JRCPTB

Joint Royal Colleges of Physicians Training Board

Rehabilitation Medicine Training Curriculum

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

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1. Introduction

Training in Rehabilitation Medicine will produce doctors with the capabilities required to acquire a certificate of completion of training (CCT) in Rehabilitation Medicine in order to work as independent practitioners in this specialty. This curriculum defines the purpose, content of learning, process of training and the programme of assessment for Rehabilitation Medicine training.

2. Purpose

2.1 Purpose statement

The curriculum's purpose is to give the trainee doctor the specialist knowledge and skills needed to provide any rehabilitation service and team the doctor works with the medical expertise needed to provide a high quality, holistic and patient-centred service aimed at ameliorating the wider consequences of any illness. This will require relevant medical, disease knowledge, but the focus is upon using this knowledge to enhance the rehabilitation process, including delivering medical rehabilitation treatments. The doctor will be able to support rehabilitation in any setting from the intensive care unit to the home, and to patients with any illness or problems and at any age. The curriculum needs to have sufficient flexibility to train doctors entering the programme following core training in medicine, surgery, psychiatry, paediatrics, anaesthesia, ophthalmology, obstetrics and gynaecology or general practice.

There is overwhelming evidence that rehabilitation provided by teams with appropriate expert knowledge and skills, who work collaboratively and include formal liaison or goal-setting meetings, that have an active education programme, and that engage families in the process improve patient outcome and often are very cost effective. [1].

There is much evidence that the population need exceeds, by a large amount, the availability of teams meeting the standard known to be effective [1][2][3][4]. There is also evidence that incomplete teams without relevant expertise and not working as a collaborative whole are less effective, possibly ineffective [5]. Official documents highlight the lack of specialist hospital and community rehabilitation services [6][7].

Doctors are an essential part of any rehabilitation team. The UK has one of the lowest levels of rehabilitation doctors in the developed world [8], and the lowest number of rehabilitation physicians per head of population in Europe: 0.2 per 100,000 compared with 1.9 (Sweden), 2.0 (Germany), 2.9 (France), 3.7 (Italy)[8].

This new curriculum will ensure that trainees can work in the much wider variety of settings where they are needed than the current 2010 curriculum achieves. It will facilitate transfer of other trainees into the speciality by recognising relevant training already accomplished, thereby increasing numbers of trained specialists. It will equip trainees with the knowledge

and skills to meet the currently unmet need in areas of practice which are covered in almost all other comparable healthcare systems across the world, such as rehabilitation services for children.

This curriculum will ensure that the trainee develops the full range of generic professional capabilities, with their underlying knowledge and skills. It focuses on their application in the practice of Rehabilitation Medicine, which requires more development of some generic abilities than is needed in other specialities. It will also ensure that the trainee develops the full range of speciality-specific capabilities, with the underlying professional knowledge and skills.

The objectives of the curriculum are:

- to set out a range of specific professional capabilities that encompass all knowledge, skills and activities needed to practice Rehabilitation Medicine at consultant level
- to set expected standards of knowledge and performance of various professional skills and activities at each stage
- to suggest indicative training times and experiences needed to achieve the required standards
- to set out a programme of assessment procedures to be used, such as mini-CEX, the case conference assessment tool, teaching assessments and multi-source feedback.

Scope of practice

It is anticipated that, when fully trained, the doctor will be:

- Safe and competent to practice rehabilitation of patients of any age, in liaison with other specialists if needed; for example, children undergoing rehabilitation may well be managed together with a paediatrician.
- Capable of assessing and initiating rehabilitation for patients with any disability and disabling condition, especially but not exclusively those who present with more complex difficulties spanning different clinical domains and requiring input from different agencies.
- Able to work constructively with a wide range of other medical specialities, a wide range of different professions, and a wide range of other related organisations and agencies, particularly being able to set priorities and to encourage shared responsibility between professions and services.
- Able to practice in the clinical specialist area(s) associated with the post she or he is appointed to safely, with an appropriate level of additional knowledge and skill.
- Able to maintain professional knowledge and skills, able to acquire advanced knowledge and skills needed in appointed job, and able to learn to practice in new clinical areas if or when the need arises.
- Able to contribute effectively to the management and education of members of any teams and services he or she works with.
- Able to contribute effectively to wider NHS quality control, service development, educational and training, and other similar management activities.

The skills learned will be relevant to many other medical specialities, particularly stroke medicine, neurology and neurosurgery, trauma, liaison psychiatry, learning disability, orthopaedic surgery and rheumatology, general practice, general internal medicine especially geriatric services, palliative medicine, and community paediatrics.

There are no 'notable exceptions'. The curriculum does not specifically cover rehabilitation of adult psychiatric patients or people with a learning disability. However, it includes the potential to experience rehabilitation in all areas of healthcare. A fully trained rehabilitation consultant should be able to undertake rehabilitation in all areas, with support from the appropriate disease-specialist team if needed. These areas were not initially included when the speciality was first recognised in the UK (1988) but increasingly the speciality is seeing patients with a much broader range of conditions - as occurs in most other countries.

2.2 High level outcomes - capabilities in practice

The Rehabilitation Medicine capabilities in practice (CiPs) describe the professional tasks or work within the scope of Rehabilitation Medicine. Each CiP has a set of descriptors associated with the capability. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and behaviours which should be demonstrated for a decision that the doctor can be entrusted with that role to be made. By the completion of training and award of a CCT, the doctor must demonstrate that they are capable of unsupervised practice in all specified domains.

The CiPs have been mapped to the generic professional capabilities (GPC) domains and subsections to reflect the professional generic capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each CiP required, the doctor in training's performance meets or exceeds the minimum expected level for completion of training, as defined in the curriculum.

The Rehabilitation Medicine CiPs comprise eight specialty CiPs and the six generic CiPs shared across all physician specialties.

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
1. Able to successfully function within NHS organisational and management systems. 2. Able to deal with ethical and legal issues related to clinical practice. 3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement. 4. Is focused on patient safety and delivers effective quality improvement in patient care. 5. Carrying out research and managing data appropriately. 6. Acting as a clinical teacher and clinical supervisor.
Specialty CiPs

1. Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors.
2. Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant's own specific service.
3. Able to work as a full and equal member of any multidisciplinary rehabilitation team.
4. Able to identify and set priorities within a rehabilitation plan.
5. Able to diagnose and manage existing and new medical problems in a rehabilitation context.
6. Able to recognise need for and to deliver successfully specific medical rehabilitation treatments.
7. Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams.
8. Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases.

The eight specialty CiPs will require exposure to and experience of the whole range of rehabilitation problems currently seen in practice, including but not restricted to neurological, spinal cord injury, musculo-skeletal and trauma, and prosthetics rehabilitation. The trainee will have the knowledge and skills to take on a role within such a specialist service safely.

Output

At the end of training, the trainee should be able to:

- Provide a formulation of the situation and a suitable management plan for any patient referred, no matter what their age, condition or complexity, and in any setting.
- Manage safely and effectively all the long-term rehabilitation needs of patients with conditions within the doctor's areas of expertise, in any setting and encompassing all degrees of severity and complexity.
- Recognise when a patient's clinical situation requires additional input from another part of the health service.
- Contribute actively to the management, development and quality improvement of the rehabilitation services he or she is a member of.
- Assess disabled patients for, and to deliver safely and effectively, a range of specific medically-based treatments.
- Demonstrate good use of the generic professional capabilities within the context of the patient population seen and multidisciplinary teams involved.
- Make decisions that achieve the best outcome while also respecting the patient's wishes and values, using all information available, especially that provided by the team.
- Participate actively in the multidisciplinary team, not only clinically, but also contributing to team education and quality improvement, and developing appropriate protocols etc.

