

Rehabilitation Medicine Syllabus.

Guidance on what a trainee needs to learn.

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Provenance.

This syllabus was initially constructed by a Training Advisory Group under the aegis of the Rehabilitation Medicine Specialist Advisory Committee. It was consulted on widely among consultants and trainees between 17th March and 16th April 2021. The final version was agreed to be a satisfactory syllabus by the Specialist Advisory Committee at its meeting in May 2021. It will remain under review by the committee.

Feedback.

This needs improvement. Any suggestions for additions or removals, suggestions for improvement or any other comments should be sent to the chair of the specialist advisory committee.

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Summary

This is a syllabus for doctors training in Rehabilitation Medicine, and their trainers (Clinical Supervisors, Educational Supervisors, and Training Programme Directors). It is to be used in conjunction with the Rehabilitation Medicine curriculum and its Rough Guide. The curriculum is the definitive document that determines what must be learned and known by doctors wishing to gain a Certificate of Completion of Training (CCT). The Rough Guide interprets and explains the curriculum. The Syllabus outlines 39 competencies that will contribute to the 14 Capabilities in Practice set out in the curriculum.

The purpose of the syllabus is to set out a suggested programme of more specific, tangible knowledge and skills related to the 14 Capabilities in Practice that lead to a Certificate of Completion of Training. The syllabus is a guide. It is not a comprehensive list of everything that must be learned, nor will achieving everything within the syllabus equate to gaining a CCT, nor does not achieving competence equate to failing a capability. It is a formative training and learning aid, not a summative system of assessment. It is for use by trainees and trainers if they wish to use it and find it helpful. Nothing within it is mandatory.

The 39 competencies within the syllabus have been structured into six different domains: research and scholarship (n = 1); rehabilitation process (n = 4); generic capabilities in practice (n = 4); Specialist capabilities in practice (n = 2); across conditions competencies (n = 8 general and n = 7 specific); and condition-specific competencies (n = 13). The competencies are not of equal importance, and do not cover equal amounts of knowledge or skills, and they will not require equal times. Similarly, the domains are not of equal size, and will require different amounts of time and effort.

Performance in each competency can be graded from 1 to 4, with four being at the level needed to be a consultant. The grading system was developed to give trainees and trainers a means to assess how competent a trainee is in an area of practice, to decide whether further learning is needed, and to decide whether progress is being made. Decisions on achieving entrustability in the 14 capabilities will not be based on these syllabus items. Trainees and trainers can choose to use the grading system if they find it useful. It is not part of any required system of assessment.

The syllabus is only a guide, a framework for the trainee and trainer to use in assessing progress, training needs and training goals. Current training programmes will need to be adjusted to enable trainees to achieve the whole range of competencies. The redesign of training programmes is being discussed within the Specialist Advisory Committee. The syllabus should be reviewed formally at each meeting of the Specialist Advisory Committee. Feedback, comments on the syllabus and suggestions for improvement are always welcome.

1.0 PREAMBLE.

Rehabilitation Medicine takes a holistic approach to a patient's problems, and also to the resolution of those problems, in as far as they can be resolved. Success depends upon a considerably broader range of knowledge and skills than in traditional medical specialities, much more akin to that needed in General Practice. Rehabilitation physicians can be described as being 'the expert generalists'.

1.1 *In the not-atypical case of a 45-year-old woman seen six months after traumatic injuries affecting the brain, the left leg, and the face, the doctor may need to call on knowledge about:*

- *effects of facial disfigurement and how they are ameliorated*
- *procedures protecting vulnerable adult, because she has cognitive losses and is being exploited financially*
- *the law in relation to her Mental Capacity to decide about further operations on her leg, carrying significant risk*
- *ethical issues, as her children may be at risk and need protection*
- *drug management of epilepsy, and mood disturbance*
- *housing, as she is at risk of being made homeless through rent arrears*
- *rehabilitation interventions to improve or compensate for forgetfulness*
- *law relating to driving, as she wishes to return to driving*
- *diagnosis and management of worsening right shoulder pain, as yet of uncertain cause*

1.2 *The concomitant skills needed by the doctor include:*

- *understanding the patient's situation **from her perspective***
- *an ability to analyse and formulate the situation to decide:*
 - *priorities among the many problems*
 - *which problems are resolvable, and how*
 - *what professions and organisations are likely to help*
- *being able to diagnose a new musculoskeletal problem*
- *managing epilepsy and mood disturbance*
- *assessing mental capacity and deciding on a person's best interests*
- *accesses and approaching the many different people to might help*
- *how to chair a multi-professional, multi-agency meeting successfully*
- *establishing a constructive relationship with the patient*
 - *understanding her priorities and wishes*
 - *negotiating a plan that maintains her safety, without losing collaboration*

1.3 The range of knowledge and skills that would be useful in rehabilitation is such that it is implausible that any doctor, even after 40 years in the speciality, will know anywhere near everything that is or might be relevant.

1.4 The goal of training in Rehabilitation Medicine, captured in the 14 Capabilities in Practice, is to ensure that a trainee has learned enough to be able to undertake initial management of any patient seen, with all decisions made at the time being safe and constructive. The training programme cannot give a doctor high expertise in all fields of rehabilitation. Consultants acquire increased experience of and interest in particular fields of practice over their professional life-time.

2.0 GENERAL MEDICAL KNOWLEDGE AND SKILLS.

As the work on this syllabus progressed, a not infrequent comment was that “(unspecified) trainees are not able to examine the nervous system, examine joints, manage common medical illnesses” and, on similar lines, “trainees do not know any neurology, anatomy, etc” with the implication that the syllabus needed to cover these basic areas of knowledge and skill.

- 2.1 The curriculum covers the **specialist** areas of expertise needed by a fully qualified and trained doctor to practice in a specific **speciality**. The curriculum assumes that all doctors, including trainees, will learn and maintain their **general professional expertise**.
- 2.2 This aspect of a doctor’s learning and expertise, **general professional expertise**, is covered in the General Medical Council (GMC) guide, “Generic Professional Capabilities Framework”, and in the associated “Generic professional capabilities: guidance on implementation for colleges and faculties.”. These play a central role in all medical curricula. The framework is included within the assessment process within the ePortfolio, and assessments need to be linked to them. More details on professional expertise and the GMC documents are available in Appendix one.
[NOTE: do not confuse GMC Generic Professional Capabilities with curriculum generic Capabilities in Practice.]
- 2.3 The trainee needs to be aware of this professional responsibility and, if their Educational Supervisor or others have concerns about **basic professional competence**, the concerns need to be addressed in relation to the GMC professional guidance. Both the curriculum and the syllabus assume that general professional expertise is established and maintained.

3.0 THE SYLLABUS

The syllabus has been written to facilitate trainees in gaining the **specialist expertise** associated with and leading to being a recognised **specialist** physician in Rehabilitation Medicine.

3.1 Purpose.

The syllabus is intended to offer both trainees and trainers a non-mandatory framework to work within, when considering what the trainee needs to learn to obtain their Certificate of Completion of Training (CCT). It may help the trainee to structure and organise their learning, to evaluate their progress and to discover what they should focus on learning. It may help the trainer to assess what progress is being made, and what remains to be learned.

- 3.2 The primary focus of the syllabus is on learning enough to achieve the eight **specialist** Capabilities in Practice. Nonetheless, both trainee and their trainers need to remember that the trainee must show evidence in relation to the six **generic** Capabilities in Practice. Four competencies in the syllabus do relate specifically to generic capabilities.
- 3.3 The nine GMC Generic Professional Capabilities must also be kept in mind. Apart from Domain nine of the GMC Generic Professional Capabilities, this syllabus does not discuss them. Nonetheless, the syllabus does indicate possible links between each competency and the GMC Generic Professional Capabilities, because this linking will be required by the e-Portfolio.
- 3.4 **Training context.**

Although all trainees should be active in pursuing their own learning, the syllabus recognises that trainees do need guidance, a framework or agenda, to help them identify their specific educational and training needs. Educational supervisors are responsible for guiding, advising, and assessing trainees, and they will also be able to use the syllabus as a framework to ensure training cover similar areas across all training programmes.

- 3.5 The syllabus is **supplementary** to the **curriculum**. The curriculum outlines the higher-level outcomes expected (the Capabilities in Practice), the nature of the expected training programme, and how progress and achievement is assessed. Everything in the syllabus must be read and considered in that context. The syllabus suggests areas of knowledge and skill needed to acquire the necessary **specialist** capabilities. Except for four aspects where particular attention is needed, the syllabus does not cover what is needed to achieve the **generic** capabilities.
- 3.6 The **Rough Guide** (to the **curriculum**) primarily explains and expands on the curriculum. It is not a syllabus. The trainee should consult the Rough Guide for clarification of any aspects of the curriculum that are unclear. If the Rough Guide does not help, then the trainee or trainer should contact the chair of the Specialist Advisory Committee.
- 3.7 The **syllabus** is not a definitive document, and the use of the syllabus and achievement of the competencies are not mandatory. It does not lay out competencies that, if achieved, will automatically lead to someone being entrustable. Conversely, failure to have a particular competency does not necessarily mean that a trainee cannot be considered entrustable. **The syllabus should be used, not adhered to.**
- 3.8 The syllabus does not include everything that might need to be learned. A wise trainee will gain experience and competence in matters that are not specified in the syllabus. The fact that something is not on the syllabus should not and cannot be used as a reason not to gain the experience or learn the competence, especially if advised to do so by an educational supervisor. Conversely, it is not essential that each and every competency should be achieved completely, although most of the competencies will follow naturally from the experience of trainees in their training programme.
- 3.9 The syllabus can neither define all the details that should be learned in a particular area of practice, nor can it define all the areas of practice that should be learned. The syllabus gives a range of indicative and illustrative areas that will encompass perhaps 80% of what is needed.
- 3.10 Trainees in rehabilitation, as in most other specialities, enter with different strengths and weaknesses, and they have different areas of interest. The syllabus illustrates the range of clinical expertise needed to achieve entrustability. Some trainees will already be competent in some areas, on account of previous experience. The trainee and Educational Supervisor can use the syllabus to identify areas needing attention.
- 3.11 **Competency**
The syllabus is centred on competencies, which can be considered as intermediate steps between basic knowledge and skills. For example, knowing the anatomy of the forearm, and also having the skill to inject into a specific muscle, may then lead to one competency, being "*able to recognise and manage spasticity*". This competency would then be one of several that, between them, lead the trainee to be "**Able to recognise need for and to**

deliver successfully specific medical rehabilitation treatments.” (specialist Capability in Practice 6).

- 3.12 For readers familiar with the design of a neural network, the competency is a node between input (knowledge and skills) and output (one (or more) of the 14 Capabilities in Practice).
- 3.13 Each competency is set out in the same way and, as far as possible, a competency is covered in one page, but some require two. The layout is shown in the table below, with explanation of each part. Some competencies will have references (documents, website links etc) to guide the trainees to a starting point or particular piece of knowledge. The list is indicative and advisory; it is neither required reading nor necessarily sufficient reading. As with the whole syllabus, it is guidance.

Table one

The general layout of a competency, with an explanation of each part.

Heading	Comment
Competency	<i>A single sentence specifying the nature of the competence being covered.</i>
Additional	<i>Additional material, if needed, to explain what it is and/or its scope and/or why it is needed.</i>
Behaviours.	<i>Examples of how this will manifest in clinical practice. They should be observable behaviours.</i>
Knowledge	<i>List of indicative pieces of knowledge needed to become competent.</i>
Skills	<i>List of indicative skills (practical activities and abilities) needed to become competent.</i>
Evidence	<i>Suggested types of evidence</i>
Links	<i>Suggestions of the Capabilities in Practice (both generic and specialist) that it is likely to link to, and of likely GMC Generic Professional Capabilities to link to.</i>

3.14 Overall structure of syllabus.

The syllabus sets out 39 competencies that should cover at least 80% of the likely competencies needed by newly appointed consultants.

- 3.15 The range of competencies that the consultant body in the UK cover **as a group** will be much larger, but many will be extensions to these 39 core competencies. At the same time the competencies of **a single consultant** who has been in post for 5-10 years may well not include all of these 40 competencies. A competency that is not used for a few years tends to decline.
- 3.16 It is important to acknowledge that many consultants develop either considerable extra competence in an area mentioned in the syllabus or one or more other competencies (or both). The syllabus can never include all competencies seen in any speciality. Training to gain any additional competencies needed in a post, or to gain greater competency in an existing skill, is the responsibility of the employer who cannot expect a trainee to have exactly the competencies of a retiring consultant.
- 3.17 The competencies are listed in Table two. on the next two pages. They are divided into six groups, A - F. This was necessary to reduce duplication of competencies that are needed

in several different areas. These groups bring together competencies that have something in common. The groups are described briefly in the table. More detail about each group is within the list of competencies. Each competency also has a number, 1-39.

- 3.18 Therefore each competency is identified by group and number; for example, F30 is a **condition-specific** competency, and covers **rehabilitation after trauma**.
- 3.19 It must also be acknowledged that there are no competencies relating to location, such as community rehabilitation, nursing home rehabilitation or hyperacute ward rehabilitation. The curriculum already outlines that trainees need to gain experience in all possible settings. Many of the skills, and much of the knowledge needed in different settings are already included within other competencies. The medical skills needed in hyperacute rehabilitation are covered by the GMC requirement (see Section 2 above).
- 3.20 In other words, the syllabus complements the curriculum, and the curriculum requirements, which are mandated, must be fulfilled. Hyperacute rehabilitation is specifically required “where possible” in relation to trauma rehabilitation.
- 3.21 **Assessment of competency.**
There was, and there continues to be considerable debate about assessing competence. This debate extended into the use of grading. These two debates will be summarised here. If the reader wishes to ignore these debates, go to 3.32 to see the grading system suggested.
- 3.22 **To grade, or not to grade?**
On the one hand, assessing competence could take up an inordinate amount of time, particularly when the results do not, in themselves, influence decisions on entrustability directly. Moreover, although criteria are set out in a way used in several syllabi, they do depend upon judgement and may lead to unhelpful arguments.
- 3.23 On the other hand both the trainee and the trainer need some structured way to assess progress and learning. If there is no guidance on the measurement of competence, the syllabus loses most of its value, because no-one will have evidence that the trainee is, or is not, making progress.
- 3.24 It has been suggested that the grading used in the ePortfolio for most assessments should be used. This is ‘below level expected for stage of training’, ‘at level expected for stage of training’, and ‘above level expected for stage of training’. This approach was rejected for two reasons.
- 3.25 First, the method outlined in 3.24 is entirely subjective with no guidance at all. At least the competency grading suggested has some reasonably clear guidance. It is used in many syllabi.
- 3.26 Second, acquiring many competencies is a relatively short-term affair, and cannot reasonably be judged against expectation over a four-year period. Indeed, it will be necessary to acquire some competencies relatively early in training.
- 3.27 **Use of the grading.**
There was also a concern about how grading would be used.

