competence in self-care</td>
<td></td>
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<tr>
<td>Understanding of primary and secondary prevention</td>
<td>Discuss management plans and follow up</td>
<td></td>
<td></td>
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<tr>
<td>Understanding of screening programmes</td>
<td>Advise on lifestyle</td>
<td></td>
<td></td>
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<tr>
<td>The concept of self-care</td>
<td>Assess risk factors for the individual</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Develop a management plan to maximise self-care</td>
<td></td>
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<td></td>
<td>Encourage patients to use support networks</td>
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4.6 Relationships with Patients and Communication
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<tr>
<th>Item</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Within the consultation</td>
<td>A comprehensive understanding of: interview structure, effective listening, need to clarify information given by patient, use of comprehensible language, use of open and closed questions, gauging patients’ ideas concerns and comprehension, use of written materials and interpreters and acting in a professional manner</td>
<td>Demonstrate good communication skills to others in the team Manage follow-up effectively Accurately record details of discussions with the patient Identify and manage communication barriers</td>
<td>Show willingness to provide patients with a second opinion, to identify other sources of information, ensure the patient is well informed, and to be aware of significant others</td>
<td>3</td>
<td>Mini-CEX, MSF, PS</td>
</tr>
<tr>
<td>(ii) Breaking Bad News</td>
<td>A thorough understanding of: interview structure, normal bereavement process, cultural differences, selection of appropriate setting, encouragement of questioning, avoidance of undue optimism or pessimism, and acting with honesty and empathy</td>
<td>Demonstrate to others good practice Counsel families on difficult decisions</td>
<td>Take leadership in breaking bad news Respect the different ways people react to bad news</td>
<td>3</td>
<td>Mini-CEX, MSF, PS</td>
</tr>
<tr>
<td>(iii) Complaints and Medical Error</td>
<td>Develop comprehensive awareness of: local complaints procedure, factors likely to lead to complaints, need to adopt behaviour to prevent complaints, ability to deal with dissatisfied patients or relatives, need to recognise when something has gone wrong, and act with honesty and sensitivity in a non-confrontational manner Outline principles of effective apology Identify sources of support when a complaint is made</td>
<td>Contribute to processes whereby complaints are review and learned from Explain to the patient the events leading up to a medical error Deliver an appropriate apology Distinguish between system and individual errors</td>
<td>Take leadership over complaint issues Recognise the impact of complaints and medical errors on staff, patients, and NHS Contribute to a transparent culture around complaints and errors Recognise the rights of patients, family members and carers to make a complaint</td>
<td>3,4</td>
<td>Cbd,Mini-CEX, MSF, PS</td>
</tr>
</tbody>
</table>
### 4.7 Clinical Governance

<table>
<thead>
<tr>
<th>Item</th>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The organisational framework for Clinical Governance at local, health authority and national levels</strong></td>
<td>Define important aspects of clinical governance. Explain medical and clinical audit, research and development, integrated care pathways, evidence-based practice, clinical effectiveness and clinical risk systems. Define procedures and effective action when things go wrong. Complaints procedures.</td>
<td>Ability to undertake medical and clinical audit, and participate in audit cycles. Critically appraise medical data research. Practice evidence-based medicine and use best practice. Be able to deal with complaints and learn from them. Report and investigate critical incidents and adverse events and modify practice. Take action if you or a colleague may not be fit to practise.</td>
<td>Care of your patient is your first concern. Learn from mistakes, errors and complaints. Recognise the importance of team work, and share best practice.</td>
<td>1,2,4</td>
<td>Evidence of audit, CbD</td>
</tr>
<tr>
<td>(ii) Risk Management</td>
<td>Knowledge of Health &amp; Safety policy e.g. needle stick injuries. Know complications and side effects of therapies</td>
<td>Discuss risks with patients Balance risks and benefits with patients</td>
<td>Willingness to admit error to patients, relatives and colleagues</td>
<td>1,2,3</td>
<td>CbD, PS</td>
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<tr>
<td>(iii) Evidence</td>
<td>Principles of evidence-based medicine</td>
<td>Able to critically appraise evidence, use databases, libraries and the internet Ability to discuss relevance of evidence with patients</td>
<td>Use evidence to support patient care</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>(iv) Audit</td>
<td>The role of audit in patient care and management The steps involved in the audit cycle</td>
<td>Design and carry out audit project including choice of appropriate standard, outcome measures and analysis of results Complete the audit cycle to demonstrate whether change in practice has occurred Support audit in multi-disciplinary team</td>
<td>Consider the relevance of audit to patient care and clinical governance</td>
<td>1,2,4</td>
<td>Audit assessment</td>
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</tr>
<tr>
<td>Guidelines</td>
<td>Advantages and disadvantages of guidelines Methods of determining best practice</td>
<td>Use of guidelines Evaluation of guidelines</td>
<td>Show regard for individual patient needs when using guidelines Willingness to use guidelines</td>
<td></td>
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</table>

4.8 Structure of the NHS and Principles of Management
<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Skills</th>
<th>Behaviours</th>
<th>GMP</th>
<th>Assessment of Competence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The structure of the NHS Local trusts’ structure and executives and directors Role of GMC, Royal Colleges, specialist societies and postgraduate deaneries Guidance on management from GMC Principles of clinical coding, European Working Time Directive, service frameworks, regulatory agencies, finance and budgeting, resource allocation and role of independent healthcare providers</td>
<td>Management of skills and people Develop a business plan Employ new technologies including information technology</td>
<td>An understanding of the importance of a health service to the population A willingness to assume managerial responsibilities The importance of allocation of health resources Willingness to improve managerial skills</td>
<td>1,2</td>
<td>MSF</td>
</tr>
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5 Teaching and Learning