- Identify and then liaise with the wide range of statutory and non-statutory services and organisations that are integral to the successful rehabilitation of their patients.
- Make and document justified and morally sound decisions and recommendations in clinically and ethically challenging situations, especially in patients who lack mental capacity.
- Continue their own professional development.
- Contribute to the education and training not only of trainee doctors, but of all professions within health and social services.
- Contribute positively and actively both to quality improvement processes and to research activities within the whole NHS.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

Interdependencies

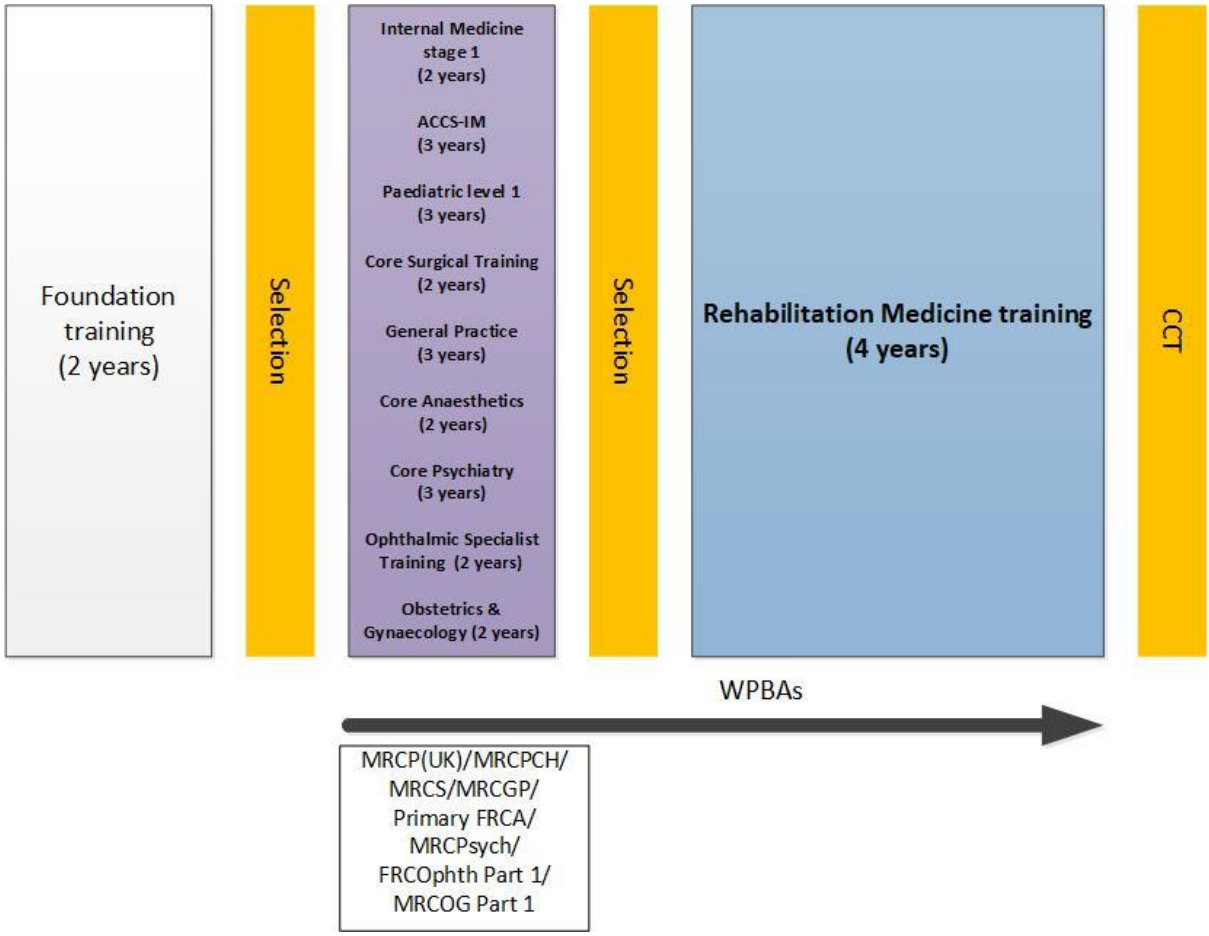
Interdependency is inevitable because people with disability will use all health care services and all medical (including surgical and psychiatric) specialities. Patients seen in rehabilitation may have almost any disease or other diagnosis, and rehabilitation doctors need wide general medical awareness. Further, just as some specialities have greater awareness of rehabilitation, so consultants in Rehabilitation Medicine need better knowledge of the diseases particularly associated with their main area(s) of practice; for example, someone in a neurological rehabilitation service needs a higher level of neurological expertise.

Many patients will need input from a disease specialist and a rehabilitation specialist at the same time. Some curricula, such as stroke medicine, geriatrics and learning disability will cover some of the principles and practice of rehabilitation. Conversely some of the rehabilitation curriculum will be transferable to those specialities and others, such as rheumatology and palliative medicine.

2.3 Training pathway

Rehabilitation Medicine training is a group 2 specialty. Trainees will need to have gained key capabilities in clinical prioritisation, holistic patient care, continuity of care, outpatient care, management of long-term conditions and experience of MDT working from their early training. Entry into higher specialist training will require completion of one of the following programmes: Internal Medicine Training stage one (two years), ACCS-Internal Medicine (three years), Level 1 Paediatrics training (three years), Core Surgical Training (two years), Core Level Training in Anaesthetics (two years), Core Psychiatry Training (three years), Basic (ST1 and ST2) Obstetrics and Gynaecology training (two years), ST1 and ST2 of Ophthalmic Specialist Training (two years), or completion of a General Practice specialty training programme (three years) which include completion of the associated high stakes assessments which will provide the skills described above and are detailed in the training pathway diagram below.

Training pathway for Rehabilitation Medicine



2.4 Duration of training

Training in Rehabilitation Medicine will usually be completed in four years of full-time training. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training more rapidly than the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good physician. There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

2.5 Flexibility and accreditation of transferable capabilities

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). This will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. The curriculum will allow trainees to train in academic medicine alongside their acquisition of clinical and generic capabilities, and these skills will be transferable across other specialties.

The broad range of entry criteria means that trainees come with quite different core training and will have transferable capabilities. For example, a surgical entrant may have little experience of neurological and other medical illnesses but good exposure to trauma and orthopaedics, meaning that they may need additional training in neurology but less training in musculo-skeletal practice. It also means that some trainees may have already gained some experience in rehabilitation. For example, doctors working in learning disability, psychiatry, paediatrics and neurology may have experience of rehabilitation. As rehabilitation tends to accumulate cases with long-term often progressive and rare disorders, trainees may have gained experience of long-term medical conditions.

In Rehabilitation Medicine, flexible training should be easily possible. Trainees from almost all specialities may have gained some knowledge and skills that transfer across into rehabilitation, but those specialities more likely to include significant transferable knowledge and skills include:

- Neurology (and other neuroscience specialities)
- Rheumatology
- Orthopaedic Surgery
- Trauma surgery, and accident and emergency medicine
- Sports and Exercise Medicine
- Psychiatry, including both liaison psychiatry and learning disability
- Chronic pain services
- General Practice
- General medicine
- Geriatric medicine
- Paediatrics
- Palliative Medicine

The accreditation of transferable competency framework [9] and gap analysis tool will facilitate transfers when a trainee requests one. The level of transferable experience will be judged on a case-by-case basis, and each trainee would be assessed in terms of actual training received and capabilities achieved up to that point.

2.6 Less than full time training

Trainees are entitled to opt for less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide.

2.7 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic Professional Capabilities (GPC) framework [10] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of the GMC's Generic Professional Capabilities

Good medical practice (GMP) [11] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent. The nine domains and subsections of the GPC framework are directly identifiable in the curriculum. They are mapped to each of the generic and specialty CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

3. Content of Learning

The practice of Rehabilitation Medicine requires both the generic and the speciality knowledge, skills, attitudes and assessment skills needed to manage patients presenting with a wide range of different disabilities related to an even wider range of impairments of bodily function and underlying diseases (or, not infrequently, no underlying causative disease), and set in a broad range of social, cultural and physical settings. It involves particular emphasis on clinical reasoning, managing complex multi-factorial problems, recognising appropriately both the limits of and the need for medical investigations and treatments, and identifying when other medical specialities and/or health and social care professions and/or organisations need to be involved, and how to liaise most effectively with other teams.

The curriculum is recursive, and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from needing direct supervision to being entrusted to act unsupervised.

3.1 Capabilities in practice (CiPs)

CiPs describe the professional tasks or work within the scope of Rehabilitation Medicine. CiPs are based on the concept of entrustable professional activities [12] which use the professional judgement of appropriately trained, expert assessors as a defensible way of forming global judgements of professional performance.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the knowledge, skills and attitudes which should be demonstrated. Doctors in training may use these capabilities to provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The descriptors are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the CiP descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the CiPs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that

will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and the GPC framework.

In order to complete training and be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty CiPs. Once a trainee has achieved level 4 sign off for a CiP it will not be necessary to repeat assessment of that CiP if capability is maintained (in line with standard professional conduct).

This section of the curriculum details the six generic CiPs and eight specialty CiPs for Rehabilitation Medicine. The expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision are given for each CiP. The list of evidence for each CiP is not prescriptive and other types of evidence may be equally valid for that CiP.