- 3.28 Initially the expectation was that trainees would document and record competencies as they were agreed by clinical or educational supervisors. It soon became obvious that this was neither practical nor desirable:
- it would take much time and effort if used as a certifiable fact
 - no trainee could achieve all, and there would always be some trainees who could not get adequate exposure to gain some competencies
 - it would discourage active learning, and encourage a passive, 'tick-box' approach
- 3.29 Instead we agreed that assessment and grading of competency is entirely intended to help the trainer and trainee to judge whether the training is progressing satisfactorily.
- 3.30 The assessment and grading system suggested is not intended to be, and it should not be used as, a criterion in relation to capabilities. The evidence on competence is similar to all other evidence (e.g. Work-Based Assessments and Structured Learning Events); to be considered and used and interpreted within the whole body of evidence.
- 3.31 A trainer and trainee can discuss whether the grading system will be a useful marker of progress, and also whether it could be a useful marker of specific areas of weakness, needing attention. It is a **formative** assessment, guiding and improving learning. It is not intended to be and cannot be used as a **summative** assessment.

3.32 **In summary**, we emphasise that the grading of competency:

- is not compulsory
- is not to be used as the sole or predominant determinant of a trainee's capabilities
- is intended to help the trainee and trainer determine
 - what needs further learning, and
 - whether learning is occurring

3.33 **The grading system.**

A systematic approach to the assessment of competency is given in **Table two**. This grading system is adapted from that used in the neurosurgery syllabus, and it is similar to systems used in other syllabuses. The same grading system is used for every competency. The grading is based on three factors:

- a progression in the degree of **complexity** that a trainee can manage;
- a reduction in the extent **supervision** and **support** needed
- an initial emphasis on **knowledge**, a later emphasis on **skills**

3.34 **Training in the syllabus.**

The syllabus simply reflects the curriculum, which has been agreed by all four nations, the General Medical Council, NHS provider Trusts, Commissioners and other organisations. The change in training that will follow from adopting the new curriculum was outlined in the submission; it was required as a part of the submission process.

3.35 Nevertheless, it is recognised that some training programmes may find it difficult immediately to fit in experience in every competency. However:

- the agreed curriculum requires experience across the spectrum of competencies set out
- there are some months left before the curriculum is in force, and some changes in training programmes can be planned

- it is not expected that the trainee will have full-time, prolonged exposure to each major clinical competency (i.e, F27-F39)
- there is a working party developing a more structured national training programme for online use.

3.27 At present it is worth stressing that:

- many of the competencies can be gained in existing programmes; (A1-E26)
- many trainees over the last ten years will have gained exposure to a significant proportion of the condition-specific competencies, so it is possible to do so;
- planning can start, because the curriculum starts in August 2021, and change does not need to wait until the syllabus is agreed;
- there is no formal requirement for a trainee to complete all, or indeed any of these competencies.

3.28 **References and sources.**

The few references are at the end. More importantly, there is a table giving some documents that may guide the trainee. They are selected and limited.

Table three
Descriptors used for all competencies

Level	Level	Exit descriptors: <i>at this level the trainee</i>
A	Has observed, and has performed under supervision.	<ul style="list-style-type: none"> • Has adequate knowledge of the process • Undertakes the whole process with supervision. • Performs some parts of the process with reasonable fluency
B	Does simple cases fluently; has supervision and support.	<ul style="list-style-type: none"> • Knows the whole process, the evidence and reasons that underlie it • Carries out a straightforward process fluently from start to finish. • Demonstrates judgement on when to seek advice from the supervisor (knows own limitations).
C	Completes most cases; distant supervision usually, with direct help rarely.	<ul style="list-style-type: none"> • Adapts to common variations encountered in the process (a skill), without direct support • Recognises and analyses correctly common difficulties encountered during the process. • Manages most of the common difficulties. • Knows and demonstrates when help is needed. • Usually requires advice, not hands-on support
D	Competent alone, including managing unusual events	<ul style="list-style-type: none"> • Manages both straightforward and difficult situations to a satisfactory level, without external input. (a skill) • Competent to the level of a UK consultant. • Supervises trainees.

Table two
Sections and competencies within the Rehabilitation Medicine syllabus.

N	Section	Topic	Comment
A	Research and scholarship (GPC 9)		<i>This is GMC Generic Professional Capability nine, which will be relevant throughout a medical career</i>
1		<i>Finding information when needed</i>	<i>This competency is vital within rehabilitation, because the range of possible diseases, conditions, problems and solutions that may be encountered is huge, and the need to find information will arise frequently, almost daily, throughout a career.</i>
B	Rehabilitation process		<i>This section covers four vital rehabilitation skills needed in all areas of practice: every disorder, every setting, every age, and every patient encounter.</i>
2		<i>Using the biopsychosocial model</i>	<i>A good understanding of the biopsychosocial model is essential. It underlies all effective rehabilitation. The competency includes not only using it in all clinical contexts, but in other contexts such as service management, quality improvement and research</i>
3		<i>Clinical assessment of a patient</i>	<i>This covers the collection of clinical data holistically, to cover all important illness domains, which includes establishing or confirming the disease diagnosis.</i>
4		<i>Full formulation of a patient's situation</i>	<i>Using collected data to analyse the clinical situation, to identify the major areas of importance influencing the situation, and to suggest management options. It is a key analytic skill.</i>
5		<i>Person-centred rehabilitation planning</i>	<i>Delivering a rehabilitation programme tailored to a person's needs, wishes and situation can only happen if the planning process is thorough, and person centred. Many skills are needed.</i>
C	Generic capabilities in practice		<i>These competencies relate to the generic Capabilities in Practice, and cover areas that are not in the generic standards given but are particularly important areas within rehabilitation.</i>
6		<i>Obtaining funding (CiP 1)</i>	<i>An important area of work, this has to do with understanding commissioning within the NHS, and how resources are allocated to a patient, both within and from outside the NHS</i>
7		<i>Ensuring the best interests process is used (CiP 2)</i>	<i>Focuses on Mental Capacity Act and ethical aspects of best interests, use of the ReSPECT approach, etc. Not just as applied to prolonged disorders of consciousness and gastrostomy feeding. Part of daily clinical practice for most consultants.</i>
8		<i>Undertaking quality improvement (CiP 4)</i>	<i>How to identify need, plan, select and manage data etc. This is a vital part of training with its own formal assessment process.</i>

N	Section	Topic	Comment
9	<i>Delivering a teaching programme (CiP 6)</i>		<i>How to identify a need, plan a programme of teaching, set learning objectives etc. More than just delivering a session of teaching.</i>
D	Specialist capabilities in practice		<i>These are competencies that relate directly to specialist Capabilities in Practice, covering areas not specifically covered elsewhere.</i>
10	<i>Use drugs appropriately for common problems (CiP 6)</i>		<i>The ability to use drugs correctly and the ability to review and stop drugs are both vital as many patients accumulate drugs without review. Covering pain, emotional distress, epilepsy and other common medial problems</i>
11	<i>Refer appropriately to other organisations (CiP 7)</i>		<i>Understanding the roles of Department of Work and Pensions, Employment, Housing, Social services, voluntary organisations etc. Additionally, stresses the need to appreciate their individual cultures, and priorities and processes.</i>
E	Across condition competencies		<i>These are competencies arising in many different areas of rehabilitation, are not confined to a particular disease or condition. The first eight are generic rehabilitation treatment competencies; the remaining seven are generic problem-management competencies</i>
	Treatment		
12	<i>Exercise (being physically active)</i>		<i>Exercise with cardio-respiratory consequences is a vital treatment. Knowledge of exercise physiology/types and principles relating to exercise and its benefits</i>
13	<i>Practicing activities</i>		<i>Principles of learning how to undertake activities, both practical and neurophysiological. This is necessary because the patient's ability to learn how to undertake an activity is a central feature of rehabilitation.</i>
14	<i>Psychosocial interventions</i>		<i>Covering areas such as providing emotional support and practical support, and some knowledge of sociology/social psychology, stigma etc</i>
15	<i>Education/self-management</i>		<i>Covering principles of educating and teaching patients, families and others, especially about self-management of their condition. "Learning how to learn and adapt"</i>
16	<i>How to tailor specific intervention</i>		<i>Covering not the 100s of different treatments but how to select and how to monitor the success or otherwise of individual treatments. Requires knowledge of measurement</i>
17	<i>Assistive technology</i>		<i>Advances in technology has transformed the lives of disabled patients, and the advances will continue to do so. A good awareness of how assistive technology can help, and matching patients to technologies is important.</i>
18	<i>Vocational rehabilitation</i>		<i>There are few specialist vocational rehabilitation services (from any source), and being able to advise patients and employers is important,</i>

N	Section	Topic	Comment
19		<i>Palliative/end-of-life</i>	<i>Many patients have progressive disabling disorders that culminate in an early death, and being able to recognise when end-of-life planning is appropriate, and to set out a plan is a necessary expertise.</i>
	Problem-management		
20		<i>Bowel & bladder management</i>	<i>Problems with bowels and bladder occur in many conditions, and awareness of causes, assessments, and principles of management are needed.</i>
21		<i>Chronic pain</i>	<i>Pain, especially chronic pain, is a frequent accompaniment of a disabling illness. A high level of expertise is needed in day-to-day clinical work.</i>
22		<i>Spasticity and its complications</i>	<i>Spasticity is common in many neurological disorders, and it can be difficult to manage. It is associated with contracture and skin breakdown.</i>
23		<i>Sexual dysfunction</i>	<i>Some disabling conditions directly affect sexual function, and disability itself can affect both sexual function and also forming or maintaining sexually intimate relationships. Being competent at recognising and managing these is important.</i>
24		<i>Swallowing/dysphagia</i>	<i>Difficulties with feeding, drinking, swallowing and maintaining adequate hydration and nutrition is common in many conditions, and expertise in diagnosis and management is vital.</i>
25		<i>Communication</i>	<i>Communication is part of everyone's life, but some patients can develop major problems with it. Good ability to analyse the cause of poor communication is important in many conditions.</i>
26		<i>Cognitive dysfunction</i>	<i>Cognitive dysfunction is most common in neurological disabilities, but it is present in many other areas of practice.</i>
F	Condition specific competencies		
27		<i>Neurological rehabilitation – acute</i>	<i>Acute neurological conditions have formed the main area of growth in rehabilitation since about 1970, and is now a significant part of the total inpatient workload</i>
28		<i>Neurological rehabilitation – long-term</i>	<i>The importance of rehabilitation for long-term and often progressive disorders has only been recognised since about 2000; it is now also a significant part of the workload in many services, usually on an out-patient basis.</i>
29		<i>Trauma rehabilitation</i>	<i>Since 2013 all major trauma centres are supposed to have input from consultants in rehabilitation medicine to provide acute (within two days) assessment and advice and to ensure a full Rehabilitation Prescription is issued on transfer out of patients of all ages.</i>
30		<i>Musculoskeletal rehabilitation</i>	<i>Musculoskeletal disorders are one of the commonest causes of disability, and it will also often be present and relevant in people with other disabilities.</i>

N	Section	Topic	Comment
31	<i>Spinal cord injury rehabilitation</i>		<i>Spinal cord injury rehabilitation is currently focused on specialist in-patient units, but in practice some patients never reach the specialist unit, and long-term support may well be a local responsibility. Every consultant needs to be competent in this.</i>
32	<i>Cardiac rehabilitation</i>		<i>Cardiac rehabilitation has been and still is run independently of other rehabilitation services. Nevertheless, cardiac problems are seen in many patients seen with other conditions, and complex cardiac rehabilitation problems may need expert rehabilitation advice.</i>
33	<i>Pulmonary rehabilitation</i>		<i>Pulmonary rehabilitation has also been and still is run independently of other rehabilitation services, but it may become part of rehabilitation services particularly as patients with Covid-19 will need more than pulmonary rehabilitation alone.</i>
34	<i>Rehabilitation in elderly</i>		<i>For many years in the UK, geriatrics was the major rehabilitation service; it was and still is closely involved in much rehabilitation for example with stroke, and Parkinson's disease. And the majority of disabled people are aged over 65 years or even 75 years.</i>
35	<i>Paediatric rehabilitation</i>		<i>Rehabilitation for children is a sub-speciality within paediatrics, but rehabilitation specialists will have much to offer because of their rehabilitation expertise, working collaboratively with the paediatric services.</i>
36	<i>Burns/dermatological rehabilitation</i>		<i>The development of trauma rehabilitation has drawn attention to the need for active rehabilitation input into services managing patients with burns. Rehabilitation expertise could also assist people with other skin disorders.</i>
37	<i>Psychiatric rehabilitation (inc Learning Disability)</i>		<i>This competency covers two related problems: diagnosis and management of emotional distress and disorders; and diagnosis and management of people with challenging behaviours. These problems arise in all areas of rehabilitation.. The causes include psychoses, emotional disturbance and cognitive problems, and learning a structured way to think about behavioural analysis helps in all rehabilitation.</i>
38	<i>Limb loss rehabilitation</i>		<i>This covers limb loss from all causes. Amputation is the commonest, but congenital limb abnormalities are the most challenging area, needing special expertise.</i>
39	<i>Visual and auditory impairments</i>		<i>Though in many ways visual and auditory losses are quite different, for many years 'sensory impairment services' have covered both and often have close links with Social Services. Visual and hearing impairments are common, and are seen in many people with other conditions.</i>

Section A

Research and scholarship

This has been included and placed first, because it is an area of knowledge and skill which underpins all areas of professional practice, generic and specialist, yet it has no specific mention in any syllabus or curriculum as far as we are aware. However, it is required because, to gain a Certification of Completion of Training (CCT), a trainee must perform satisfactorily against the nine domains of the General Medical Council's Generic Professional Capability Framework; this competence is Generic Professional Capability nine.

The term, research, in this context is **not** referring to the specialism of planning and undertaking larger scale systematic studies to advance public knowledge. It is using the term in its earlier sense of searching intensively, primarily to increase the trainee's knowledge and the knowledge of his or her rehabilitation team. It reflects scholarship, 'learning at a high level'.

The trainee who becomes competent in this will find every other aspect of their training, and indeed their whole career much easier.

Continuous learning competency (A1)

Competency	During daily professional work, is able to identify a piece of information needed to improve professional performance, and to find a sufficient answer within 15 minutes
Clarification	<i>This is an essential professional competence, and it covers both clinical and non-clinical matters.</i>
Behaviours.	<p>The trainee:</p> <ul style="list-style-type: none"> • Has insight into the limits of their own knowledge and skills • Identifies gaps in their knowledge/skills during daily professional work • Takes responsibility for learning, to reduce an identified gap in their knowledge or skills • Is familiar with common sources of further information such as medical data-bases, web-sites of specialist societies or condition-specific patient organisations etc • Can undertake a quick search to gain sufficient new information concerning the problem identified • Undertakes a search most working days, sharing findings with team members involved in the index case stimulating the search • Uses the information gained in the situation that revealed the need, if possible. • Approaches other people, within the team or elsewhere, to learn skills
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • Medical data-bases (e.g. Medline) and how to access them • Sources for local, regional or national policies and guidelines • Sources for information on how NHS and other statutory bodies function • The search engines available, both general (e.g. Google) and specific (e.g. PubMed, Google Scholar) • Specific sources of information that exist – journals, voluntary societies, guidelines etc • Who to approach for help, e.g. a librarian
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Identify something that he or she needs to know or be able to do, usually as part of their reflective practice. • Set aside or find time to acquire the information or skill within a few days • Find appropriate source of information or learning quickly • Use key terms and refine a search quickly in the light of what is found • Recognise when has sufficient new information to reduce the gap in knowledge or skills • Able to store and organise any documents downloaded so that can access them easily (e.g. use of Zotero to store them)
Evidence	<ul style="list-style-type: none"> • Reflections on examples of learning and experience
Links	<ul style="list-style-type: none"> • CiPs: generic 5. GPC: domain 9;

Section B
The rehabilitation process.