5.1 Training in Musculoskeletal Medicine

The core learning method for training in Musculoskeletal Medicine is work-based experiential learning supported by independent self-directed learning and by education programmes run by a number of different providers. Current providers include the British Institute of Musculoskeletal Medicine with a modular course approved by the Royal College of General Practitioners and accredited by the Royal colleges (External Approved List), the London College of Osteopathic Medicine, and the Society of Orthopaedic Medicine with courses/ diplomas/ MSc in association with Middlesex University. Key to the success of the work-based learning will be appropriate clinical and educational supervision. This will be overseen by 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 their appraisals. The formal education programme will generally be away from the clinical site. It will allow the opportunity for collaborative learning between trainees and trainers. 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 educational activities, such as certain specialist meetings (e.g., the British Institute of Musculoskeletal Medicine, the Society of Orthopaedic Medicine and the Primary Care Rheumatology Society) 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.

5.2 Teaching and Learning Methods

The curriculum will be delivered through a variety of learning experiences. Trainees will learn clinical skills appropriate to their level of training and to their attachments. 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 today?) 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 Musculoskeletal Medicine. The bulk of learning occurs as a result of clinical experience (Experiential learning) and self-directed study. The degree of self-directed 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 provides a learning opportunity, which will be enhanced by following the patient through the course of their condition: 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.

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 mentor.

6. There are many situations where clinical problems are discussed with clinicians in other disciplines, such as radiology, and pathology. 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.

3. Small group sessions of data interpretation, particularly covering problem areas identified by trainees.

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 patients with mentor.

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
2. Educational courses such as those run by the Association for Medical Osteopathy, British Institute of Musculoskeletal Medicine, the British Society for Rehabilitation Medicine (BSRM), the International Academy of Manual and Musculoskeletal Medicine, the Primary Care Rheumatology Society and the Society of Orthopaedic Medicine.

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 doctor.
2. Presenting cases at 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 an opportunity to develop critical thinking and the ability to review medical literature. This is a desirable 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 Musculoskeletal Medicine 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.

5.3 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.

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 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;
- 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:

Examinations and Certificates
- The Diploma of Musculoskeletal Medicine (DMSMed)
- The Diploma of Orthopaedic Medicine (DOM)
- MSc in Orthopaedic Medicine (MScOM)
- Membership of the London College of Osteopathic Medicine

The DMSMed is administered by the British Institute of Musculoskeletal Medicine, the DOM by the Society of Orthopaedic Medicine, and the MScOM by Middlesex University.
The aim of these examinations is to assess a trainee’s knowledge and understanding of the clinical sciences relevant to Musculoskeletal Medicine, and to test knowledge, skills and attitudes in the management of disorders to a level appropriate for unsupervised practice in Musculoskeletal Medicine.

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 on the JRCPTB website www.jrcptb.org.uk. Workplace-based assessments should be recorded in the trainee’s Portfolio. 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
The trainee’s progress will be reviewed at intervals in the training period. No formal system is yet in place but it is envisaged that a review similar to the Annual Review of Competence Progression (ARCP) by established specialties. 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).

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

Appeals. One of the functions of a faculty of Musculoskeletal Medicine would be to undertake or develop procedures for complaints and appeals.

7 Supervision and Feedback
Those trainees acquiring these competencies as part of training in a recognised specialty will at all times have a named Educational and Clinical 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, and other meetings and discussions with supervisors and colleagues.

Clinical supervision in Musculoskeletal Medicine 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 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 Musculoskeletal Medicine team and can address any identified concerns about the performance of the trainee or identified issues concerning patient or doctor safety.

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. 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.

Musculoskeletal Medicine has multi-disciplinary input and there will be opportunities for constructive feedback in both formal and informal settings from supervising doctors, and other 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 Portfolio.

8 Managing Curriculum Implementation
It is envisaged that implementation of the curriculum will be overseen by the proposed faculty of Musculoskeletal Medicine, which will develop a quality management system to ensure satisfactory training.

The educational supervisors and trainers can access the up-to-date curriculum from the faculty’s 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
If enrolling for training in Musculoskeletal Medicine within an established specialty, the doctor will come under the regulations of that specialty. They will start a Portfolio for Musculoskeletal Medicine. This Portfolio allows evidence to be built up to inform decisions on a trainee’s progress and provides tools to support trainees’ education and development. For those acquiring MSM competence outside a recognised specialty, such portfolio evidence will be crucial to demonstrating training to any accreditation process coming into force at a later date.

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

Any training supervisor's main responsibilities are to use Portfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee’s record of progress with reference to the Competencies document.

A ‘faculty of Musculoskeletal Medicine’ could use the Portfolio to monitor the progress of trainees.

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

Evaluation will be the responsibility of the faculty.

Interaction with the NHS will be particularly important to understand the performance of doctors using specialist skills in Musculoskeletal Medicine within the NHS and feedback will be required as to the continuing needs for that specialty as defined by the curriculum.

Trainee contribution to curriculum review will be facilitated through the involvement of trainees in local faculties of education and through informal feedback during
The faculty should 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 curriculum. The curriculum will indicate the last date of formal review monitoring and document revision.

10  Equality and Diversity
The requirements of equality and diversity legislation will be observed, 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 faculty 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 methods such as:
- monitoring of recruitment processes;
- ensuring that faculty representatives and educational supervisors have attended appropriate training sessions and diversity training (at least as an e-learning module)
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature.
- 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.

References
Standards for curricula and assessment systems. General Medical Council, April 2010
Development of a competency framework for general practitioners with a special interest in musculoskeletal/rheumatology practice