3.2 Generic capabilities in practice

The six generic CiPs cover the universal requirements of all specialties as described in GMP and the GPC framework. Assessment of the generic CiPs will be underpinned by the descriptors for the nine GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns. It will not be necessary to assign a level of supervision for these non-clinical CiPs.

In order to ensure consistency and transferability, the generic CiPs have been grouped under the GMP-aligned categories used in the Foundation Programme curriculum plus an additional category for wider professional practice:

- Professional behaviour and trust
- Communication, team-working and leadership
- Safety and quality
- Wider professional practice

For each generic CiP there is a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

KEY TO TABLES

cCAT	case Conference assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	GCP	Good Clinical Practice
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey
QIPAT	Quality improvement project assessment tool	TO	Teaching observation

Generic capabilities in practice (CiPs)	
Category 1: Professional behaviour and trust	
1. Able to function successfully within NHS organisational and management systems	
Descriptors	• Aware of and adheres to the GMC professional requirements. • Aware of public health issues including population health, social detriments of health and global health perspectives. • Demonstrates effective clinical leadership. • Demonstrates promotion of an open and transparent culture. • Keeps practice up to date through learning and teaching. • Demonstrates engagement in career planning. • Demonstrates capabilities in dealing with complexity and uncertainty. • Aware of the role of and processes for commissioning. • Aware of the need to use resources wisely.
GPCs	Domain 1: Professional values and behaviours Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF Active role in governance structures Management course End of placement reports

2. Able to deal with ethical and legal issues related to clinical practice	
Descriptors	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups. • Behaves in accordance with ethical and legal requirements. • Demonstrates ability to offer apology or explanation when appropriate. • Demonstrates ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently.
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF CbD DOPS Mini-CEX End of life care and capacity assessment End of placement reports
Category 2: Communication, teamworking and leadership	
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement	
Descriptors	• Communicates clearly with patients and carers in a variety of settings. • Communicates effectively with clinical and other professional colleagues. • Identifies and manages barriers to communication (eg cognitive impairment, speech and hearing problems, capacity issues). • Demonstrates effective consultation skills including effective verbal and nonverbal interpersonal skills. • Shares decision making by informing the patient, prioritising the patient's wishes, and respecting the patient's beliefs, concerns and expectations. • Shares decision making with children and young people. • Applies management and team working skills appropriately, including influencing, negotiating, re-assessing priorities and effectively managing complex, dynamic situations.
GPCs	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 5: Capabilities in leadership and teamworking

Evidence to inform decision	MCR MSF PS End of placement reports
Category 3: Safety and quality	
4. Is focused on patient safety and delivers effective quality improvement in patient care	
Descriptors	• Makes patient safety a priority in clinical practice. • Raises and escalates concerns where there is an issue with patient safety or quality of care. • Demonstrates commitment to learning from patient safety investigations and complaints. • Shares good practice appropriately. • Contributes to and delivers quality improvement. • Understands basic Human Factors principles and practice at individual, team, organisational and system levels. • Understands the importance of non-technical skills and crisis resource management. • Recognises and works within limit of personal competence. • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments.
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF QIPAT End of placement reports
Category 4: Wider professional practice	
5. Carrying out research and managing data appropriately	
Descriptors	• Manages clinical information/data appropriately. • Understands principles of research and academic writing. • Demonstrates ability to carry out critical appraisal of the literature. • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients.

	• Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry. • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice. • Follows guidelines on ethical conduct in research and consent for research. • Understands public health epidemiology and global health patterns. • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate.
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 7: Capabilities in safeguarding vulnerable groups Domain 9: Capabilities in research and scholarship
Evidence to inform decision	MCR MSF GCP certificate (if involved in clinical research) Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports
6. Acting as a clinical teacher and clinical supervisor	
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals. • Delivers effective feedback with action plan. • Able to supervise less experienced trainees in their clinical assessment and management of patients. • Able to supervise less experienced trainees in carrying out appropriate practical procedures. • Able to act a clinical supervisor to doctors in earlier stages of training.
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO Relevant training course End of placement reports

3.3 Specialty capabilities in practice

The specialty CiPs describe the clinical tasks or activities which are essential to the practice of Rehabilitation Medicine. The CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of

training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Specialty CiPs	
1. Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors	

Descriptors	• Uses the holistic biopsychosocial model of illness for all areas of professional practice:
	  ○ uses the framework to structure letters and reports
	  ○ uses the model when discussing patient problems with other team members
	  ○ teaches the model to other doctors, and to other professions
	  ○ uses the model, but not the jargon, when explaining a situation to a patient and/or the family
	  ○ shows familiarity with the concepts
	  ○ can explain its concepts and uses to others.
	• Identifies the patient's disease(s), and which losses are attributable to the disease(s), and which may have other explanations:
	  ○ able to confirm that the given diagnosis/diagnoses is/are correct, and/or able to suggest alternative or additional diagnosis/diagnoses
	  ○ knows what impairments are likely for the patient's disease(s), and looks for them
	  ○ knows what disabilities are usual for the patient's disease(s), and looks for them.
	• Identifies factors outside disease that may be causing or exacerbating disabilities:
	  ○ able to look for and recognise any emotional and/or psychological processes that are influencing the person's disabilities
	  ○ considers what physical factors may be influencing the nature and/or extent of disabilities
	  ○ considers what social factors, such a family attitudes, may be influencing the nature and/or extent of disabilities.
	• Considers what personal factors, such as expectations, may be influencing the nature and/or extent of disabilities.

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups

	Domain 8: Capabilities in education and training
Evidence to inform decision	MCR CbD Case reports and referral letters Teaching feedback Reflection mini-CEX QIPAT
2. Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant's own specific service	

Descriptors	• Considers and shows awareness of reasons for referral and expectations of all interested parties, not just the referring person or organisation.
	• Always undertakes a full assessment and provides a clear, reasoned analysis (formulation) of the case in the letter or report.
	• Shows awareness of all other relevant and potentially appropriate services.
	• Always offers a plan for future management when asked for advice, even if rehabilitation in the service approached is not the appropriate solution.
	• If the patient is considered unlikely to benefit from the rehabilitation service:
	  ○ explains clearly and documents the reasoning behind
	  ○ not offering the person the requested rehabilitation, and
	  ○ the alternative plans suggested
	  ○ when appropriate, initiates contact with or referral to the alternative service(s) suggested.
	• If accepted into the rehabilitation service:
	  ○ outlines the expected processes and timescales
	  ○ specifies any actions required of the referrer in association with acceptance
	  ○ takes responsibility for ensuring that all processes internal to the rehabilitation occur in a timely manner.

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease).* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training

Evidence to inform decision	MCR MSF Letters written after assessing a patient Copies of documents written after a rehabilitation planning meeting CbD mini-CEX Reflection
3. Able to work as a full and equal member of any multidisciplinary rehabilitation team	

Descriptors	• Communicates well with all team members verbally and in any other appropriate way (e.g.in patient notes).
	• Documents significant meetings with conclusions and actions specified.
	• When acting as leader (chair) of a meeting:
	  ○ ensures that all people present are heard and listened to
	  ○ treats all comments and contributors with respect
	  ○ ensures that all jargon is explained
	  ○ curtails contributions that are:
	  ▪ repeating material
	  ▪ not related to the meeting
	  ▪ disrespectful of others
	  ▪ in any other way likely to disrupt the meeting and/or waste time and/or are inappropriate
	• When not acting as leader of a meeting:
	  ○ contributes information, advice and analysis without usurping the role of the chair
	  ○ supports any chair who has less experience or who gets into difficulty
	  ○ if appropriate, gives constructive feedback to the chair or any other team member, if this is needed.
	• In team meetings where goals are considered and set:
	  ○ ensures that, at all times, the team considers all aspects of the situation and all potential actions including those by outside agencies
	  ○ ensures that patient values and expectations are central to the process
	  ○ ensures that long-term, social goals are discussed and set
	  ○ ensures that plans for transfer of care, including discharge are always considered.
	• Respects and learns from the knowledge and skills of all team members:
	  ○ asks a team member for explanation of or detail about an aspect of their assessment or treatment without implying criticism or doubt.
	• Educates team members routinely during normal clinical work:
	  ○ explains, or refers to evidence about some topic.
	• Liaises with appropriate team members about any specific medical problems or treatments.
	• Participates in team and service management and educational activities.

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

	• clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	cCAT MSF CbD mini-CEX MCR Reflection Documents from team meetings
4. Able to identify and set priorities within a rehabilitation plan	

Descriptors	• In any team rehabilitation planning meeting:
	  ○ ensures that long-term outcome goals are considered
	  ○ ensures that discharge from the service and/or transfer to other services are considered.
	• Recognises when a discussion (not only in team meetings) is focused on immediate and achievable actions without thought of long-term matters.
	• Able to open out a discussion without causing distress.
	• Can identify, articulate and negotiate priorities.
	• Introduces new goals, previously overlooked, and/or reduces or removes goals that are unnecessary or of low importance.