This has been included because, although in its principal features the rehabilitation process is analogous to the process used in all areas of healthcare, there are sufficient differences in some aspects to warrant special attention.

These differences arise from three inter-related features of rehabilitation:

- its use of the biopsychosocial model of illness; which leads on to:
- its holistic nature, taking all factors into account rather than only the disease and factors directly relating to disease; which leads on to:
- a need to use all evidence to create a formulation; **and**
- rehabilitation’s much greater dependence on multidisciplinary teamwork. (more accurately defined as **multi-professional** teamwork)

The analogies are as follows (rehabilitation on the right):

Medical process	Rehabilitation process	<i>Comment</i>
history and examination	assessment	<i>both involve collecting information</i>
diagnosis	formulation	<i>both are a summary of the situation</i>
management plan	rehabilitation planning	<i>both set out what will be done next</i>

The competencies reflect the use of the biopsychosocial model, and the three phases of the process shown above.

B2

Use of the biopsychosocial model of illness competency

Competency.	Able to use and explain the biopsychosocial model of illness in all situations relating to rehabilitation.
Additional	<i>None</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • Uses the model to analyse and to describe clinical problems • Structures letters, reports and summaries. to ensure all parts of the biopsychosocial model are covered • Explains situations to patients using the model • Structures rehabilitation audit and quality improvement on the model • Teaches on the model and how to use the model • Introduces the model into management and commissioning discussions • Analyses research papers and research data using the model
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • the model’s structure: eight domains (broad groups of items); and quality of life and choice. • the concepts of general systems theory and complexity in relation to the model • examples of how it aids the rehabilitation process • measures of complexity based on the model • use in World Health Organisation’s International Classification of Functioning, Disability, and Health • differences between the four patient-centred domains (levels of description), and the four patient-centred contexts • detailed understanding of the relevance of each domain to rehabilitation • its evolution since 1977 • its contrast with the biomedical model of illness • Its relationship to and influence on goal setting in rehabilitation
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • use and talk about the model without slipping into use of jargon, • demonstrate its utility through use • structure letters and reports using it, without obvious labelling • explain why it necessitates a multi-disciplinary team approach • evaluate a measure’s utility within the model • keep in mind all aspects of the model when considering a difficult problem, not overlooking aspects outside the area of concern (i.e. to be holistic at all times and in all circumstances)
Evidence	<ul style="list-style-type: none"> • all
Links:	<ul style="list-style-type: none"> • CiPs: speciality CiPs 1, 2, 3, 4, 7, and 8 GPC: domain 8

B3
Assessment competency

Competency.	Able to select and use standardised assessment or measurement tools when assessing and managing patients.
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • demonstrates good familiarity with tools commonly used by rehabilitation teams; • finds information about tools used by the team • integrates the use of standard data-collection tools into clinical work; • explains and interprets data derived from tools used by team members; • shows awareness of limitations of assessments used by the team; • reviews tools used and, if a better tool is identified, discusses the new tool with the team; • devises simple measures for patient use in self-management; • selects appropriate assessment and measurement procedures and tools when undertaking audit (and research, if done)
Knowledge	<p>The trainee has a good knowledge or understanding of:</p> <ul style="list-style-type: none"> • Principles of psychometrics: validity, reliability, sensitivity, item response theory (Rasch analysis). • Principles of screening: specificity, sensitivity, predictive value etc., & dependence upon context (prior probability) • Different requirements for use clinically and in audit or research • Measures commonly used locally and nationally; • Measures covering impairment, and disability, both generic and a few disease-specific measures. • On-line data-bases of measures, • Different purposes of assessment: identifying problems, giving a prognosis; measuring change/ detecting differences; determining appropriateness for a specific intervention etc • Practical use in service evaluation or research, • Practical use clinically, evaluating effect of an intervention.
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Find information about tools, new to him or her, being used in a team; • Find a tool suitable for a particular purpose; • Evaluate the suitability of a tool for its proposed use; • Choose a tool, taking into account purpose, patient(s), and feasibility; • Develop a simple personalised measure to evaluate a particular patient's change over time; • Collect assessment information as part of an overall clinical history and examination; • Interpret the results in the clinical context and explain them to others; • Adhere to guidance when using a tool in research or audit; • Adapt a tool to the clinical context
Evidence	<ul style="list-style-type: none"> • miniCEX, Cbd, reflections, clinical documents
Links:	<ul style="list-style-type: none"> • CiPs: generic 5, specialist 2 and 3. GPC domain 2

B4
Formulation competency

Competency.	Able to set-out, verbally and in writing, an analysis of a patient’s clinical situation focused on main problems and the factors that are important in its aetiology or management.
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • states patient formulations clearly, both verbally and in written documents: • specifies the main rehabilitation problems (no more than 4) in any formulation • specifies the main factors relevant to the problems, as part of explanation and/or in determining management, and explains reasons • specifies what other factors were considered or looked for • specifies what areas of uncertainty remain • explains the formulation to the patient, family and other relevant parties (e.g. Social Services care manager) in an understandable way • reviews formulations as time passes and revises them as and when new information arises • includes prognosis within formulation
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • Impairments likely or unlikely to be present with the patient’s disease • Types of impairments that cause the observed or reported disabilities • How combinations of impairments can interact to increase disability • How patient attitudes and expectations moderate/influence disability • How the attitudes and expectations of important others can modulate disability • How the physical environment can cause or can alleviate disability • the prognoses of most common conditions (diseases and associated impairment and disabilities) seen • The general principles underlying prognostication
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Recognise what is important, and what is not important • Appreciate what factors might influence problems and confirm or discount them, based on clinical evidence • explain and justify formulation to anyone, especially the patient and family • summarise a complex formulation verbally and on paper • explain, when giving the formulation, how some factors influence other factors • use the formulation when considering treatments and when setting management goals
Evidence	<ul style="list-style-type: none"> • miniCEX, Cbd, reflections, clinical documents
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 1 and 4. GPC: domain 2

B5

Rehabilitation planning competency

Competency.	Able to participate actively in a rehabilitation meeting about a patient involving different professions and organisations, including leading it.
Additional	<i>None</i>
Behaviours	<p>Note: <i>These apply whether the trainee chairs a meeting, or is a participant.</i></p> <ul style="list-style-type: none"> • When not the chair, the trainee supports the chair as needed, ensuring these “behaviours” of the meeting are met: <p>The trainee:</p> <ul style="list-style-type: none"> • Maintains a focus on the purpose of the meeting, avoiding detours or irrelevant contributions • Minimises repetition of discussion or information • Ensures that all contributions are understandable to, and understood by, all present • Ensuring that all parties treat all other people with respect • Ensures that all parties contribute, supporting less confident or experienced attendees • Summarises, both during the meeting and especially at the end • Sets goals that are important, and are clearly expressed • Ensures that the patient’s interests and perspectives are always considered and given priority • Documents the meeting fully, and then sends copies of the document to all who have an interest.
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • Theories underlying the setting of goals • The knowledge and skills of all professions likely to be involved • The main concerns, interests and priorities of other organisations involved, even if no-one from the organisation is present • Relevant policies, and relevant legal and ethical guidance • Teamwork principles – what makes a good team and how to foster it
Skills	<p>Is able to:</p> <ul style="list-style-type: none"> • Prepare effectively for any planned meeting • Recognise what is important, and what is not important • Engage all team members in the meeting, supporting those with less experience • Handle differences of opinion sensitively, through negotiation and explanation • Demonstrate respect for all points of view • support and facilitate a chair in achieving the meeting’s goals, without usurping their role or causing distress
Evidence	<ul style="list-style-type: none"> • CCAT, miniCEX, CbD, reflections, clinical documents
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 1 and 4. GPC: domain 5

Section C

Generic Capabilities in Practice

The competencies needed for the generic capabilities apply to doctors in all specialities. The descriptions are uniform, as a requirement of the Joint Royal Colleges Physicians Training Board (JRCPTB). However, there are four competencies that are needed by trainees and consultants in Rehabilitation Medicine, that fall within the generic Capabilities in Practice. They are competencies that other trainees in other specialities may not need specifically.

These competencies have been located in a group together, relating to generic Capabilities in Practice as it seems most appropriate to do so. They will all naturally link to one or more generic capabilities. They may link to other, specialist capabilities.

This also should remind all trainees and educational supervisors that links will be needed from other competencies to generic capabilities. These four competencies are necessary but not sufficient.

C6 Obtaining funding competency

Competency.	Able to identify and, if needed, access and use funding streams available for the disability-related needs of rehabilitation patients.
Additional	<i>Covers all aspects of sources of funding, including commissioning</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • Accepts responsibility for helping to obtain funding for patients, and is proactive in obtaining funding • Discusses funding openly with patients and families • Knows about or can find information on funding support from statutory bodies for people who are ill and disabled • Knows about or can find information on funding support from non-statutory bodies, charities etc • Negotiates bureaucracies, finds forms, and completes them • Completes forms promptly, and gives all requested or required information • advocates for rehabilitation patients
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • Continuing Healthcare funding criteria and processes • Other sources of NHS funding – Individual Funding Requests etc (needs to keep up-to-date!) • Main areas of other statutory funding specifically for disabled people – housing, social services, employment support, equipment etc • How to find other sources of funding – e.g. from specific charities,
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Identify funding sources that relate to specific factors about the patient such as their illness, or their current or previous work. • write support letters that are honest while providing supportive evidence clearly and persuasively • think broadly about resources and funding for an individual patient, being inventive within the bounds of honesty • advocate for patients, especially those who are socially disadvantaged and unsupported
Evidence	<ul style="list-style-type: none"> • CbD, reflective entries, individual success
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 and 2, speciality 7 and 8. GPC domains 2 and 3.

C7

Best interests meeting competency

Competency.	Able to set up, chair, negotiate and document a best interests meeting (for a patient lacking mental capacity)
Additional	<i>Needs full understanding and knowledge of Mental Capacity Act 2005. This applies to all decisions, not only major medical treatment decisions</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • always considers whether a patient has adequate mental capacity, when making a major decision with a patient • explains, to families and healthcare professionals, the nature of ‘best interests’ and how they are determined; • ensures that best interests are considered and recorded fully for any major decision in a patient lacking mental capacity to decide • ensures careful preparation occurs before any meeting, if possible • in a meeting deciding best interests: <ul style="list-style-type: none"> ○ works through the process clearly and explicitly ○ gives all important facts in a clear, logical order ○ ensures full engagement of family members, advocates and other non-healthcare staff present, supporting them as needed ○ summarises and ensures understanding of the issues ○ establishes agreement, or clarifies the nature of and reasons for disagreement ○ reaches a clear decision, or plan to reach a decision • produces a clear, comprehensive document after the meeting (either personally, or checking carefully and editing as needed any record kept by someone else) • if a situation arises where conscience or other considerations limits the decisions the trainee can make, declares this and passes responsibility to another clinician.
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • principles of the Mental Capacity Act 2005 • distinction between intentionally causing death, and actions where death is a predictable but unintended consequence <ul style="list-style-type: none"> ○ Difference between euthanasia and not continuing life supporting treatment • nature of Advance Decision, Advance Statement, and Advance Care Plan including ReSPECT document • when and why to involve an Independent Mental Capacity Advocate • General Medical Council guidance of treatment decisions
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • elicit factors relevant to making a decision without causing distress or making any leading or judgemental comments • support people lacking confidence to report facts or express opinions • remain non-judgemental whatever is said • summarise complex issues and discussions clearly and succinctly
Evidence	<ul style="list-style-type: none"> • CbD, CCAT, reflective entries, miniCEX, record of a best interests meeting
Links:	<ul style="list-style-type: none"> • CiPs: generic 2 and 3, speciality 3, 4, and 8. GPC: domains 1, 5, and 7.

C8
Quality improvement competency

Competency.	Able to identify an area needing improvement, negotiate all bureaucratic and other required processes, gain cooperation, identify data needed and obtain it, analyse data, draw a conclusion and write up a report.
Additional	<i>None</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • seeks help and support throughout, engaging all interested parties • liaises with the organisation’s quality improvement department (or equivalent with another name) • is proportionate with the attention and the resource, mostly time, devoted to different parts of the process • retains a focus on the main area of interest • collects appropriate data, planning collection and data handling and analysis before starting • ensures that time and resource for analysis, drawing conclusion, planning next steps, and writing up is identified and accounted for before starting
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • basic principles of standardised data collection, reduction of bias and variation, etc • data protection regulations • principles of handling sensitive clinical data securely • basic statistical analytic techniques • national and local policies governing audit and quality improvement • ethical aspects of quality improvement
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • engage all the staff involved • explain the project to anyone, briefly and clearly • use a structured, methodical approach throughout • see what is important and what is relevant, and to see what is not important • generate an improvement plan based on the data collected
Evidence	<ul style="list-style-type: none"> • QIPAT, documents produced during the project
Links:	<ul style="list-style-type: none"> • CiPs: generic 1, 2, 4, and 5, speciality 3 and 7 GPC: domains 5, 6, and 9

C9

Deliver teaching programme competency

Competency.	Able to construct and deliver a course of teaching on a topic with at least four sessions each of over 20 minutes, with feedback gathered
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • identifies a subject to teach, and an audience for the teaching programme • sets out objectives for the programme • structures the programme to ensure it covers the topic • prepares each session in advance • has appropriate means for collecting feedback • allows time for questions and discussion • delivers teaching in a place and a style appropriate to intended audience • reflects on the feedback and identifies areas to change or improve
Knowledge	<p>The trainee has good knowledge about:</p> <ul style="list-style-type: none"> • the use of Powerpoint and other teaching aids • principles of teaching • sources of advice • different styles and ways of teaching
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • plan a programme as a whole, with a clear overall structure • plan an individual teaching session, with a clear structure and goal • construct clear slides • speak clearly and at appropriate level • vary the style of presentation, uses different techniques • encourage discussion and questions
Evidence	<ul style="list-style-type: none"> • documents about the programme • feedback • Teaching Observation • certificate from a training in educational skills
Links:	<ul style="list-style-type: none"> • CiPs: generic 6, specialist 3. GPC: domain 8

Section D
Specialist capabilities in practice.