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • communication and interpersonal skills • dealing with complexity and uncertainty Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	CbD Mini-CEX MCR Reflection cCAT MSF Documents from team meetings

5. Able to diagnose and manage existing and new medical problems in a rehabilitation context	

Descriptors	• Recognises when a patient either:
	  ○ has been referred with an incorrect disease diagnosis, and/or
	  ○ has developed a new disease.
	• Recognises when a patient, usually an in-patient, is acutely unwell and needs urgent attention.
	• Initiates, if needed, any urgent investigations, treatment and other management needed to:
	  ○ establish the cause
	  ○ stabilise the patient's state to maintain life
	  ○ reduce and control any pain and distress.
	• Recognises when assistance is needed from other specialist services:
	  ○ makes a referral with appropriate urgency
	  ○ as needed, ensure transfer of responsibility occurs smoothly with full handover of all information.
	• In situations when a patient lacks capacity:
	  ○ considers what is in the patient's best interests, as guided by relevant mental capacity legislation:
	  ▪ specifically involves the relatives and friends of the patient
	  ○ considers whether a formal meeting is needed:
	  ▪ specifically, for a major decision where time is available.
	• Throughout, communicates clearly with patient and/or family covering:
	  ○ diagnosis and/or
	  ○ investigations and their results, and/or
	  ○ treatment(s) given, and/or
	  ○ prognosis, and/or transfer to other services.

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	CbD Mini-CEX MCR Reflection cCAT MSF Logbook

6. Able to recognise need for and to deliver successfully specific medical rehabilitation treatments	

Descriptors	• Identifies correctly patients who may benefit from specific rehabilitation medical treatments, documenting that:
	  ○ considered a treatment, its benefits and risks
	  ○ researched current evidence or guidance, if necessary
	  ○ discussed risks and benefits with the patient and/or family
	  ○ discussed the treatment with relevant other professionals involved, specifically:
	  ▪ how treatment might influence the patient's abilities
	  ▪ how the clinician might need to alter their own treatment to enhance any benefit
	  ○ reasoning behind final decision
	  ○ gained informed consent (if possible) or considered what was in a patient's best interests.
	• Does not offer or undertake a specific rehabilitation medical treatment to patients who will not have a net benefit:
	  ○ If a patient or other person requested or persists in requesting a treatment, explains and documents reasoning clearly, answering all questions.
	• If necessary and if appropriate, offers to seek a second opinion.

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	DOPS CbD Mini-CEX MCR Patient survey Letters and clinical notes
7. Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams	

Descriptors	• Knows, sufficiently to engage constructively, how all other relevant organisations (e.g. social services, housing, education, department of work and pensions, mental health services, major voluntary organisations) function:
	  ○ understands their sources of income and how service is financed
	  ○ understands their responsibilities, and their limits and regulations
	  ○ knows which professions work within the organisation and their expertise.

	• Considers possible involvement of other organisations in rehabilitation plans for all patients with complex needs:
	  ○ suggests their involvement in rehabilitation planning meetings
	  ○ initiates or undertakes referrals to other services
	  ○ investigates suitability of making a referral, by direct contact and/or researching through the internet.
	• Demonstrates engagement working with other services within NHS and partner organisations, both outside the NHS and outside Healthcare:
	  ○ attends meeting called by other services about a patient
	  ○ contributes to, and may lead any meeting whoever organised it.
	• Copies letters and other relevant documentation to organisations and services involved with a patient (in compliance with any legislation, usually with the patient's agreement or knowledge).

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	CbD Mini-CEX MCR Reflection cCAT MSF Logbook Letters and clinical notes
8. Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases	

Descriptors	• Accepts personal responsibility for resolving complex problems in people with disability which involve health services, even if admission to or major involvement of the rehabilitation service is not the solution.
	• Identifies the many factors that need to be considered in a complex case:
	  ○ clinical, relating to the patient
	  ○ cultural, relating to the patient, family, others
	  ○ organisational, relating to relationships between different organisations – social services, housing, employers, insurance companies, commissioners etc
	  ○ political considering the broader implications of a particular decision

	○ legal, being aware of all legal matters that may be relevant ○ ethical. • Able to get necessary information on the relevant factors: ○ inviting people to attend a meeting and/or ○ researching and documenting relevant information. • Able to negotiate and mediate between conflicting or competing parties in a meeting and/or individually. • Reaches an agreed decision with a plan, and/or an agreed way forward to achieve an agreed solution later. • Documents the process in sufficient detail for others to understand the facts, influences and reasoning behind the resolution.
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training
Evidence to inform decision	CbD Mini-CEX MCR Reflection cCAT MSF Logbook Letters and clinical notes

3.4 Presentations and conditions

The scope of Rehabilitation Medicine is broad and cannot be encapsulated by a finite list of problems presented, diseases and impairments present, and relevant contextual factors. Any attempt to list all these would be extensive but inevitably incomplete and rapidly become out of date.

The table below details the disabilities, diseases, impairments and training issues relevant to Rehabilitation Medicine

- the **functional limitations** the patient presents with

    - the (goal-directed) activities (i.e. disabilities) that they consider to be limited in some way, and that they (or others) want explained and ameliorated;
- the **disease diagnoses** commonly associated with the limitations
    - ultimately any and all diseases **may** cause limitation on any activity, but the more common ones responsible are given
- the **impairments** ('symptoms and signs') that commonly underlie the disability
    - this again is not exhaustive, but covers those that a trainee is likely to see
- the **types of intervention**, and the **issues** that the trainee will gain experience in
    - not an exhaustive list, and many could feature in every domain

Patients will usually present to and are seen within the context of a multidisciplinary team, and the doctor's role will differ according to the problem and the other expertise available within the team concerned. However, a Rehabilitation Medicine consultant needs to have reasonable knowledge about all aspects of a patient's problem, sufficient to identify when referral to another agency, service or professional is needed.

Each of these disability domains and sets of issues should be regarded as a clinical context in which trainees should be able to demonstrate capabilities in practice and generic professional capabilities. Trainees will need to become familiar with the knowledge, skills and attitudes around managing patients with these conditions at all levels - disease, impairment, disability, social integration, and all contexts. The role is always to identify the presence and importance of factors that may be changeable, and either to use their own medical treatment knowledge to effect change or, much more commonly, to know who may help and how to contact them. This person or these people will frequently be outside the team, and often outside the health services. The patient should always be at the centre of knowledge, learning and care, and a holistic approach should always be used.

All trainees must demonstrate core clinical skills, including information gathering through history and physical examination and information sharing with patients, families and all members of the team and, as appropriate, with other services involved. Although the rehabilitation physician will usually not be responsible for specialist disease treatments, they must (a) identify and/or confirm the correct disease diagnosis/diagnoses and (b) ensure that the patient receives appropriate disease treatments. It helps to be familiar with specialist treatments for diseases seen commonly.

The particular problems presented, diseases and impairments present, and relevant issues listed here cover the main areas faced by any rehabilitation physician, and by the team they work within. The relative frequency and relative importance of each listed item varies according to the nature of the team and the patient's priorities.

It is obvious from the list that most presenting problems are caused by a wide variety of diseases across many medical specialties and, conversely, that particular diseases can cause problems across a wide variety of functional domains.

Rehabilitation presentations and conditions - Disabilities, diseases, impairments, training issues arising

Disability domain	Pathologies/diagnoses	Impairments	Issues
Mobility: • including all transfers • around house • in and out of house • local community • public transport • driving	Common diagnoses: • Neurological • Muscle diseases • Orthopaedic • rheumatological • Limb loss/absence • Functional disorders • Cardio-respiratory	Common impairments: • Muscle strength and control • Spasticity • Pain • Fear, beliefs, motivation • Restricted joint movements • Balance • Exercise tolerance/fitness • Insight, lack of safety awareness • Visual impairments • Cognition/awareness • Episodic altered consciousness	Treatments and/or issues: • Training the activity • Adaptive techniques • Housing/accommodation • Equipment and training • Adaptations to environment • Carers/family giving support • Care package • Clinical monitoring (e.g. skin, number of falls) • Wheelchairs • Specialised transport facilities • Car adaptations • DVLA rules about driving • Advice about flights, trains etc

Disability domain	Pathologies/diagnoses	Impairments	Issues
Dexterity: • bimanual **and** • only one arm	Common diagnoses: • Neurological • Muscle diseases • Orthopaedic • rheumatological • Structural loss (amputation) • Functional disorders • Congenital abnormalities • Burns and trauma	Common impairments: • Weakness and/or spasticity • Sensory losses • Pain • Joint changes – swelling, loss of range etc • Altered motor control – Incoordination or ataxia • Apraxia and other cognitive losses • Perceptual losses • Visual impairments	Treatments and/or issues: • Specialist equipment for individual problems • Seating/posture • Dominant/non-dominant hand • Work/hobbies/interests • Body image • Orthoses • Prostheses •
Communication: • Verbal • non-verbal • oral & writing • speech & language	Common diagnoses: • Neurological • Functional disorder • Facial damage • Dental/skull trauma • Local carcinoma • Respiratory disorders	Common impairments: • Dysarthria/slurring • Aphasia (dysphasia) • Speech apraxia • Cognitive losses • Dyslexia and related disorders • Dysphonia/aphonia	Treatments and/or issues: • Technological aids – phones, iPads, alarms etc • Low-tech aids – writing pads, eye pointing to chart • Training speech production • Training alternative strategies
Personal care: • Washing, shaving • teeth • Selecting clothes, dressing • Make up, hair	Common diagnoses: • Burns • Traumatic damage to limbs • Neurological • Rheumatological • Functional disorder • Muscle disorders	Common impairments: • Apraxia and other planning disorders • Weakness, spasticity • Ataxia/incoordination • Pain • Loss of range of movement • Fatigue	Treatments and/or issues: • Training old or new techniques • Adapting to different clothes • Adapted clothing • Training carers • Small items of equipment

Disability domain	Pathologies/diagnoses	Impairments	Issues
Continence & toileting • Bowel management • Bladder management • Toilets	Common diagnoses: • Neurological disorders especially of spinal cord • Functional illness • Gastrointestinal disorders • Bladder and urinary tract disorders	Common impairments: • Urgency; bladder & bowel • Inability; urinary retention • Constipation/diarrhoea • Loss of control • Motivation/apathy • Mood disorder • Cognitive losses	Treatments and/or issues: • Catheters, convenes and similar • Pads • Colonostomy, ileostomy • Carers • Adapted toilets, rails, etc • Other equipment/adaptations • Retraining control • Drugs – as cause • Drugs – as treatment

Feeding and swallowing:
• Getting food to mouth
• Chewing and swallowing
• Food and fluids
	Common diagnoses:
	• Neurological disorders
	• Mouth & pharyngeal tumours
	• Functional disorders
	• Mental Health disorders
		Common impairments:
		• Dysphagia
		• Choking
		• Fatigue
		• Lack of insight
		• apraxia
		• Respiratory complications
			Treatments and/or issues:
			• Ethical issues
			  ○ Risk, choice, control
			  ○ Withdrawal of feeding/hydration
			• Cultural issues
			  ○ Eating as a social function
			• Swallowing practice
			• Family and carers assisting
			• Dietary adaptation
			• Medication delivery
			• Clinically assisted nutrition & hydration
			  ○ Gastrostomy management

Disability domain	Pathologies/diagnoses	Impairments	Issues
Vocational activities: • Paid work • Voluntary work • Training • Education	Common diagnoses: • Neurological • Cardio-respiratory • Musculo-skeletal • Trauma • Gastroenterological • Mental Health • Functional disorder	Common impairments: • Cognitive losses • Communication • Dysthymia • Disorders of planning, initiation and organisation • Pain • Weakness and motor disorders • Social interaction disorders	Treatments and/or issues: • Employment rights • Adaptations at work • Unemployment benefits • Retraining/education • Department of work & pensions • Adjustment to loss/change in social roles
Community activities: • shopping • travel • religious • ceremonial • public • clubs and other groups • civic and political	Common diagnoses • Functional disorders • Mental health problems • Neurological • Orthopaedic • Rheumatological • Mental Health • Cardio-respiratory	Common impairments: • Cognitive losses including language & memory • Executive disorders of planning, initiation and organisation • Weakness/altered motor control • Speech and social interaction • Social phobia, self-image • Loss of self-confidence • Deafness • Visual impairment	Treatments and/or issues: • Stigmatization, social attitudes • Public Transport • Day centres • Facilities for people with disability • Cognitive overload • Practice, coping techniques • Alternative activities

Disability domain	Pathologies/diagnoses	Impairments	Issues
Leisure activities: • Social, inter-personal • Individual • Intellectual • physical	Common diagnoses: • Mental Health • Neurological • Functional disorders	Common impairments: • Cognitive losses • Executive disorders • Impaired speech • Motor impairments • Phobias, low self-esteem • Chronic pain	Treatments and/or issues: • Support groups for people with the person's disorder • Family and/or carer support to patient • practice
Citizen activities: • participation in democracy • interacting with government agencies • all other bureaucracy	Common diagnoses: • Neurological • Mental Health • Visual	Common impairments: • Cognitive losses • Speech impairments • Planning or initiation deficits • Reduced insight • Deafness • Low or absent vision	Treatments and/or issues" • Financial advice agencies • Ethical and legal matters • Mental capacity legislation • Human Rights • Support agencies
Social interaction: • content and style of behaviour with others • verbal and non-verbal aspects • making & maintaining friendship	Common diagnoses: • Brain damage • 'Personality disorders' • other ill-defined mental health conditions • Alcohol and drug abuse • Mental health disorder	Common impairments: • 'dysexecutive disorders' • Emotional dysfunction or lack of control • Confusion, and sensory dysfunction	Treatments and/or issues: • Safety of patient • Safety of others • Use/misuse of medication • Ethical and legal issues - restraint, deprivation of liberty • Funding and organisations; who is responsible

Disability domain	Pathologies/diagnoses	Impairments	Issues

Partner relationships:
• Making and maintaining partnership(s)
• Sexual activities
• Family responsibilities
• childcare
	Common diagnoses:
	• Neurological disorders,
	• spinal cord damage/disease
	• Chronic pain
	• Disfigurement, altered body image or structure
	• Mental Health disorders
	• Functional disorders
		Common impairments:
		• Emotional dysfunction
		• Sensory disturbance, especially genital
		• Erectile or arousal dysfunction
		• Bodily change – burns, bladder catheter,
			Treatments and/or issues:
			• Legal and ethical
			  ○ Rights of partner and patient
			  ○ Safeguarding (children, partner)
			• Drugs (stopping / starting)
			• Relationship counselling
			• Marriage guidance etc

Domestic activities: • cooking • housekeeping • minor repairs • garden	Common diagnoses: • Neurological • Rheumatological • Mental Health • Functional disorders	Common impairments: • Cognitive dysfunction • Executive dysfunction • Motor dysfunction • Pain, sensory dysfunction • Insight/safety awareness impaired	Treatments and/or issues: • Safety (in kitchen especially) • Risk analysis and resolution • Ethical - provision of support and funding; risk • Social/cultural expectations • Adaptation, equipment
Self-management: • Setting goals • Learning • Problem-solving • Adjusting goals • Planning & organizing	Common diagnoses: • Neurological • Mental Health • Functional disorders	Common impairments: • Cognitive disorders • Emotional dysfunction • Executive disorders • Insight, self awareness	Treatments and/or issues: • Professional relinquishing control • Influence of family • Input from family • Use of assistive technology • Structuring time

3.5 Practical procedures

Trainees are required to be able to perform botulinum toxin injection for limb spasticity unsupervised by the end of ST4. This will be assessed using summative direct observation of procedural skills (DOPS).

Trainees may have the opportunity to learn other procedures during training, but competence is not mandatory. A list of the most common procedures that may be experienced is given below:

- shoulder joint injection (for pain)
- other joint injections
- complex botulinum toxin injection techniques
- baclofen pump adjustment and refilling
- ultrasound examinations of joints
- bladder scanning.

When a trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct).

Procedure	ST3	ST4	ST5	ST6
Botulinum toxin injection for limb spasticity	Able to perform the procedure under supervision	Competent to perform the procedure unsupervised	Maintain	Maintain

4. Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE), NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries'. A training programme director (TPD) will be responsible for coordinating the specialty training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Trainees will have an appropriate clinical supervisor and a named educational supervisor. The clinical supervisor and educational supervisor may be the same person.

The curriculum specifies the range of diseases, impairments and disabilities that must be seen; and the range of contexts that they must be seen in; and the range of problems and severities of those problems that must be seen (see section 3.4). In order to achieve the

knowledge and skills required, the trainee will need experience in a wide range of settings and services.

The following is a guide to the breadth of training required for trainees to achieve the learning outcomes.