Most of the specialist Capabilities in Practice will be linked to many of the competencies, and the links will cover most parts of the capabilities. There are two specialist capabilities that need specific competencies that may not be well-evidenced from the other competencies. Therefore, two specific competencies have been added to bolster the evidence available for these two capabilities.

D10
Use drugs appropriately for common conditions

Competency.	Able to review critically, and to prescribe and deprescribe and monitor appropriately, the drugs used by patients with long-term disability, including liaising with all parties.
Additional	<i>This refers to all medications, not only those related directly to rehabilitation.</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • reviews all drugs taken by any patient when seen for the first time, to: <ul style="list-style-type: none"> ○ minimise total intake of medications ○ simplify and rationalise regimes ○ identify possible side effects/drug interactions of prescribed medications • monitors need for and use of all drugs taken to control symptoms • checks on disease-modifying medications, consulting the BNF or specialist team as necessary • modifies use of drugs in line with increased susceptibility to side-effects (e.g. in patient with neurological condition) • gives clear, written instructions on how to monitor and modify drugs used for variable symptoms • discusses use of or changes in dose of drugs with all relevant members of the team involved • communicates promptly and clearly with the general practitioner about drugs prescribed or changed if the patient is not in hospital
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • alternative, non-pharmacological management options for problems also managed using drugs • benefits, interactions and risks of all prescribed drugs • off-licence use of drugs to control symptoms, • the symptoms that may be controlled by a drug, not mentioned in its licenced indications • basic pharmacology of drugs used, including duration of action • drugs commonly used in rehabilitation practice to control symptoms • difficulties faced by patients in managing and taking complex drug schedules
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Formulate a holistic management plan involving both pharmacological and non-pharmacological treatments • Able to prescribe / advice medication changes with a clear plan including doses, frequency, review date and duration of treatment • explain benefits and side-effects, and principles of self-management of drugs to patients and families • discuss with, and explain drug use to other professions • consider, formulate and advise on flexible, patient-controlled drug dosing where appropriate (e.g. in Parkinson’s Disease)
Evidence	<ul style="list-style-type: none"> • miniCEX, CbD, MSF, patient feedback
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 3, 5 and 6. GPC: domain 2 and 6

D11

Refer appropriately to and work with other services

Competency.	Able to identify and then refer to and engage with other services needed to assist a patient
Additional Behaviours	<p><i>This is both within the NHS, and outside the NHS</i></p> <p>The trainee</p> <ul style="list-style-type: none"> • considers and investigates what other services might be able to assist the patient whenever needs cannot be met • determines whether the purposes and procedures of a potential service will assist the patient • considers any funding or resource implications and, if necessary and possible, plans a solution • initiates a referral providing information tailored to the needs of the service being referred to, and its culture • responds promptly to any requests for more information • responds promptly to any request for support after a service has become engaged • works collaboratively with other services funded externally, if they become involved
Knowledge	<p>The trainee has a good knowledge of</p> <ul style="list-style-type: none"> • the wide range of NHS, statutory, and non-statutory services that may be able to help in rehabilitation, care, or social support • the importance of understanding the service’s perspective when making contact • the funding arrangement for different services • the possibility of external funding from personal injury claims • the guidance appertaining to private case managers and other professionals who may become involved with patients also receiving NHS care
Skills	<p>The trainee is able to</p> <ul style="list-style-type: none"> • search for niche agencies and organisations (e.g. charities) who might help or support a patient • can successfully put the case for a patient to gain the service’s help • communicate pro-actively and consistently with services once engaged • maintain clear, consistent communication with services working jointly, establishing unambiguously who has clinical responsibility for the patient
Evidence	<ul style="list-style-type: none"> • minciCEX, Cbd, letters, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 and 3, specialist 2 and 7. GPC: domain 2

Section E

Across condition competencies

This section covers a range of disorders that are seen in association with many different types of underlying condition. For example, being competent to diagnose and manage pain will be important in almost all areas of practice. This section's contract to the next, and last section – condition-specific competencies – is that these competencies would be included in almost all the condition specific competencies. In contrast, the ability to describe using a standard categorisation the level of a spinal cord injury is unique to spinal cord injury rehabilitation.

These competencies can be and have been sub-divided into two:

- generic **interventions** (E12 – E19), and
- generic **problems** (E20 – E26)

This categorisation of interventions is based, in part, upon an empirical investigation into the effective actions undertaken within rehabilitation which identified five major types (the fifth is actually a 'catch-all' that covers 'everything else', but it is important). The five categories are:

- **exercise**, referring to any activity that uses muscular energy and causes cardiovascular work to increase;
- **practice**, which refers to repeatedly undertaking an activity to learn it. It may, naturally, also be exercise;
- **psychosocial** interventions, which is not easily defined but concerns attention to both the patient's emotional experiences, and to the patient's involvement in social interaction and social activities;
- **education**, which concerns education about the underlying disease or condition, and self-management, how to manage both the underlying condition and all the other consequence including (drug) treatment;
- **tailored** interventions, which refers to any specific intervention that may benefit the patient.

The generic problems selected are based on clinical experience, and on our experience when developing this syllabus, where it became increasingly evident that significant part of one condition's competency requirements were duplicated in another.

Reference

Wade DT.

What is rehabilitation? An empirical investigation leading to an evidence-based description.

Clinical Rehabilitation. 2020;34(5):571-583

<https://doi.org/10.1177/0269215520905112>

E12 Physical Exercise management

Competency.	Able to assess a patient's need for physical activity/exercise and to recommend ways of satisfying those needs that are concordant with the patient's attitudes, interests, circumstances, disability and wishes.
Additional Behaviours	<p><i>This will not usually involve any prescription, or use of a gym.</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • Always uses opportunities within consultations to bring up discussion around physical activity and sedentary behaviour • Checks that advice given is acceptable to the patient, is concordant with their life-style and circumstances, and is achievable. • Usually recommends activities that are part of or an extension of a person's existing range of activities • Considers motivational interviewing techniques, such as measurement of achievements and patient-directed setting and upgrading of goals • Employs available evidence to highlight benefits of exercise • Asks about and discusses any worries about harm
Knowledge	<p>The trainee has sufficient knowledge about:</p> <ul style="list-style-type: none"> • exercise physiology, to be able to advise safely, and explain • WHO and UK Chief Medical Officer physical activity guidelines for various populations: early years (birth- 5years), children and young people (5-18 years), adults and older adults, pregnancy and after pregnancy, and specific disabilities or impairments • General health benefits of initiating/increasing physical activity and reducing sedentary behaviour • barriers to participation in exercise and how to reduce them • Motivational interviewing techniques to elicit behaviour change • relative exercise intensity of different types of daily activity • how to access local exercise locations (gyms, parks, leisure centres) • any resources available to support the person in undertaking exercise • potential risks and adverse effects in different conditions, and how to minimise them • erroneous beliefs commonly held by patients, families, and some professionals, and how to overcome them
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Conducting a 10-minute consultation around benefits of physical activity • motivate people to change behaviour and life-style • tailor advice to a patient' personal characteristics and resources
Evidence	<ul style="list-style-type: none"> • Reflective entries, course certificates, mini-CEX, Cbd
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 3 and 6. GPC domain 4

E13
Activity practice competency

Competency.	Able to advise team, patient and others about benefits of practicing activities, best ways to undertake it, and reasons for the advice given.
Additional Behaviours	<p><i>The emphasis is on understanding why practice is essential and is a core intervention</i></p> <p>The trainee</p> <ul style="list-style-type: none"> • Explains to patient and the family their role in improving performance of wanted activities, referring to reasons and evidence • Normalises practice, emphasising it is not treatment but is part of daily life • Whenever appropriate, uses the team’s approach to facilitating a patient in practicing an activity • Teaches about the evidence-base behind the emphasis on practicing, and the likely theoretical rationale • Gives simple examples to patients and others of the importance of practice in other contexts
Knowledge	<p>The trainee knows about</p> <ul style="list-style-type: none"> • theories of learning, • the importance of feedback in the learning process • practical ways of increasing learning and practice • the impact of disease (neurological) on learning and on the ability to practice • the impact of neurologically active drugs upon the learning process • the impact of emotional state on learning process • motivational techniques to encourage practice
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • match any advice and examples given to the patient’s situation and their beliefs • explain using examples familiar to the listener or audience • be inventive in illustrating how an activity can be practiced more
Evidence	<ul style="list-style-type: none"> • Cbd, miniCEX, Reflections, letters, CCAT
Links:	<ul style="list-style-type: none"> • CiPs: generic 3 and 6; specialist 3. GPC domain 2

E14

Psychosocial management competency.

Competency.	Able to assess for and recognise the presence of emotional and social factors that are impacting on the patient, and to identify the interventions that may help.
Additional Behaviours	<p><i>Includes use of drugs for emotional distress</i></p> <p>The trainee</p> <ul style="list-style-type: none"> • considers, assesses for and asks the patient about emotional changes and problems as a routine • investigates a patient's social context, focusing on factors that may increase disability and/or reduce chance of improvement • discusses these openly with the patient, family, and team members, stressing importance of social contacts • first explores non-pharmacological actions such as <ul style="list-style-type: none"> ○ psychological therapies for emotional problems ○ teaching strategies to improve social interaction and network • explains relevance of identified psychosocial factors • considers the role of drugs for emotional problems, but always <ul style="list-style-type: none"> ○ discusses their benefits and harms with the patient ○ discusses the role of drugs with others involved in managing emotional state, e.g. psychologist or nurse
Knowledge	<p>Has good knowledge of:</p> <ul style="list-style-type: none"> • strengths and limitations of structured questionnaires in identifying emotional distress (mood disturbance; depression, anxiety) • the range of non-pharmacological interventions for improving a patient's emotional state • the extent of interaction between social circumstances and mood and well-being • the risks, benefits, and dosing regimes of psychotropic drugs used • assessment of risk of self-harm and suicide
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • elicit information about emotional state and social circumstances without causing further distress to the patient • be non-judgemental whatever the situation is or whatever information is given • suggest ways to alter and/or increase social networks, engagement and support that are possible without causing offence or distress
Evidence	<ul style="list-style-type: none"> • CbD, miniCEX, reflections, letters
Links:	<ul style="list-style-type: none"> • CiPs: specialist 3, 5, and 6. GPC: domains 2 and 5

E15

Patient education and self-management competency.

Competency.	Able to educate patients and families about all aspects of their illness (not just disease), and able to teach self-management skills.
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • Explains (as appropriate) all aspects of their situation to a patient and family – covering all aspect of the biopsychosocial model if needed • Explains principles of self-management to a patient and family • Teaches a patient how to set their own goals and how to monitor progress (disease, symptoms, activities) • Teaches a patient how to monitor the need for and how to adjust the dose of drugs • Advises on simple, practical ways to measure changes in performance of activities • gives the patient and family guidance as to suitable written materials and websites to learn more about self-management of their condition
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • Principles of self-management, including self-directed setting of goals • Some specific self-management techniques that are effective • Measuring performance using practical simple functional tests • Where to access and/or how to find patient educational materials • Research into effectiveness of self-management
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Be inventive in advising on measurement of activities • Able to explain medical terms and processes to patients so that they understand • Can provide written advice as part of a letter, or on a separate document tailored to the patient • draw up a protocol for the self-adjustment and monitoring of drugs
Evidence	<ul style="list-style-type: none"> • patient feedback or survey, miniCEX, documents (made for patients), reflection
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, speciality 3, 5, and 6. GPC: domain 2

E16

Tailoring specific interventions to patient’s needs.

Competency.	Able to identify and tailor specific interventions for a patient, including, if necessary, an evaluation at a suitable point to determine effectiveness.
Additional Behaviours	<p><i>This applies particularly to medical interventions but covers all interventions</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • considers all aspects of the biopsychosocial model, seeking interventions to help; • thinks flexibly and inventively about possible interventions over and above those used regularly • ensures the interventions within a package for a patient: <ul style="list-style-type: none"> ○ meet as many of the needs as possible ○ are compatible with each other, ○ are consistent with the patient’s wishes, ○ are the most efficient mixture, with no duplication ○ are deliverable; • ensures different parties involved liaise, and coordinate actions • considers critically whether formal evaluation of the effect of any specific action(s) is needed <ul style="list-style-type: none"> ○ if so, plans how and when the effectiveness will be evaluated • changes or stops any intervention found not to be beneficial
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • a wide range of possible interventions covering each domain • simple ways to evaluate outcomes in each aspect of the biopsychosocial model of illness • the evidence about benefits and risks of each intervention, where this is available • where to seek information about interventions for problems that are not being addressed by the existing package
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • research for ideas when a solution is not identified • find evidence of risk/benefit when does not know it • think around a problem • ask others (including patient and family) if they know solutions or have ideas • recognise which problems do not have a solution
Evidence	<ul style="list-style-type: none"> • CbD, reflection, letters, MCR, miniCEX
Links:	<ul style="list-style-type: none"> • CiPs: generic 5, speciality 2, 3, 4, 6, and 8. GPC: domains 2, 5, and 9

E17
Assistive technology (AT) competency.

Competency.	Able to assess suitability of and a patient’s ability to benefit from assistive technology either during rehabilitation or as a long-term support (or both)
Additional	<i>Assistive technology (AT) covers electronic equipment (e.g. environmental controls, communication aids) and all other equipment excluding prosthetic limbs.</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • Assesses both a patient’s disability and their ability to use Assistive Technology aids if needed • Considers use for any patient at any stage in their rehabilitation, as part of a comprehensive plan along with environmental modifications and personal assistance. • Discusses available possibilities and assesses appropriate options with the patient and the team • Identifies resources needed to obtain necessary equipment, if not immediately and freely available • Considers, and discusses with the patient, whether any assistive technology will be used • Ensures that patient (and family if appropriate) is fully taught how to use the equipment • Ensures that any risks are evaluated and reduced as far as possible • Ensures that necessary monitoring and servicing is available
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • NHS England Specification for AT including Electronic Assistive Technology Services (EAT) and augmentative and alternate communication services (AAC) for all ages including patient inclusion and exclusion criteria. • Support and safety goals of technology in leisure, education, employment, those with sensory impairments, cognitive impairments, prosthetics, orthotics, wheelchairs and seating. • Treatment goals of technology, e.g. retraining motor control • The most common diagnoses and disabilities. • EAT in form of environmental control and computer access, Telecare and telehealth services and SMART home technology. • Basic principles of different types of switch activation (e.g. finger, breathing etc), different means of linking switch to equipment (e.g. wire, Bluetooth), different equipment used. • Basic principles behind and workings of most common technologies (both EAT and non-EAT). • Means to support patients with specific losses such as: cognition (e.g. Alarms, pill boxes, timetables); mobility (e.g. sticks, frames); visual loss and hearing loss etc • Risks and harms associated with technologies • Outcome measures for assistive technology.

	<ul style="list-style-type: none"> • Seating and wheelchair systems: types of cushions, head and limb rests, manual and powered systems part of postural management, recline and tilt and space. Pressure relief systems and mapping • Use of orthotics for mobility (e.g. shoes, insoles, fabric braces, orthoses covering one or more joints) • Advances technology use in orthoses (e.g. micro-processors, functional electrical stimulation) • Other uses of orthoses (e.g. for the arm, the spine) • Other types of orthosis (e.g. exo-skeletons)
Skills	<p>The trainee is able to</p> <ul style="list-style-type: none"> • explain both advantages and disadvantages of a technology to a patient • match the patient’s cognitive abilities, dexterity, and other basic skills to the technology to ensure it can be used • Identify suitable point of access to the technology eg direct touch, modified touch, mouse control, voice, eye control, switch, brain computer access. • Ability to perform a seating prescription and develop overall postural management plan with the therapist and seating engineers. • Able to suggest appropriate orthotic prescription for a patient
Evidence	<ul style="list-style-type: none"> • miniCEX, CbD, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: generic 1, speciality 3 and 7 GPC: nil

E18
Vocational rehabilitation

Competency.	Able to give advice on a patient's ability to work, and to liaise with employers and other about adaptations needed in work and in physical environment, and to advise when specialist input is needed.
Additional Behaviours	<p><i>Vocation includes education, and unpaid work</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • enquires about work, education or voluntary work with every patient • formulates a vocational rehabilitation analysis when considering a patient's work • discusses future involvement in vocational activities with any patient who might be able to participate in a vocational activity • establishes the nature of any vocational activity discussed, establishing its physical, cognitive, and communicative demands • liaises with occupational health physicians if they are involved • refers to Department of Work and Pensions for any allowances and support that may be available • discusses unpaid voluntary activities or other meaningful leisure activities for anyone previously in work and unable to work
Knowledge	<p>Has a good knowledge of:</p> <ul style="list-style-type: none"> • the 'flag system' to formulate obstacles to working • legislation applying both to the employer and employee, such as the Health and Safety at Work Act, and the Equality Act • the roles and responsibilities of other professionals such as occupational medicine, occupational health, Job Centre Plus, social work • the relationship between work, health and wellbeing, and some of the evidence in this area. • range of financial, rehabilitative and other help available • assistive technologies that may facilitate vocational activities • rules about medical conditions such as epilepsy, and work including driving
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • Takes a detailed educational and occupational history identifying potentially transferable skills • assess readiness for vocational rehabilitation, has an understanding of motivational interviewing along with other psychological models and their role in vocational rehabilitation • identify specific areas for rehabilitation related to a work requirement or task, such as insight building, work hardening, fatigue management, cognitive strategies, managing communication and relationships with colleagues, as well as functional tasks and adapting to physical issues • apply results of formal assessments to the patient's work • explain to employers the nature of a patient's problems and needs • explain to the patient what changes may be needed in work activities

	<ul style="list-style-type: none">• balance the benefits of work against the extra demands that may be made on the patient to ensure a satisfactory work-life balance
Evidence	<ul style="list-style-type: none">• miniCES; Cbd, CCAT, reflective entries
Links:	<ul style="list-style-type: none">• CiPs: generic 2, specialist 7 GPC: domain 2

E19
Palliative care

Competency.	Able to recognise when primary end-of-life and palliative care is the priority and to initiate appropriate treatments.
Additional Behaviours	<p><i>Palliative approaches should be applied within all competencies</i></p> <p>The trainee</p> <ul style="list-style-type: none"> • recognises when it is appropriate to move into end-of-life care • discusses and encourages advance care planning with most patients (e.g. use of ReSPECT process) • palliates symptoms associated with long-term disorders • palliates symptoms associated with end-of-life, including when withdrawing treatment (e.g. gastrostomy feeding) • shows awareness of ethical aspects of end-of-life care • respects the cultural, religious and personal beliefs and expectations of the patient and their family • seeks advice from and involvement of specialist palliative care services when needed • works within national and local policies and laws
Knowledge	<p>The trainee has good knowledge of</p> <ul style="list-style-type: none"> • guidelines and policies concerning stopping life-prolonging treatments, specifically <ul style="list-style-type: none"> ○ BMA/RCP guidance 2018 • spirituality, and attitudes associated with major religions • drugs used to alleviate distress and other symptoms associated with dying • role of counselling and other support services • resources available to people who wish to die, or are dying, at home • legal responsibilities when a person requests assistance with suicide or a person or family request euthanasia • legal aspects of donating bodily organs • funding arrangements to support end-of-life care at home • fundamental aspects of making a will and witnessing a will
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • initiate and undertake discussions about future wishes without causing distress or threatening a professional relationship • support family and staff as needed • use palliative drugs, including different modes of delivery • manage people with a prolonged disorder of consciousness
Evidence	<ul style="list-style-type: none"> • miniCEX, BbD, reflective entries, MSF
Links:	<ul style="list-style-type: none"> • CiPs: generic 1, 2, and 3; specialist 6, 7, and 8. GPC: domain 2 and 5

E 20

Bowel and bladder management competency

Competency.	Able to assess, to provide advice about, and to manage neurogenic bladder and bowel dysfunction
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • Recognises the impact of bladder and bowel dysfunction on the patient's quality of life • Consults with colleagues from other specialties in determining a management strategy. Liaises with the wider team about management options. • Reviews the underlying pathophysiology in a systematic manner based on the aetiology • Ensures reversal or treatment of any remediable factors • Actively investigates the patient's wishes and circumstances in determining treatment options • considers the need for regular surveillance to avoid complications • ensures appropriate follow-up or patient self-referral as determined by the potential for fluctuations in bowel/bladder dysfunction
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • Pathophysiology of neurogenic bowel and bladder dysfunction. • appropriate bladder management to reduce risk of upper renal tract damage. • Influence of gender and age on options for bladder management • Different options for maintaining bladder and bowel continence • Complications, short and long term, relating to neuropathic bladder and bowel dysfunction • Pharmacological options for managing neuropathic bladder and bowel dysfunction. • Non-pharmacological options for managing neuropathic bowel dysfunction including surgical options. • Diagnosis, management and reduction of risk of urinary tract infection • Understanding of the role of investigation and surveillance including urodynamics in managing neuropathic bladder and bowel dysfunction
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Advise on suitable options for bladder and bowel management • Liaise with colleagues in formulating a suitable management plan • Arrange investigation, interpret investigations and modify treatment plans appropriately correlating with the clinical situation • Prescribe suitable medications to improve bladder and bowel management • Educate patients and carers on bladder and bowel management. • Refer appropriately to specialists when necessary while maintaining overall responsibility for rehabilitation and long-term care
Evidence	<ul style="list-style-type: none"> • miniCEX, CbD, MSF, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 5 and 6. GPC: domain 2

E21
Chronic pain

Competency.	Able to assess severity and nature of chronic pain, identifying precipitating and maintaining factors, and planning a systematic and multi-modal approach to its management
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • takes a comprehensive history giving appropriate attention to all contextual factors, beliefs and expectations, and previous treatments • discusses, openly and non-judgementally, the patient's own understanding of the cause and significance of the pain • diagnoses any specific, treatable surgical or medical cause • does not over-investigate, or focus excessively on looking for specific biological causes • shares with the patient and relevant others a holistic formulation of the chronic pain, clearly but showing understanding of and respect for the patient's position • outlines and discusses a systematic approach, using several different types of intervention in most cases • determine the potential for rehabilitation
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • the complex and multi-factorial nature of chronic pain • the evidence (also limited) concerning the effectiveness of behavioural and other techniques like physical modalities • some pain assessment tools, and their limitations • drug rationalisation, and reduction and withdrawal of opioid drugs • the 'placebo' response • the indications, contraindications and (in)effectiveness of the following interventions for chronic benign pain: <ul style="list-style-type: none"> ○ drugs: non-narcotic and opioid analgesics; anti-depressants, anticonvulsants, and major tranquillisers; steroids ○ procedures: local anaesthetic locally and regionally, sympathetic blockade, epidural and intrathecal injections
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • take a comprehensive history of the patient's pain and disabilities related to it • elicit information about non-pain issues in a non-threatening manner • identify common neuromusculoskeletal types of chronic pain and cancer pain • give an explanation and management strategy at variance with a patient's expectations while still retaining a good clinical relationship • manage drugs without causing distress • write a rehabilitation management plan specifying further medical and rehabilitation treatments in appropriate treatment venues, with particular emphasis on: the roles of psychological interventions, appropriate drug therapy, functional restoration
Evidence	<ul style="list-style-type: none"> • miniCEX, CbD, MSF, patient Feedback, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 1 and 6. GPC: domain 1 and 2

E22
Spasticity and its complications

Competency.	Able to identify spasticity and its complications, to determine its causes, and to formulate a goal-directed, patient-centred plan, including pharmacological, surgical and non-pharmacological aspects.
Additional Behaviours	<p><i>Includes spasms associated with spasticity, contractures and skin breakdown</i></p> <ul style="list-style-type: none"> • Distinguishes spasticity from other movement control disorders (dystonia, chorea, epileptic seizures, myoclonus) • Looks for and identifies factors causing or exacerbating spasticity • Evaluates severity and significance to the patient in a systematic way, using measures if needed • Generates a management plan (strategy) including non-pharmacological or invasive actions, involving the whole team • Looks for direct complications such as contractures, skin breakdown and pain • Reviews ongoing use of drugs, including botulinum toxin, to confirm that benefits outweigh harms and costs • Identify goals of treatment and able to use appropriate outcome measures to monitor response to interventions • Able to support teams in the community to manage complex spasticity patients
Knowledge	<p>Has a good knowledge of:</p> <ul style="list-style-type: none"> • the neurophysiological and neuroanatomical basis of spasticity • the clinical, neuro-anatomical and neurophysiological basis of other movement disorders • the pharmacological basis of the specific drugs used to manage spasticity • the role of factors influencing the nature and severity of spasticity • the evidence concerning the management of contractures • the use of more invasive treatments such as intra-thecal baclofen, and phenol injections, together with the risks and benefits • the importance of postural management and preventative procedures in severe or long-term spasticity • limitation of pharmacological and non-pharmacological interventions • role of surgery including selective neurectomies, tendon lengthening, tendon transfers, contracture release, joint fusions etc. • use of botulinum toxin injection using ultrasound guide/EMG/NS techniques.
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • assess for, give, and evaluate the effects of botulinum toxin injections • measure spasticity and its effects using simple standard measures • explain to a patient how to self-manage spasticity including titration of drug doses • reduce and withdraw medication without precipitating problems
Evidence	<ul style="list-style-type: none"> • DOPS (botulinum toxin); miniCES, CbD, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, 4 and 5; specialist 2, 3, and 6 GPC: domain 2 and 6

E23
Sexual dysfunction

Competency.	Able to ask about, diagnose, and suggest management strategies for sexual dysfunction and/or disturbance in intimate personal relationships associated with disability.
Additional Behaviours	<p><i>Covers more than just direct sexual physiology.</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • explores concerns about sexual relationships and function in a sensitive but unambiguous manner • is always non-judgemental about and respectful of a patient’s wishes, concerns, and choices • shows awareness of the multifactorial nature of sexual dysfunction, explaining this clearly to the patient (and his/her partner if appropriate) • does not focus entirely on one aspect, especially not solely on physiological functioning • always considers effects of drugs, emotion, previous sexual history (including abuse), associated motor or communication disorders or incontinence • makes no assumptions; always confirms that his/her understanding is correct • recommends appropriate psychological, pharmacological, behavioural or other interventions • consults with and/or refers to other services or agencies as needed
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • neuro-physiological and contextual and psychological factors associated with sexual functioning • other resources available to support a patient with relationship problems, especially if long-standing • aware of risks and benefits of specific pharmacological and other treatments • availability of sperm and egg storage services • risks commonly assumed to be associated with sexual activity • evidence concerning risk associated with pregnancy in the patient’s condition • evidence concerning risks associated with medication • relationship services available
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • ask about and discuss sexual and relationship matters naturally • explore psychological aspects sensitively
Evidence	<ul style="list-style-type: none"> • miniCEX, CbD, reflective entries, patient feedback
Links:	<ul style="list-style-type: none"> • CiPs: generic 3. specialist 5 and 6 GPC: domain 1 and 2

E24
Swallowing and dysphagia

Competency.	Able to assess swallowing to identify problems, able to coordinate interventions, to give general advice, and to manage pro-actively possible decisions concerning assisted nutrition and hydration.
Additional Behaviours	<p><i>Covers all feeding, not just use of gastrostomy feeding</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • asks about and discusses feeding, swallowing, nutrition and hydration as a routine • performs a safe simple direct assessment if needed • Looks for evidence of medical complications resulting from swallowing impairment e.g. aspiration, recurrent respiratory infections • initiates discussions about future wishes in any patient at risk of developing swallowing and feeding difficulties <ul style="list-style-type: none"> ○ documents the results of any discussion clearly • seeks specialist assistance from (usually) dieticians and speech and language therapists as needed • coordinates interventions to manage to swallowing difficulties • shows awareness of the broader aspects of feeding – social, pleasure, gratification, control over others etc • initiates a team review and, if the patient lacks capacity, initiates a best interests meeting on any patient where naso-gastric or gastrostomy feeding is being considered • reviews use of enteral feeding in people lacking capacity on a regular basis, at least once a year
Knowledge	<p>Has good knowledge of:</p> <ul style="list-style-type: none"> • the neurophysiology and neuro-anatomy of swallowing, and its disturbance • Prognosis of swallowing impairments based on clinical features and pathology • the speech disorders, cough impairment and other clinical features that may be associated with dysphagia • Pharmacological therapy for secretion management • Indications for and role of formal specialist investigations including video fluoroscopy studies and fiberoptic endoscopic evaluation of swallowing • the social, emotional and motivational aspects of feeding • the legal and ethical aspects of enteral feeding • the process of inserting naso-gastric and gastrostomy tubes
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • perform, safely, a simple test of swallowing • Clinically evaluate complications resulting from swallowing impairment • Identify and address any factors that are impacting on swallow (e.g. sedating/ muscle relaxant drugs, reversible pathology such as hydrocephalus)

	<ul style="list-style-type: none">• Assess and coordinate interventions for dysphagia e.g. medical interventions for respiratory secretions/sialorrhea• initiate discussions about the broader aspects of swallowing and feeding difficulties• recognise when disturbed swallow mechanisms may not be the primary problem• Able to lead a best interest discussion on future feeding in patients with swallowing difficulties
Evidence	<ul style="list-style-type: none">• miniCEX, CbD, MSF, patient feedback, reflective entries, letters
Links:	<ul style="list-style-type: none">• CiPs: generic 1, 2, 3 and 4; specialist 2, 3, 4, 7 and 8. GPC: domain 1, 2, 3, 5, 6 and 7