Neurological rehabilitation (excluding spinal cord injury)
Neurologically-based conditions constitute the largest single workload for inpatient rehabilitation services and are responsible for much of the severe long-term disability in the community. Every trainee must gain experience in managing patients with neurological (including neuromuscular) conditions. This experience should include:

- inpatients, outpatients, nursing home visits, ward referrals
- acute conditions, adult-onset progressive conditions, and all conditions starting at birth or within childhood
- disorders of affecting (primarily) the brain, the spinal cord, peripheral nerves (including traumatic damage) and muscles (muscular dystrophies)
- some specific relatively uncommon problems, such as:
    - Prolonged disorders of consciousness
    - challenging behaviours
    - patients with rare disorders
- functional neurological disorders.

Spinal cord injuries
Trainees must gain experience working with patients with recently acquired traumatic injury or other damage to the spinal cord, including both the cauda equina and very high spinal cord injuries. This experience should include:

- inpatients, outpatients, nursing homes, acute referral wards (e.g. trauma)
- all phases including acute phase, from initial assessment; rehabilitation phase; long-term care and management including advising on patients admitted to hospital with other health conditions
- tetraplegia (cervical spinal cord injury), paraplegia, and cauda equina damage; complete and incomplete spinal cord injuries
- Experience of some specific conditions such as:
    - people needing ventilatory support
    - sexual functioning.

Musculo-skeletal disorders
Musculo-skeletal disorders (which in this context includes chronic spinal pain) are the most common disabling conditions. Although patients with these conditions rarely need inpatient services, they constitute the /majority of community-based patients. The musculo-skeletal experience should include:

- outpatients, and community services (including exercise prescriptions)
- clinical experience with chronic pain services, domiciliary services, specialist orthopaedic and rheumatological services, and services for functional disorders such as fibromyalgia and hypermobility syndrome
- involvement with orthotics services.

Trauma rehabilitation
It is important that trainees gain experience in rehabilitation after major trauma. This experience should include:

- acute inpatients, outpatients, domiciliary/community services
- assessing acutely injured patients from a rehabilitation perspective:
    - using the currently required trauma rehabilitation prescription
    - guided by a medical rehabilitation consultant or, in their absence, a therapy or nurse consultant
- gaining experience in:
    - burns
    - neurological and general intensive care
    - major skeletal trauma
    - acute spinal cord injury
    - traumatic limb loss

Where possible it should also include:

- rehabilitation out-patient clinics after discharge
- seeing children and teenagers
- hyperacute inpatient rehabilitation.

Where a placement with a rehabilitation consultant in a major trauma centre is not possible, a trainee should be supported to spend time in a major trauma centre with an active trauma rehabilitation service that has consultant medical input.

Rehabilitation involving assistive technology
This covers a range of rehabilitation knowledge and skills that are sometime described by the following terms:

- prosthetic rehabilitation
- orthotics
- wheelchairs and other mobility equipment
- assistive technologies covering particularly aids to communication and environmental controls.

In relation to prostheses, this experience should include:

- assessing patients with a limb loss spanning
    - both single limb loss and multiple limb loss
    - traumatic, vascular, and congenital causes
    - loss at all common levels of the limb (arm and leg)
        - the use of a range of different prostheses and including rehabilitation when not prescribed a prosthesis
- involvement in assessment of, advice to and management of
    - medical aspects such as pain, skin damage, pre-operative advice
    - patients of all ages:
        - children, otherwise fit younger adults, and older adults with vascular disorders
    - special requirement associated with sport and leisure activities, and work
    - driving, for amputees missing an arm or a leg.

In relation to all other assistive technologies, this experience should include:

- involvement with patients having a wide range of underlying conditions
- experience in the assessment for and provision of a wide range of different assistive technologies from very simple (e.g. post-it notes and white boards) to complex
- understanding the role of assistive technologies in different setting, for example home, hospital wards, Intensive Care Units, nursing homes, work, and public places
- use of assistive technology to support people with a wide range of impairments and needs, such as supporting memory, structuring use of time, communication, etc.

Palliative medicine

Rehabilitation medicine is involved in palliation of symptoms from first patient contact. It is also involved, less frequently, in the end-of-life care of some patients, usually in an advisory capacity rather than on an inpatient basis. An indicative 1-2-week placement in a palliative care service, or involvement on a day basis for 5-10 days would be invaluable experience for all trainees.

Liaison psychiatry and/or learning disability psychiatry

The psychological aspects of disability and rehabilitation are of central importance, being relevant in every area of practice, and every trainee needs exposure to all aspects. This includes an understanding of disturbed and challenging behaviours.

Clinical psychologists should be integral members of every rehabilitation team, but medical aspects covered by psychiatry are rarely integrated into services. It is recommended that trainees spend at least 20 days working in a psychiatric service. Depending upon what is available, this may be a liaison psychiatry service, a learning disability service, primarily in the community, or even a general adult psychiatric service. In a few areas it might be gained in a specialist brain injury unit focused on patients with brain injury and very challenging behaviour.

Paediatric rehabilitation

An increasing number of children are surviving into adulthood with severe disability.

It is recommended that trainees spend an indicative period of 10 days with a consultant paediatrician with an interest in long-term management of disabled children. This person will often be a community paediatrician and may have a sub-specialty qualification in paediatric neuro-disability. The trainee should also attend handover clinics, from paediatric to adult services

Cardio-respiratory rehabilitation

Most specialist cardiac and respiratory services will have one or more of nurses, physiotherapists, occupational therapists or clinical psychologists involved in rehabilitation some of their patients. Many patients already seen by rehabilitation services will have significant cardiac or respiratory problems contributing to their rehabilitation needs. It is recommended that trainees are exposed to any cardiac and respiratory rehabilitation that is available within their deanery.

Pain service
The management of pain is part of all medical practice, but many patients seen within rehabilitation services have long-lasting, quite severe and often intractable pain. Trainees should have experience within one or more of their local pain services, focusing on chronic and long-term pain in particular. A placement of an indicative two consecutive weeks is recommended, to include exposure to inpatient care, if available, out-reach and out-patient services.

4.2 Teaching and learning methods

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

This section identifies the types of situations in which a trainee will learn.

Learning with peers
In Rehabilitation Medicine opportunities for trainees to learn with their medical peers is limited by the small numbers within any programme, because often a trainee will only meet one or two peers on a regular basis. This difficulty can be overcome, to an extent, in several ways. First, other local training programmes will include both local teaching sessions of great relevance, such as in neurology, sports and exercise medicine and psychiatry. The trainee doctors from different specialities will be able to share experience and ideas.

Second, rehabilitation is above all a team activity and post-graduate training for many of the professions would offer excellent training for medical trainees. This would include clinical psychology, physiotherapy, speech and language therapy, occupational therapy and nursing but could extend to social work, orthoptists and many others. Training programme directors should develop links with local post-graduate training for any relevant profession and encourage trainees to attend relevant training. The trainees from different professions will be able to share experience and ideas.

Work-based experiential learning
The key aspect of most training is to learn through undertaking an activity. The content of work-based experiential learning will be decided by the local faculty for education but includes active participation in many different activities.

Seeing new referrals in different settings
This is a crucial learning opportunity, because it is relatively unstructured and unpredictable and requires both good knowledge and good skills. The educational objectives specifically associated with this experience includes:

- To appreciate how the expectations of the referring person and of the patient and family may vary and differ, and may relate to the setting and context.
- To learn to interpret and understand the unstated or implicit content of the referral.

- To tailor the assessment to the requirements of and the expectations associated with the referral.
- To write a letter after the assessment that reflects and considers the expectations of all parties.
- To become very familiar with all aspects of the biopsychosocial model of illness, using it to ensure that all important factors are considered.
- To be able to develop an initial plan, including a plan that does not involve the rehabilitation service itself.

The trainee will start with relatively straightforward referrals where there are few unknowns, such as a ward referral for rehabilitation after stroke, with limited responsibility for making decisions. New out-patient referrals are probably the next step. However, it is essential that the trainee increasingly sees referrals in many different settings, with many different types of problems. The trainee should expect and ask for feedback on the letters written, initially in every case - they additionally provide an opportunity for a case-based discussion.

Seeing patients for follow-up
Seeing patients after their initial contact with rehabilitation offers two training opportunities. The trainee will see a much wider variety of patients and problems than arises within the in-patient population. And it allows the trainee to gain experience in how patients change and adapt over time.

This should not be restricted simply to hospital-based out-patient clinics, which are anyway often difficult for patients to attend. It should include any available form: day-hospital patients, visiting patients at home or in a nursing home with professionals who work in the community, telephone and/or videophone consultations, email or postal contact, and using questionnaires etc.

The educational objectives particularly associated with this experience are:
- developing and maintaining a relationship with a patient and their family over time as the condition changes;
- appreciating the broad range of problems faced by patients with apparently similar impairments;
- learning what impairments and problems are more or less common in different conditions and circumstances;
- learning to tailor methods of follow-up to different circumstances;
- learning how different professions can contribute, particularly in relation to patients living in the community.

Participating in larger, complex meetings about patients
Good communication and coordination is central to successful rehabilitation, especially when multiple agencies and organisations are involved. Consultants in rehabilitation are often best-placed to lead and influence such meetings, and being able to participate in and, often, chair such meetings is an essential skill. These meetings may be external to the rehabilitation service and health service.

The educational objectives specifically associated with this experience are:

- chairing meetings where most people are unaware of all the important information and work in different systems with different terminologies and priorities;
- maintaining a focus upon the goals, needs and wishes of the patient in the face of the wishes of other people involved to fit the patient to the services on offer;
- educating others about the biopsychosocial model of illness and the practice of rehabilitation quickly and as far as is needed to achieve a good outcome;
- summarising the meeting and writing an appropriate letter thereafter.

Attending meetings that review a group of patients in rehabilitation

This includes ward rounds on inpatients, and any meetings that review patients actively involved with the rehabilitation service such as outpatients, day-patients, or in other ways such as community or hospital out-reach. The skill of attending and often leading meetings that discuss a large group of patients is important; the in-patient ward round is only one example.

The specific educational objectives of this experience are:

- learning how to pick-up on medical problems requiring attention based on the reports of other professionals, particularly when the patient is not present;
- ensuring that the meeting runs efficiently, focusing on patients who need attention but passing over other patients quickly;
- learning how to record problems discussed and actions needed quickly and in an understandable way;
- realising that the problems associated with each setting and group have much in common, but that solutions vary for historical and other reasons.

Participating in multidisciplinary team meetings

This refers to meetings of a specific rehabilitation service, including both goal-setting meetings, discharge meetings, any other form of rehabilitation review and planning meeting, and team educational and development meetings.

The specific education objectives associated with this experience are:

- learning how to identify, defuse and manage conflict and disagreement within a team;
- learning about the knowledge and skills each team member has, and learning some of the knowledge and skills;
- becoming an integral and equal member of a team, supporting team members in their own training and development.

Palliative and end of life care

Trainees should have significant experience of palliative care with the objective of:

- Enhancing skills in recognising the patient with limited reversibility of their medical condition and the dying patient.
- Enhancing ability to recognise the range of interventions that can be delivered in hospital and other settings (eg community, hospice or care home).

- Increasing confidence in managing physical symptoms in patients and psychosocial distress in patients and families.
- Increasing confidence in developing appropriate advance care plans, including DNA/CPR decisions.

It is accepted that some of these learning objectives and experience of end of life care may be achieved during attachments to routine posts, but few rehabilitation posts give much exposure. Consequently, it is felt that an attachment with a specific palliative care team and/or consultant will give a broader perspective in this complex and important area so, if such an attachment can be arranged, it is felt to be desirable.

Working within specialist clinics
This covers two slightly different matters, though they overlap. The first group refers to specialist clinics within a rehabilitation service. This includes clinics such a wheelchair assessment, initial assessment of someone needing a prosthesis, a clinic adjusting a baclofen pump, a clinic for handing over responsibility for disabled children to adult services, and a spasticity clinic that includes botulinum toxin injections.

Each deanery will have a reasonable number of specialist rehabilitation clinics and each trainee should attend at least a few clinics. The number needed will vary according to the clinic. It may sometimes be necessary to visit a clinic in a neighbouring deanery

The second type of specialist clinic is one run by another medical specialty, such as rheumatology concentrating on a particular long-term and disabling condition such as ankylosing spondylitis. Attending specialist clinics is a quick way to learn about rarer conditions; it is also an opportunity to identify the rehabilitation needs of those attending.

The specific educational objectives associated with this experience are:
- to gain exposure to a range of disabling conditions, all likely to be seen at some time, in a setting where the trainee can learn the particular knowledge of the condition needed, and the common problems seen in that condition
- to gain exposure to a range of specialist rehabilitation skills, many of which are important core skills.

Formal postgraduate teaching.
Most deaneries are too small to set up and sustain a programme of postgraduate training in Rehabilitation Medicine from within their own rehabilitation resources. There are several solutions.

First, postgraduate teaching in other larger specialties such geriatrics, and neurology may well have sessions that are very relevant to rehabilitation trainees. Attendance should be encouraged not only to obtain good training, but also to develop a better understanding of the other specialty.

Second, there are several national training courses run, for example in prosthetics and orthotics, and wherever possible trainees should attend one during their training. This

includes attendance at the British Society of Rehabilitation Medicine annual meeting, which always has specific educational sessions in addition to more scientific sessions.

Third, each year there will be national or international meetings run by another profession or another specialty where the content is directly relevant to trainees in rehabilitation medicine. Examples include meetings of the British Neuro-Psychiatry Association, the Society for Research in Rehabilitation, and special interest groups of different professions.

Next, some trainees can attend meeting set up and run by a neighbouring deanery. For example, trainees from Northern Ireland currently attend training meetings run in Scotland.

Last, there are opportunities to set up or attend local Grand Rounds, journal clubs (for all professions), case reviews etc.

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

- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- reading journals
- developing the invaluable skill of searching and finding information about a clinical question sufficient to move on, within 15 minutes.
- achieving personal learning goals beyond the essential, core curriculum.

Formal study courses
Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management courses and communication courses.

4.3 Academic training

The four nations have different arrangements for academic training and doctors in training should consult the local deanery for further guidance. Trainees may train in academic medicine as an academic clinical fellow (ACF), academic clinical lecturer (ACL) or equivalent.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the Deanery as to what is appropriate together with guidance from the appropriate SAC that the proposed period and scope of study is sensible.

4.4 Taking time out of programme

There are a number of circumstances when a trainee may seek to spend some time out of specialty training, such as undertaking a period of research or taking up a fellowship post. All such requests must be agreed by the postgraduate dean in advance and trainees are advised to discuss their proposals as early as possible. Full guidance on taking time out of programme can be found in the Gold Guide.

4.5 Acting up as a consultant

A trainee coming towards the end of their training may spend up to three months "acting-up" as a consultant, provided that a consultant supervisor is identified for the post and satisfactory progress is made. As long as the trainee remains within an approved training programme, the GMC does not need to approve this period of "acting up" and their original CCT date will not be affected. More information on acting up as a consultant can be found in the Gold Guide.

5. Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:

- assess trainees' actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand 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
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- identify trainees who should be advised to consider changes of career direction.

5.2 Programme of Assessment

The programme of assessment refers to the integrated framework of assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is:

- to provide robust evidence of the level of a trainee's performance,
- to ensure and to communicate clearly the expected levels of performance at critical progression points in the curriculum, and eventually
- to demonstrate satisfactory completion of training as required by the curriculum.

A range of different types of assessment is used to generate the evidence required for global judgements to be made about satisfactory performance, with progression in performance until training is complete. All assessments, including those conducted in the workplace, can be linked to the relevant curricular learning outcomes.

The programme of assessment emphasises the importance and centrality of professional judgment by trainers in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curriculum. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees to gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. 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.

This approach, using assessments to give structured feedback to the trainee, depends crucially upon trainees undergoing assessment on a regular, routine basis throughout the training programme. Assessment should not be seen as a chore, with the goal of acquiring the minimum number required all over a short time. A trainee should expect at least one assessment every week. This also requires that clinical trainers are given time, and take the time, to undertake assessments and to give feedback.

Reflection and feedback should be an integral component to all workplace based assessments (WPBAs). In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future

development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of capabilities in practice (CiPs) involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment anchor statements

- Below expectations for this year of training; may not meet the requirements for critical progression point.
- Meeting expectations for this year of training; expected to progress to next stage of training.
- Above expectations for this year of training; expected to progress to next stage of training.

Towards the end of each training year, trainees will make a self-assessment of their progression for each capability in practice and record this in their e-Portfolio with signposting to the evidence to support their rating.

The educational supervisor (ES) will then review the evidence in the e-Portfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee's self-assessment and record their judgement on the trainee's performance in their Educational Supervisor report, with commentary.

For generic capabilities in practice, the educational supervisor will indicate whether the trainee is meeting expectations or not using the global anchor statements above. Trainees will need to be meeting expectations for the stage of training as a minimum to be judged satisfactory to progress to the next training year.