**E25
Communication**

Competency.	Able to assess and analyse any communication disorder to discover its nature and cause, and able to suggest most probable methods for the patient to improve communication.
Additional	<i>Relates to all communication, including but not limited to language disturbance</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • distinguishes accurately between disorders of language, general cognition, and speech production • establishes some form of communication with anyone who is not unconscious • uses terms dysphasia, dysarthria, dysphonia correctly (could be ‘a’ not ‘dys’) • recommends appropriate management strategies for patients with communication difficulties • checks for presence of the impairments most likely to be associated with the specific communication disorder • explains to, and educates family and others involved about the nature of the communication disorder • refers to a speech and language therapist (or psychologist if primarily a cognitive dysfunction) for detailed assessment and advice • considers role of communication aids, discussing ones appropriate for the disorder
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • neurological and neuroanatomical basis of language disorders <ul style="list-style-type: none"> ○ and the impairments associated with them • neurological and neuroanatomical basis of articulatory and phonation disorders <ul style="list-style-type: none"> ○ and the impairments associated with them • ways to improve communication with people with a communication disorder • the range of low-tech and high-tech aids to communication • distinction between communication difficulty and lack of mental capacity • when communication aids can, and cannot help
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • distinguish language disorders from articulatory and phonation disorders <ul style="list-style-type: none"> ○ aware of apraxia of speech and how it might be distinguished • explain clearly to families and others the nature and cause of most common communication disorders • communicate effectively with most patients with a communication disorder
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, MSF, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: generic 3, specialist 1 and 3. GPC: domain 2 and 7

E26
Cognitive dysfunction

Competency.	Able to assess general cognitive functioning, including different domains, and able to set out a strategy or further investigation and management.
Additional Behaviours	<p><i>This is in any patient, not just those with a neurological disability.</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • always considers and documents (in some way) a patient’s overall cognitive level, with particular reference to <ul style="list-style-type: none"> ○ previous, usual level of function, including opinion of family ○ complaints about cognitive function ○ mental capacity to make major decisions, if possibly altered • assesses in detail, when needed, to establish function in various domains (e.g. memory, problem-solving, initiation, planning) • uses, when appropriate, a short formal assessment (e.g. Montreal Cognitive Assessment) • explains cognitive losses to patient and family • arranges formal assessment when appropriate • considers implications of any cognitive dysfunction for rehabilitation, for safety and for decision-making • assesses Mental Capacity formally when necessary • reviews all drugs for their impact on cognition • uses, and shows awareness of, simple techniques to support a patient’s cognitive function • advises family, and team members if necessary, on simple ways to support the patient
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • strengths and weaknesses of short screening assessments • strengths and weaknesses of more formal detailed assessments • impact of emotional distress, fatigue, and motivation on performance on tests used, and on general function • impact of drugs on cognition • techniques to support the safety and function of a patient with cognitive dysfunction • evidence concerning effectiveness of various rehabilitation strategies • main domains of cognition usually considered (e.g. memory, attention, perception, planning etc)
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • incorporate a more formal cognitive screening assessment into a standard clinical history and examination • communicate effectively with a person with moderate cognitive loss • explain nature and extent of cognitive loss to patient and family clearly and sensitively • assess cognition without causing distress to the patient and family • recognise uses and limitations of detailed cognitive assessment
Evidence	<ul style="list-style-type: none"> • miniCEX, CbD, MSF, letters
Links:	<ul style="list-style-type: none"> • CiPs: generic 3 and 4, specialist 1, 3 and 8 GPC: domain 2 and 7

Section F
Condition specific competencies

This, last section considers specific clinically-defined areas of practice that are primarily defined by medical, disease diagnosis. This follows the traditional approach to classifying health services, being based around disease categories or age. Although there is much more to rehabilitation than simply knowing about rehabilitation of patients with a particular class of disease, it is still important to know about particular diseases.

The range of conditions outlined is much more that has traditionally and historically been included in Rehabilitation Medicine training previously (2007 and 2010), as outlined in curricula in 2007 and 2010. The range is also wider than has been part of some contracted, specified services up to 2020. Nonetheless, many of these areas have been covered by some services and, as long-Covid demonstrates, a very broad range of training is needed. Trainees will need a much broader range of knowledge and skills than in the past.

Many of the competencies needed within these conditions have been covered in the 26 competencies already outlined.

The content of the competencies outlined here should be read in the context of the following assumptions:

- **the 26 competencies already outlines are achieved**
- **a referral has been made for rehabilitation, and the patient's disease-specific diagnostic and treatment needs are being or have been satisfied (which is not to say that the Rehabilitation Medicine trainee has no responsibility in that sphere, but it is not their primary concern)**
- **the behaviours, knowledge, and skills specified are those needed specifically for the condition or patient group concerned**

F27
Acute neurological rehabilitation

Competency.	Able to assess rehabilitation needs of, give rehabilitation advice about, and take rehabilitation responsibility for any patient with an acute-onset neurological condition, from its onset.
Additional	<i>Concerns these patients until their initial rehabilitation episode ends; longer-term rehabilitation input is included in competency F28</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • writes a clear letter after initial assessment, copied to the GP • gives an outline of possible rehabilitation needs and prognosis, emphasising uncertainty and giving upper and lower bounds to any prognosis • follows a patient through their acute medical or surgical phase, until patient is transferred or dies or is discharged <ul style="list-style-type: none"> ○ undertakes follow-up if discharge with any problems outstanding • assesses the psychological, emotional and social aspects of each patient, • liaises with both the acute team and the rehabilitation team about the patient before and after transfer of responsibility • sees family members at initial assessment, or as soon as possible after • monitors for and manages any specific neurological complications • seeks advice from disease-specialist service when needed • assesses a patient's level of cognition, or awareness and consciousness fully and documents it • considers, from the outset, mental capacity and the need for a best interests approach.
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • medical and prognostic aspects of commonly-seen acute neurological conditions – stroke, hypoxic injury, infections, traumatic brain injury, encephalitis, meningitis etc <ul style="list-style-type: none"> ○ including likely complications and secondary prevention • epileptic seizures – diagnosis and treatment • Headaches - diagnosis and treatment • Dizziness\vertigo - diagnosis and treatment • Management of challenging behaviour • value of further investigation – when needed or not needed • support organisations for patient and families • appropriate measures of cognition (e.g. Montreal Cognitive Assessment) and consciousness/awareness (e.g. Coma Recovery Scale – Revised) • guideline on management of people in a prolonged disorder of consciousness
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • diagnose and manage most complications safely and independently • judge when it is appropriate to seek specialist help (outside rehabilitation) or to undertake investigation • discuss uncertainties with families and the team clearly

	<ul style="list-style-type: none">• estimate prognosis and rehabilitation needs from a relatively early stage• manage common neurological problems, such as anti-convulsant medication for epilepsy
Evidence	<ul style="list-style-type: none">• miniCEX, CbD, letters after assessment, MSF, patient feedback
Links:	<ul style="list-style-type: none">• CiPs: generic 1, 2, 3 and 4; specialist 1 to 8 GPC: domain 1, 2, 5 and 6

F28

Long-term neurological rehabilitation

Competency.	Able to assess rehabilitation needs of, give rehabilitation advice about, and take rehabilitation responsibility for patient with a long-term neurological condition from its onset or when became long-term.
Additional Behaviours	<p data-bbox="336 412 1091 450"><i>Includes post-acute phase, and includes spinal cord injury</i></p> <p data-bbox="336 456 504 483">The trainee:</p> <ul data-bbox="336 495 1342 1644" style="list-style-type: none"> • establishes time course of the condition prior to first contact • reviews the diagnosis critically, with focus on the initial symptoms and any diagnostic tests undertaken • establishes rapport with patient/family and carers in the consultation • assesses the physical, psychological, emotional and social aspects of long-term neurological conditions on patient, family and care providers • encourages self-management through education, providing written support, using remote consultation when needed etc • provides support and education to family and carers • considers and is alert to evidence of abuse including physical, psychological, financial, over-medication abuse etc • reviews medication in every consultation. • reviews diagnosis of any new symptoms or problems, and investigates or refers to an appropriate specialist if required • discusses advance care planning at an early stage • supports patient, family, carers, GP and other teams in the community • supports the patient, family and care team when patient admitted to a new setting (e.g. hospital, care home) • liaises closely with all other services and people involved with the patient • identifies need for other specialist input including neurology, orthopaedics, orthotics etc. • liaises with local paediatric teams about transition of young adults • encourages patients and GPs to make contact for help/advice when needed • encourages self-management by the patient and carers
Knowledge	<p data-bbox="336 1650 868 1684">The trainee has a good knowledge of:</p> <ul data-bbox="336 1695 1342 2083" style="list-style-type: none"> • Medical and prognostic aspects of commonly seen long-term neurological conditions <ul data-bbox="373 1771 1342 1845" style="list-style-type: none"> ○ including any likely developments needing intervention ○ and prognostic factors for rate of decline and death, where known • where to find information about less common conditions • local specialist and/or non-statutory services likely to be needed • nursing homes and other resources used by the patients locally (e.g. day centres, support groups) • use of disease modifying agents in those diseases with them • 'alternative' therapies likely to be tried

	<ul style="list-style-type: none"> • DVLA guidelines and availability of driving mobility assessment centre in the local area • self-management • guidance on long-term management of prolonged disorders of consciousness
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • maintain a good patient relationship over time • explain uncertainty about the future in a sensitive, unambiguous way • assess and manage common problems (e.g. pain, spasticity, bladder and bowel dysfunction) see E20, E21, E22 • identify when goal-based inpatient rehabilitation is needed • identify vocational needs, psychological issues, sexual and relationship issues etc and refer them to appropriate services. • discuss risks and harms of unproven alternative therapies in a factual but non-judgemental manner
Evidence	<ul style="list-style-type: none"> • miniCEX, Cbd, MSF, patient survey
Links:	<ul style="list-style-type: none"> • CiPs: generic 1, 2, 3 and 4; specialist 1 to 8 GPC: domain 2, 5 and 7

F29

Trauma rehabilitation (including hyper-acute rehabilitation)

Competency.	Able to assess rehabilitation needs of, give rehabilitation advice about, and take rehabilitation responsibility for any patient in the early days and weeks after trauma.
Additional Behaviours	<p><i>Longer-term rehabilitation is covered in other condition-specific competencies</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • takes a systematic approach to identifying and assessing a patient's injuries and needs when first assessing a patient • liaises closely with all other (trauma) services involved with a patient at all times; <ul style="list-style-type: none"> ○ including with trauma rehabilitation team and specialist centre team if likely to be involved • documents assessment, advice, plan and actions undertaken clearly in the Rehabilitation Prescription and/or in a letter • sees the family to obtain and to give information at an early stage • assesses the psychological, emotional and social aspects of each patient, • makes appropriate onward referrals • acknowledges uncertainties about prognosis openly • ensures the Mental Capacity Act is adhered to in all major decisions • ensures that shared clinical responsibility is clearly delineated, if responsibility is shared
Knowledge	<p>Has a good knowledge of:</p> <ul style="list-style-type: none"> • Definition of major trauma using the Injury Severity Score • Organisation and models of major trauma rehabilitation services • Role of Trauma Audit Research Network (TARN) • The relevance of primary, secondary and tertiary survey for major trauma survivors • Physiological and psychological consequences following major trauma injuries • Relevance of structured Rehabilitation Prescriptions in major trauma. • Traumatic brain injury classification systems, and their weaknesses • Complications of traumatic brain injury including neurological, autonomic, endocrine, behavioural and cognitive • diagnosis and management of confusion, delirium, and agitated behaviour in early phases after trauma • acute withdrawal problems from drugs including alcohol, and their management • Post traumatic amnesia, and its clinical features • Indications and complications of acute neurosurgical and medical interventions for traumatic brain injury • Post-traumatic seizures prognosis and management • Consequences of prolonged intensive care stay • Diagnosis, prognosis and management of traumatic plexopathies and peripheral nerve injuries • Tracheostomy management in hyperacute settings • Complications and management of spinal cord injury in acute phase

	<ul style="list-style-type: none"> • Principles of fixation, mobilisation and damage control orthopaedics following musculo-skeletal injuries • Complications of orthopaedic interventions • Classification of pelvic, spinal and limb orthopaedic injuries • Orthoplastic staged surgical intervention options for open fractures and principles of rehabilitation • Management and complications of solid organ and hollow viscous injuries • Nutritional management following major trauma injuries • Rib fracture classification and management options • Management of blunt and penetrating cardiothoracic injuries and complications of surgical interventions • Principles of rehabilitation following traumatic amputation • Principles of traumatic wound management • Driving restrictions following major trauma injuries • guidance on safe early mobilisation, and any specific precautions needed in most common injuries • standardised rehabilitation assessments recommended
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • Assess major trauma patients to identify their rehabilitation needs • Complete the specialist rehabilitation prescription • Assess and manage common sequelae of traumatic brain injury in the hyperacute setting including post-traumatic amnesia, paroxysmal sympathetic hyperactivity, electrolyte disturbances, seizures, neurobehavioural disturbances and hydrocephalus • Assess and manage traumatic spinal cord injury in the hyperacute setting including application of the ASIA Impairment Scale • Assess traumatic plexopathy/peripheral nerve injuries and initiate appropriate investigations • Assess traumatic musculoskeletal injuries and initiate appropriate investigations • Assess and coordinate tracheostomy weaning in hyperacute settings • Assess patients with traumatic amputation and advise on initial management and prosthetic rehabilitation • work with the major trauma multidisciplinary rehabilitation team • Liaise with other specialities involved in the care of patients • see and discuss the possible long-term outcomes from an early stage, while acknowledging any realistic uncertainty
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, reflective entries, Rehabilitation prescriptions
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 to 4; specialist 1 to 8. GPC: 1, 2, 3, 5, 6 and 7

F30
Musculoskeletal rehabilitation

Competency.	Able to assess rehabilitation needs of, give rehabilitation advice about, and take rehabilitation responsibility for any patient presenting with any acute or longer-term musculoskeletal condition
Additional	<i>Includes congenital and genetically determined conditions, and chronic spinal and musculoskeletal pain</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • assesses musculo-skeletal function in a systematic manner • assesses pain in a systematic way, always covering psychological and social aspects • assesses the psychological, emotional and social aspects of each patient, especially patients with non-inflammatory disorders • uses non-pharmacological approaches to pain where possible • does not use opiates except, very rarely, as an immediate and short-term treatment • reviews need for and doses of disease-modifying drugs • refers to and liaises with surgeons appropriately • encourages self-management techniques and appropriate changes in life-style • seeks advice from disease-specialist service as appropriate
Knowledge	<p>The trainee knows:</p> <ul style="list-style-type: none"> • epidemiology, aetiology and assessment of: <ul style="list-style-type: none"> ○ Inflammatory joint disease (rheumatological disorders, seronegative arthritides) ○ Degenerative joint disease (osteoarthritis, post-traumatic arthritis, chronic back pain and spinal conditions) ○ Musculoskeletal injuries and sports related injuries (ligament sprains, tendon injuries, fractures) ○ Soft tissue conditions (impingement syndrome, hemiplegic shoulder syndrome, trochanteric pain chronic foot conditions) • about rehabilitation in older people with fragility fractures: <ul style="list-style-type: none"> ○ Patient optimisation ○ Post-operative rehabilitation programmes ○ Thromboprophylaxis ○ Osteoporosis screening and management ○ Falls assessment • Surface, cross-sectional and ultrasound anatomy of the musculoskeletal system • Use of clinic based diagnostic equipment • Gait analysis <ul style="list-style-type: none"> ○ Indications, and methods of assessment ○ information available from it (gait parameters, kinetics and kinematics) • disease-modifying and other disease-specific treatment for musculoskeletal disorders
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • examine large joints systematically