For capabilities in practice relating to Rehabilitation Medicine, the educational supervisor will make an entrustment decision for each capability in practice and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The educational supervisor will also indicate the most appropriate global anchor statement (see above) for overall performance.

Entrustability scales are behaviourally anchored ordinal scales based on progression to competence and reflect a judgment that has clinical meaning for assessors. [14]

Level descriptors for specialty CiPs

Level	Descriptor
Level 1	**Entrusted to observe only** – no provision of clinical care
Level 2	**Entrusted to act with direct supervision**: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3	**Entrusted to act with indirect supervision**: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4	**Entrusted to act unsupervised**

The Annual Review of Competency Progression (ARCP) will be informed by the educational supervisor's report and the evidence presented in the e-Portfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each capability in practice. The panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide.

Poor performance should be managed in line with the Gold Guide.

5.4 Critical progression points

There will be one key progression point at completion of Rehabilitation Medicine training. The outline grid below sets out the expected level of supervision and entrustment for Rehabilitation Medicine training over the indicative four-year training programme.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

The outline grid below sets out the expected level of supervision and entrustment for the specialty CiPs and includes the critical progression point at the end of the training programme.

Table 1: Outline grid of levels expected for Rehabilitation Medicine specialty CiPs

Level descriptors

Level 1: Entrusted to observe only – no clinical care

Level 2: Entrusted to act with direct supervision

Level 3: Entrusted to act with indirect supervision

Level 4: Entrusted to act unsupervised

	Specialty training				CCT
Specialty CiP	**ST3**	**ST4**	**ST5**	**ST6**	**CRITICAL PROGRESSION POINT**
1. Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors	**2**	**3**	**4**	**4**	
2. Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant's own specific service	**2**	**3**	**3**	**4**	
3. Able to work as a full and equal member of any multidisciplinary rehabilitation team	**2**	**3**	**3**	**4**	
4. Able to identify and set priorities within a rehabilitation plan	**2**	**2**	**3**	**4**	
5. Able to diagnose and manage existing and new medical problems in a rehabilitation context	**3**	**4**	**4**	**4**	
6. Able to recognise need for and to deliver successfully specific medical rehabilitation treatments	**2**	**3**	**4**	**4**	
7. Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams	**2**	**3**	**3**	**4**	
8. Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases	**2**	**2**	**3**	**4**	

5.5 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Workplace based assessment (WPBA)

- Direct Observation of Procedural Skills (DOPS) – summative

Formative assessment

Supervised Learning Events (SLEs)

- case Conference Assessment Tool (cCAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)

WPBA

- Direct Observation of Procedural Skills (DOPS) – formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the eportfolio and on the JRCPTB website: www.jrcptb.org.uk.

Assessment should be recorded in the trainee's eportfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

Case Conference Assessment Tool (cCAT)

This tool is specific to Rehabilitation Medicine [15], and captures information focused on skills vital within the specialty: the ability to lead (if necessary) or be a participant in a multidisciplinary meeting; to help set priorities; to communicate with a wide range of

professions and with patients and families; and to manage any conflict or other unexpected events arising in a complex meeting.

This tool applies to meetings that have many names. Some of the names used are: goal-setting meeting; goal planning meeting; discharge planning meeting; review meeting; best interests meeting; emergency meeting to manage a crisis; and case conference. It can and should be used in any multi-professional meeting about a patient, in any context.

The assessor should usually be a doctor, but other assessors are often equally able to give appropriate feedback and should be used. It is vital that detailed feedback is given because the skills required are vital, and being able to lead such meetings is a central capability.

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

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 evaluate 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. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative). A trainee can be regarded as competent to perform a procedure independently after they are signed off as such by an appropriate assessor (summative).

Multi-source 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 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, administrative staff, and other allied professionals. In Rehabilitation Medicine the raters should include a range of people encompassing all the different professions the trainee works with; this may include people from outside the trust/health board, and

outside the health service (e.g. social workers, community occupational therapists). Potential raters should be discussed and agreed with the educational supervisor. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Patient Survey (PS)

A trainee's interaction with patients should be continually observed and assessed. The Patient Survey provides a tool to assess a trainee during a consultation period. The Patient Survey assesses the trainee's performance in areas such as interpersonal skills, communication skills and professionalism.

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT **i**s designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the same quality improvement project by more than one assessor.

Teaching Observation (TO)

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

Supervisor reports

Multiple Consultant Report (MCR)

The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisors report (ESR)

The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR will include the ES's summative judgement of the trainee's performance and the entrustment decisions given for the learning outcomes (CiPs). The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors (MCRs) and formative assessments demonstrating progress over time.

5.6 Decisions on progress (ARCP)

The decisions made at critical progression points should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the clinical and specialty CiPs.

The ARCP process is described in the Gold Guide. Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's eportfolio.

As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal eportfolio review either with their educational supervisor or arranged by the local school of medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

The penultimate ARCP prior to the anticipated CCT date will include an external assessor from outside the training programme. This is known as a Penultimate Year Assessment (PYA) and will identify any outstanding targets that the trainee will need to complete to meet all the learning outcomes.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB will provide an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid will be available on the JRCPTB website: www.jrcptb.org.uk.

Poor performance should be managed in line with the Gold Guide.

5.7 Assessment blueprint

The table below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

KEY

cCAT	Case conference assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
TO	Teaching observation		

Blueprint for WPBAs mapped to CiPs

Learning outcomes	**cCAT**	**CbD**	**DOPS**	**MCR**	**Mini -CEX**	**MSF**	**PS**	**QIPAT**	**TO**
Generic CiPs									
Able to function successfully within NHS organisational and management systems				√		√			
Able to deal with ethical and legal issues related to clinical practice		√	√	√	√	√			
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement				√		√	√		
Is focused on patient safety and delivers effective quality improvement in patient care				√		√		√	
Carrying out research and managing data appropriately				√		√			
Acting as a clinical teacher and clinical supervisor				√		√			√
Specialty CiPs									
Able to formulate a full rehabilitation analysis of any clinical problem presented, to include both disease-related and disability-related factors		√		√	√				
Able to set out a rehabilitation plan for any new patient seen with any disability, this plan extending beyond the consultant's own specific service		√		√	√	√			
Able to work as a full and equal member of any multidisciplinary rehabilitation team	√			√		√			
Able to identify and set priorities within a rehabilitation plan	√	√		√	√				

Learning outcomes	cCAT	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO
Able to diagnose and manage existing and new medical problems in a rehabilitation context		√		√	√				
Able to recognise need for and to deliver successfully specific medical rehabilitation treatments	√	√	√	√	√		√		
Able to work in any setting, across organisational boundaries and in close collaboration with other specialist teams	√	√		√	√	√			
Able to make and justify decisions in the face of the many clinical, socio-cultural, prognostic, ethical, and legal uncertainties and influences that arise in complex cases	√	√		√	√				

6. Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning.

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high-quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

6.1 Supervision

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

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training.

Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.

Clinical supervisor

Consultants responsible for patients that a trainee looks after provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide a MCR for the trainee to inform the Educational Supervisor's report.

The educational and (if relevant) clinical supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the service lead (clinical director) has any concerns about the performance of the trainee, or there are issues of doctor or patient safety, these would be discussed with the clinical and educational supervisors (as well as the trainee). These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

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

Trainees

Trainees should make the safety of patients their first priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.2 Appraisal

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

Induction Appraisal

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

Mid-point Review

This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns, or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal

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

recorded. If there are significant concerns following the end of attachment appraisal, then the programme director should be informed. Supervisors should also identify areas where a trainee has performed about the level expected and highlight successes.

7. Quality Management

The organisation of training programs is the responsibility of the deaneries. The deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees into the specialty
- allocate trainees into particular rotations appropriate to their training needs
- oversee the quality of training posts provided locally
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training.

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by deaneries or by the colleges or both.

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB and the SAC. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

The JRCPTB has a role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. The SACs are actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing applications for new posts and programmes, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its specialties and subspecialties to provide meaningful quality management. The datasets include the GMC national Training Survey (NTS) data, ARCP outcomes, examination outcomes, new consultant survey, penultimate year assessments (PYA)/external advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences.

8. Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. 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 an eportfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the eportfolio

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

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

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

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

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

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

Reflections, assessments and other eportfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-

assessment ratings to record their view of their progress. The aims of the self-assessment are:

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

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

9. Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

Deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- Monitoring of recruitment processes.
- Ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- Deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every three years.
- Deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every three years.
- Ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. Deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual.
- Providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent).

- Monitoring of College Examinations.
- Ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.

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