	<ul style="list-style-type: none">• support a patient taking alternative treatment against advice• withdraw opiate medication effectively
Evidence	<ul style="list-style-type: none">• miniCEX, CbDs, MASf, reflective entries
Links:	<ul style="list-style-type: none">• CiPs: generic 1 to 4; specialist 1 to 8. GPC: 1, 2, 3, 5, 6 and 7

F31
Spinal cord injury rehabilitation

Competency.	Able to assess patient's condition and rehabilitation needs, to give advice, and to take rehabilitation responsibility for any patient with a spinal cord injury from the onset into the long-term.
Additional	<i>Also demonstrates sound understanding of pelvic dysfunction following spinal cord injury</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • Demonstrates clear understanding of the role rehabilitation from critical care to eventual hospital discharge and long-term care • liaises closely with acute care trauma team and spinal centre team from the outset • assesses each acutely injured patient, and formulates an appropriate management plan • always considers potential complications of spinal cord injury • ensures that the patient has a clear understanding of self-management before discharge • advises on a patient's needs when admitted to hospital with another non-spinal injury problem • Shows leadership and commitment to teaching
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • Spinal cord and spinal column anatomy, basic biomechanics, assessment of stability • the spinal component of the autonomic nervous system • Epidemiology, aetiology and classification of spinal cord injury – both traumatic and non-traumatic • Clinical features of complete and incomplete spinal cord, root and cauda equina syndromes • Mechanisms of traumatic spinal cord injury and initial management including stabilisation and transport • National guidelines, service specifications and commissioning of rehabilitation following spinal cord injury. • Role of national referral pathways and the national registry • standardised clinical assessment protocols • Management of the multisystem dysfunction during the acute phase including acute physiological dysfunction • Expected functional abilities for each spinal cord level injury • Diagnostic features of, and management strategies for common impairments: <i>pain, spasticity; post traumatic syringomyelia, autonomic dysreflexia; respiratory failure; neuropathic bowel and bladder; skin vulnerability, musculoskeletal issues, sexual dysfunction</i> • Available social and vocational support including role of spinal cord injury charities • spinal cord injury management in special populations- elderly, children, dual pathologies, polytrauma • Prevention and management of pressure ulcers • Indications for baclofen pump insertion, complications, long-term management and referral pathways

	<ul style="list-style-type: none"> • Ventilation and airway management in patients with spinal cord injury including in the acute setting and domiciliary ventilation. • Upper limb rehabilitation in the patient with high cervical injury • Special problems associated with cauda equina syndrome • Principles of discharge planning • special discharge considerations in those with a high spinal cord injury • Role of sports, physical activity and nutrition in individuals with spinal cord injury • advances including robotic devices and the role of repair/ recovery in spinal cord injury
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Complete a standardised neurological assessment • Differentiate between different patterns of spinal cord injury impairment and its impact on outcomes • Discuss prognosis, short- and long-term outcomes, goals and lifestyle adaptations • Diagnose, treat and prescribe appropriate interventions and medications for management of neurogenic bladder and bowel, and sexual dysfunction • Educate patients, relatives and others about spinal cord injury related impairments, pelvic dysfunction including sexual dysfunction • Appropriately assess, manage and educate a patient with autonomic dysreflexia and other autonomic disturbances • Identify the effect of associated maladies on overall functioning (e.g. brain injury, carpal tunnel syndrome) • Appropriately counsel and consent patients for tissue viability treatments • Take pro-active, preventative action to reduce risk of long-term cardiovascular and bone health disorders • Advise on the role of new devices / interventions in the field of spinal cord injury rehabilitation.
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, CCATs, reflective entries, MSF, patient feedback
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 to 4; specialist 1 to 8. GPC: 1, 2, 3, 5, 6 and 7

F32
Cardiac rehabilitation

Competency.	Able to assess a patient with a cardiac disorder, in order to advise on both the cardiac and general rehabilitation needed.
Additional Behaviours	<p><i>Detailed clinical cardiac expertise is not expected</i></p> <ul style="list-style-type: none"> • undertakes a systematic clinical assessment of the cardiac patient including: <ul style="list-style-type: none"> ○ Risk assessment, functional status, individual expectations and goals ○ reviewing and rationalising medication ○ reviews any relevant investigations including blood tests and cardiac physiological assessments ○ seeks specialist cardiac input if needed • undertakes a systematic of all other non-cardiac rehabilitation needs - information, life-style changes, self-management, psychological support, vocational advice etc
Knowledge	<p>Has a good knowledge of:</p> <ul style="list-style-type: none"> • Indication for and role of symptom-limited exercise testing prior to cardiac rehabilitation program • Components of exercise prescriptions using Frequency, Intensity, Time, Type (FITT) principles • Common cardiac pathology and interventions • Cardiac risk factors and secondary prevention management including role of medications • Exercise risk stratification including clinical features of high, moderate and low risk patients and implications for level of supervision/monitoring • Structure, pathways and duration of cardiac rehabilitation programs • Prognostic benefits and risk of cardiac rehabilitation programs • Role of patient education in increasing adherence and common interventions used (e.g. 'heart manual')
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • Screen for cardiovascular risk factors, comorbidities and level of disability • Classify symptoms (e.g. stable vs unstable angina, New York Heart Association (NYHA) functional class for dyspnoea) • Gain accurate medication history, assess if suitable and seek further advice if needed • Assess through physical examination cardiovascular risk factors, cardiovascular status and relevant pathology • Recognise and diagnose concerning cardiac pathology from clinical tests i.e. vital signs , ECG, echocardiogram reports, CXR, blood tests and seek specialist advice where needed • Determine exercise capacity either from formal exercise testing report or through perceived exertion scales. • Suggest exercise modalities and guide prescription for patients seeking maintenance advice outside of formal cardiac rehabilitation programs

	<ul style="list-style-type: none">• Address cardiac risk factors for secondary prevention and refer to appropriate services if needed• Risk-stratify patients based on clinical features (e.g. left ventricular function) undergoing rehabilitation programs and seek advice on supervision/monitoring requirements if needed
Evidence	<ul style="list-style-type: none">• miniCEX, CbDs, letters
Links:	<ul style="list-style-type: none">• CiPs: generic 1 to 4, specialist 1 to 7; GPC: 1, 2, 3, 5, 6 and 7

F33

Respiratory Impairment and Pulmonary rehabilitation

Competency.	Able to assess a patient with a respiratory disorder and to advise on both the respiratory and general programme of rehabilitation required.
Additional	<i>Good knowledge of the area is expected as a physician but not to the level of an expert respiratory specialist.</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • undertakes a systematic clinical assessment of the patient’s respiratory function • reviews any relevant respiratory physiological assessments • seeks specialist respiratory input if needed • undertakes a systematic of all other non-respiratory rehabilitation needs - information, life-style changes, self-management, psychological support, vocational advice etc
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • how physiology of respiration is altered by different types of disease. • Management of common respiratory conditions, including education and self- management. • diagnosis of respiratory failure and sleep disordered breathing including obstructive sleep apnoea. • Basic principles of investigation (Oximetry, CO2 monitoring and lung function Tests) • neurogenic respiratory impairments and their management: <ul style="list-style-type: none"> ○ secretion management, assessment of cough and cough augmentation, ○ suction, improving muscle strength. phrenic nerve stimulation and non-invasive ventilation, • long-term management of chronic respiratory conditions and role of non-invasive ventilation in respiratory and neuromuscular disease, obesity and in sleep apnoea. • respiratory management in Cerebral Palsy and other childhood onset disability. • principles of weaning ventilation in critical ill patients, spinal cord injury and acquired brain injury • Tracheostomies: types and function, principles of weaning and long-term complications and management of associated problems: <ul style="list-style-type: none"> ○ nutrition, gastroesophageal reflux, prevention of respiratory infections, oral hygiene, role of antibiotics and vaccination • treatments: Exercise prescription, Endurance and Resistance training, inspiratory muscle, posture and core trainings, neuromuscular electrical stimulation training nutrition, behaviour and self - management. • Prescription of acute and long-term Oxygen and risks. • Smoking cessation (motivational interviewing and interventions)

Skills	The trainee is able to: <ul style="list-style-type: none">• Establish through history and/or examination the severity of respiratory dysfunction.• Develop a management plan for acute and chronic neurogenic respiratory dysfunction with input from other appropriate respiratory specialists and wider MDT.• To prescribe exercise safely, promote patient self- management and refer for pulmonary rehabilitation where appropriate
Evidence	<ul style="list-style-type: none">• miniCEX, CbDs, letters
Links:	<ul style="list-style-type: none">• CiPs: generic 1 to 4, specialist 1 to 7; GPC: 1, 2, 3, 5, 6 and 7

F34
Rehabilitation in elderly

Competency.	Able to assess rehabilitation needs of, give rehabilitation advice about, and take rehabilitation responsibility for any elderly patient referred for rehabilitation.
Additional	<i>Relates primarily to people over the age of 80 years of age, or younger people with multiple morbidity and possible frailty.</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • does not make assumptions based on a person's chronological age • Shows awareness of medical, social, financial and cultural matters likely to be more common or prominent in the elderly, and: <ul style="list-style-type: none"> ○ establishes existing social support networks ○ assesses hearing and vision • gives due attention to establishing all the diseases and diagnoses the person has, over and above the presenting rehabilitation problem • specifically reviews all medications • shows awareness of how disease presentation can be less specific in the elderly • seeks advice from disease-specific service if advice is needed about a specific disease. • considers the vulnerability of the person
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • the nature of frailty • the likelihood of unusual presentations of common conditions • rehabilitation after fractured neck of femur and other fractures common in older people • the risks associated with even short periods of immobility • the risks of drugs in older people • altered doses needed when prescribing drugs in older people • the (few) resources specifically available to the elderly
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • set the rehabilitation problems in the context of several or many other long-term conditions • set rehabilitation goals appropriate to the different contexts and expectations more commonly seen in older people • recognise, in self and in others, assumptions that are being made, and to set them aside
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, reflective entries, MSF
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 to 4, specialist 1 to 8; GPC: domains 1, 2, 5, 6 and 7

F35
Paediatric rehabilitation

Competency.	Able to assess the rehabilitation needs of any child referred for rehabilitation, and to take responsibility for rehabilitation, taking into account the developmental, educational and family context of the patient
Additional	<i>Does not cover infants; extends up to age of hand-over to adult services (16 – 25 years)</i>
Behaviours	<p>The trainee</p> <ul style="list-style-type: none"> • uses age-appropriate language and techniques during all interactions • involves parents and siblings in the assessment, appropriate to the child's age and mental capacity • seeks advice on areas of specialist paediatric knowledge to inform the assessment and/or treatment, as needed • always considers developmental, educational, social and family factors when drawing up a rehabilitation plan • seeks and respects the child's wishes and opinions, including respect for confidentiality • retains full awareness of the child's vulnerability and potential for abuse at all times • shares care effectively both with specialist medical services and with other agencies, with clear communication at all times
Knowledge	<p>The trainee has good knowledge (assessment and management) about:</p> <ul style="list-style-type: none"> • child development and growth • child protection procedures, risk factors for abuse, and common signs associated with abuse, legal status of child • educational services including statementing of special educational needs • differences in drug prescriptions in younger people • Disorders starting in and/or commonly seen in childhood: <ul style="list-style-type: none"> ○ congenital & genetic syndromes, causes of learning disability ○ Congenital Limb deficiency ○ Congenital or childhood bone diseases ○ Inflammatory joint disease, haemophilia ○ Cerebral Palsy, hydrocephalus, and Spina Bifida ○ Neuromuscular diseases in childhood e.g. Duchenne muscular dystrophy, spinal muscular atrophy, ○ Paediatric Cancers • Paediatric Burns – see Burns • Basic paediatric aspects of disorders also seen in adults: <ul style="list-style-type: none"> ○ Spinal Cord Injury, brachial plexus injury, stroke, other acquired brain injury including traumatic • Transition to adult life and service delivery models
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • communicate effectively with a child and family, in a developmentally appropriate way • share care with a paediatric service, and with educational services and Social Services • Assess and develop rehabilitation plans that consider: <ul style="list-style-type: none"> ○ the child's needs ○ the needs of the family (parents and siblings)

	<ul style="list-style-type: none">○ educational needs○ psychosocial and emotional needs○ developmental factors.○ safeguarding and extra vulnerability
Evidence	<ul style="list-style-type: none">• miniCEX, CbDs, reflective entries
Links:	<ul style="list-style-type: none">• CiPs: generic 1 to 4, specialist 1 to 7; GPC: domain 1, 2, 3, 5, 6 and 7

F 36
Burns/dermatological rehabilitation

Competency.	Able to assess the need for and advise on to manage the rehabilitation of someone with burns or other disorders of the skin (all ages)
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • shows awareness of the impact of burns for patient and families including the impact of: <ul style="list-style-type: none"> ○ severity of burns, ○ treatments and multiple operations, ○ contractures, ○ cosmesis and effect on psychology. • considers both the acute and the long-term rehabilitation needs • actively discusses and helps with the stigma associated with skin disorders and disfigurement. • works collaboratively with plastic surgery, dermatology, psychologists, and advisors about cosmesis • informs patients and families about support organisation for people with burns and/or disfiguring skin conditions
Knowledge	<p>The trainee knows about:</p> <ul style="list-style-type: none"> • different types of Burns (thermal, electrical, chemical), • estimating the area of burns area • classification of burns by thickness • criteria signifying major burns injury • early burns treatment: airway, fluid resuscitation, pain, wound management, debridement, surgery (escharotomies, fasciotomy & skin grafting – full and split skin), wound dressings and compression. • management of contractures, both surgical and non-surgical, wound infection, heterotopic ossification (diagnosis and treatment), thromboembolism, hypostatic pneumonia and infection. • psychological, functional and vocational rehabilitation including role of patient support groups • chronic skin conditions: eczema, psoriasis, and conditions causing severe disfigurement e.g., Epidermolysis bullosa (EB).
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • Assess and advise on pain management both acute, and for procedures. • Assess and advise on scar and contracture management with surgical team & further surgery including amputation. • Assess further rehabilitation needs including upper and lower limb function, nutrition, bowels, psychological etc • Liaise with and help coordinate a wide variety of services and agencies
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, reflective entries
Links:	<ul style="list-style-type: none"> • CiPs: GPC:

F37

Psychiatric rehabilitation (including learning disability)

Competency.	Able to assess, give advice on and manage a patient with disturbance of emotion or thought processes affecting behaviour and social interaction.
Additional	<i>At present rehabilitation of people with primary psychiatric problems (diagnoses) is undertaken fully within psychiatric service.</i>
Behaviours	<p>The trainee:</p> <ul style="list-style-type: none"> • always considers a patient's: <ul style="list-style-type: none"> ○ experiences and perceptions of their situation ○ emotional state • uses a systematic approach when assessing a person whose social behaviour is causing concern to the patient or to others <ul style="list-style-type: none"> ○ collects information on context and antecedents ○ establishes the person's perspective ○ assesses risk of self-harm or of harm to others ○ collects information from family, friends and carers • considers whole range of possible causes (e.g. altered perception, memory problems, other people, etc) and does not jump to a conclusion • recognises when a specific psychiatric cause (e.g. mania) is present • uses non-pharmacological in preference to pharmacological treatments <p><u>When faced with more challenging behaviours (including withdrawal)</u></p> <ul style="list-style-type: none"> • takes a non-confrontational approach • maintains full awareness of ethical considerations • prioritises safety of the patient, other patients, and other people over resource considerations • seeks support and advice from others, from an early stage <ul style="list-style-type: none"> ○ seeks diagnostic/management help from specialist psychiatric services when needed • uses all techniques – pharmacologic, behavioural and, if necessary, restraint – appropriately and in a timely fashion <ul style="list-style-type: none"> ○ uses non-pharmacological treatment approaches first ○ if pharmacological treatments are used, monitors for side-effects and gives sufficient time before deciding on effectiveness • supports staff during and after any crisis or prolonged episode of behavioural or emotional stress • uses de-briefing to support staff after any stressful event or episode
Knowledge	<p>The trainee has a good knowledge of:</p> <ul style="list-style-type: none"> • the wide range of potential causes for (unexpected) development of challenging behaviour or marked emotional distress • principles of behavioural analysis and systematic collection of behavioural data • principles of behavioural management, and reduction of risk of challenging behaviours • use of Mental Capacity Act 2005, including Deprivation of Liberty Safeguarding process

	<ul style="list-style-type: none"> • use of Mental Health Act – in outline • use of drugs, and a full awareness of all their risks, drugs used to alter emotional state, facilitate sleep, or control aggressive or dangerous behaviour <ul style="list-style-type: none"> ○ adverse effects, likely benefits, pharmacokinetics
Skills	<p>Able to:</p> <ul style="list-style-type: none"> • establish and maintain rapport with a frightened or frightening patient, or a patient in despair or distress • use a systematic approach when under stress • treat the patient with respect in the face of challenging behaviour • undertake debriefing as soon as is practical after a particular episode • undertake a proportionate use of drugs, and physical restraint • support staff, explaining clearly the immediate and medium-term plans • make a clear, non-judgemental record of events, justifying decisions made • support and assist staff and other patients feeling stressed by a patient’s behaviour • use drugs and physical restraint judiciously
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, reflective entries, incident reports
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 to 4, specialist 1, 3 to 6, and 8. GPC: domain 1, 2, 3, 5, 6 and 7

F38

Limb loss rehabilitation

Competency.	Able to assess and manage any patient of any age who has a loss of any part of one or more limbs legs, from the hip or shoulder.
Additional	<i>This covers congenital absence of a limb. It is not restricted to patients using prostheses.</i>
Behaviours	The trainee: <ul style="list-style-type: none"> • shows an understanding of the full impact on a person of not having or of losing part or all of one or more limbs • advises a surgeon, if necessary, about the optimal surgical approach from the perspective of the person's later rehabilitation • assesses and advises on the patient's underlying medical conditions • determines the most effective management, including whether or not a prosthesis is likely to be useful • contributes to decisions made about the most appropriate prosthesis • undertakes active monitoring and management of the patient's rehabilitation in the long-term. • seeks advice from disease-specialist service when needed
Knowledge	The trainee has good knowledge of: <ul style="list-style-type: none"> • National organisation of services, and of commissioning • Content of relevant national guidance on services and on prostheses • Epidemiology, aetiology, and prevention of limb loss • Amputation levels, advantages and disadvantages of each level • The impact of comorbidities, including polytrauma, on the amputation technique and level • The impact of limb loss on someone's life (psychological, vocational and daily activities) • Early management of the residual limb • Rehabilitation without prosthetic limb • Rehabilitation with prosthetic limb • Prevention and management of pain • Congenital limb losses and rehabilitation of children
Skills	The trainee is able to: <ul style="list-style-type: none"> • Take a history and examine patients in pre-amputation consultations • Liaise with surgical team, about rehabilitation approach/outcome. • Take a history and examine patients seen after amputation • Participate in team multi-disciplinary discussions • Manage amputees and their residual limb post-operatively including: <ul style="list-style-type: none"> ○ Minimise limb contractures ○ Promote tissue healing ○ The management of delayed wound healing ○ Pain control (residual limb and phantom pain) • The management of associated co-morbidities and co-trauma
Evidence	miniCEX, Cbd, reflections, clinical documents
Links:	CiP generic 1, specialist CiP 2, 3, 5 and 6

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Visual and auditory impairments

Competency.	Able to assess visual and auditory impairments in the context of other rehabilitation needs to advise on what rehabilitation may reduce or ameliorate visual or auditory losses, and on how other rehabilitation should be modified to optimise benefit.
Additional Behaviours	<p><i>None</i></p> <p>The trainee:</p> <ul style="list-style-type: none"> • considers and assesses for visual and auditory impairments in all patients seen, looking for both <ul style="list-style-type: none"> ○ losses as part of underlying disabling condition, and ○ losses as pre-existing, independent impairments • adjusts all communication to optimise communication with the patient <ul style="list-style-type: none"> ○ ensures that any aids or equipment are available and used • ensures that an up-to-date evaluation of the impairment (auditory or visual) is available or is undertaken <ul style="list-style-type: none"> ○ makes a prompt referral to specialist auditory or visual rehabilitation service if information is inadequate ○ ensures any advice given or equipment suggested is provided and its use taught to the patient • advises team on nature of impairments and how rehabilitation may need to be modified • seeks advice from disease-specialist service when needed
Knowledge	<p>The trainee has good knowledge of:</p> <ul style="list-style-type: none"> • nature of specialist assessment of hearing, • hearing rehabilitation techniques • communication techniques to use when someone has limited hearing • nature of specialist assessment of visual function, • visual rehabilitation techniques • techniques to assist visual function when with a patient (e.g. good lighting) • effects of oculo-motor disorders on vision, balance and other abilities • effects of vestibular dysfunction on balance and motor control • laws around visual impairment and driving
Skills	<p>The trainee is able to:</p> <ul style="list-style-type: none"> • assist someone with limited vision when walking somewhere new • communicate with someone with impaired hearing • adapt all behaviours to the patient's visual or auditory impairments • advise the team on adaptations needed to treatments and support
Evidence	<ul style="list-style-type: none"> • miniCEX, CbDs, MSF, reflective entries, letters
Links:	<ul style="list-style-type: none"> • CiPs: generic 1 and 3; specialist 1 and 3; GPC: domain 2 and 7

Acknowledgements

The Curriculum Training Advisory Group Members were:

		Post/role, and location
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- Other people have given advice, reviewed the competencies or document as a whole, and in other ways.

Table of competencies and some suggested sources

This table gives very selected sources of further information for competencies. These are not compulsory reading, and they are not sufficient reading. The sources are just something to give an entry; none cover the whole of a competency. They are simply intended to give the trainee a place to start, and they will sometimes relate to something mentioned in the competency description. Most are website links.

Competency	Type of document	Access
A1: research		
B2: biopsychosocial model	Paper Paper	https://doi.org/10.1177/0269215517709890 https://doi.org/10.1016/j.pec.2012.12.010
B3: assessment	Paper Paper Paper	https://doi.org/10.1016/j.pec.2019.02.023 https://doi.org/10.1016/j.pec.2012.12.010 https://doi.org/10.7326/0003-4819-134-11-200106050-00020
B4: formulation	Website – psychiatry Website - rehabilitation	https://www.psychdb.com/teaching/biopsychosocial-case-formulation#filling-out-the-table https://rehabilitationmatters.com/what-is-rehabilitation-3/presentation-to-planning/formulation/
B5: planning	Goal setting review Overview of goals	https://doi.org/10.1177/0269215519846220 https://journals.sagepub.com/doi/pdf/10.1177/0269215509103551
C6: funding	Continuing NHS care	https://www.england.nhs.uk/healthcare/
C7: best interests	Paper Paper	https://doi.org/10.1177/0269215519852987 https://doi.org/10.1177/0269215519853013
C8: quality improvement	Review paper	https://www.bmj.com/content/364/bmj.k5437
C9: teaching	Top tips review How to develop	https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-020-02283-2 https://www.bmj.com/careers/article/how-to-develop-your-teaching-skills/
D10: prescribing	Website Paper	https://deprescribing.org/ https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2204035
D11: referral		
E12: exercise	WHO guidance National guidance	https://bjsm.bmj.com/content/bjsports/54/24/1451.full.pdf

		https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832868/uk-chief-medical-officers-physical-activity-guidelines.pdf
E13: practice	Review	https://doi.org/10.3389/fnsys.2019.00074
E14: psychosocial	Systematic review	https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0196151
E15: self-management	Trial paper Review	https://doi.org/10.1002/mds.22940 https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0218517
E16: tailoring intervention	Research protocol Paper Description	https://dx.doi.org/10.1136/bmjopen-2018-028261 https://doi.org/10.1016/j.apmr.2019.01.015 https://doi.org/10.1177/0269215519829803
E17: assistive technology	Systematic review Systematic review Education review	https://doi.org/10.1177/0269215510367551 https://doi.org/10.1177/1471301217733649 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/937381/UKAT_FinalReport_082520.pdf
E18: vocational rehabilitation	Review BSRM guide	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/209474/hwwb-vocational-rehabilitation.pdf https://www.bsr.org.uk/downloads/vrthewayforward2nded-final-revised-text-30-11-03.pdf
E19: palliative/end-of-life	Website Guideline	https://www.resus.org.uk/respect https://www.bma.org.uk/media/1161/bma-clinically-assisted-nutrition-hydration-canh-full-guidance.pdf
E20: bowel/bladder	Spinal injury guidance NICE bladder guide Review	https://www.mascip.co.uk/wp-content/uploads/2015/02/CV653N-Neurogenic-Guidelines-Sept-2012.pdf https://www.nice.org.uk/guidance/cg148 https://doi.org/10.1016/j.expneurol.2018.05.006
E21: Chronic Pain	NICE guideline Review	https://www.nice.org.uk/guidance/ng193 https://www.nejm.org/doi/full/10.1056/NEJMra1807061
E22: spasticity	Guideline, botulinum toxin Review Review	https://www.rcplondon.ac.uk/guidelines-policy/spasticity-adults-management-using-botulinum-toxin https://doi.org/10.1016/j.rehab.2017.10.001 https://doi.org/10.1177/1352458516643600

E23: sexual dysfunction	Overview Rehabilitation Attitudes	https://jnnp.bmj.com/content/jnnp/65/6/877.full.pdf https://doi.org/10.1177/135245850100700612 https://doi.org/10.1016/j.apmr.2020.09.379
E24: swallowing/dysphagia	Review protocol Systematic review	https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/s13643-019-1196-0 https://doi.org/10.1007/s40141-013-0030-1
E25: communication	Systematic review Systematic review	https://doi.org/10.23736/S1973-9087.20.06185-7 https://doi.org/10.1002/14651858.CD000425.pub4
E26: cognitive dysfunction	Systematic review Cochrane review and many others	https://doi.org/10.1016/j.apmr.2019.02.011 https://doi.org/10.1002/14651858.CD002842.pub3
F27: acute neurology	Guideline Cochrane review	https://www.rcplondon.ac.uk/guidelines-policy/prolonged-disorders-consciousness-following-sudden-onset-brain-injury-national-clinical-guidelines https://doi.org/10.1002/14651858.CD004170.pub3
F28: long-term neurology	Guideline Cochrane review	https://www.bma.org.uk/media/1161/bma-clinically-assisted-nutrition-hydration-canh-full-guidance.pdf https://doi.org/10.1002/14651858.CD012732.pub2
F29: trauma/hyperacute	Systematic review Audit of UK trauma rehabilitation Sepsis guidance Time-limited trials Rehabilitation prescription	https://doi.org/10.1016/j.arrct.2020.100070 https://www.kcl.ac.uk/cicelysaunders/about/rehabilitation/nhs-audit-report-v9-rgb.pdf https://www.england.nhs.uk/ourwork/clinical-policy/sepsis/nationalearlywarningscore/ https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2778535 https://www.kcl.ac.uk/cicelysaunders/resources/tools/post-icu-presentation-screen-picups-and-rehabilitation-prescription-rp
F30: musculoskeletal	Systematic review Systematic review	http://dx.doi.org/10.1136/bmjopen-2019-032329 https://doi.org/10.1136/bjsports79376
F31: spinal injury	Website	https://lms4.learnshare.com/images/brand/204/ASIA-ISCOS-Worksheet_10.2019_PRINT-Page-1-2.pdf https://lms4.learnshare.com/images/brand/204/Motor%20Exam%20Guide%20FINAL%20Feb%202020.pdf https://lms4.learnshare.com/images/brand/204/Key%20Sensory%20Points.pdf
F32: cardiac	Review paper	https://www.bmj.com/content/351/bmj.h5000

F33: pulmonary	Statement & evidence	https://www.atsjournals.org/doi/full/10.1164/rccm.201309-1634ST
F34: elderly	Cochrane review	https://doi.org/10.1002/14651858.CD004294.pub3
	Cochrane review	https://doi.org/10.1002/14651858.CD006211.pub3
F35: paediatric		https://www.rcpch.ac.uk/sites/default/files/2018-03/paediatric_neurodisability_syllabus_final.pdf
F36: burns/dermatological	Systematic review	https://doi.org/10.1016/j.burns.2017.08.009
	Systematic review	https://doi.org/10.1016/j.burns.2018.09.029
F37: psychiatric	Systematic review	https://doi.org/10.3389/fpsy.2019.00147
F38: limb-loss	Systematic review	https://doi.org/10.1080/09593985.2018.1425938
	Pilot trial	https://doi.org/10.1093/ptj/pzaa008
F39: visual and auditory	Systematic review	https://doi.org/10.3766/jaaa.16.7.8
	Systematic review	https://doi.org/10.1080/02699052.2019.1658225
	Cochrane review	https://doi.org/10.1002/14651858.CD006543.pub2

Appendix one

General Medical Council requirements for **professional** clinical competence

Trainees and trainers must be aware of the General Medical Council (GMC) guide “Generic Professional Capabilities Framework” [1] and the associated “Generic professional capabilities: guidance on implementation for colleges and faculties.” [2]. These play a central role in all medical curricula. In relation to training in Rehabilitation Medicine, three paragraphs from the guidance [2] encapsulate the importance of adhering to GMC guidance:

Para 11 (Box on page 12)

Experienced supervisors are expected to judge whether the trainee demonstrates the knowledge, skills and attributes expected within the Generic Professional Capabilities framework, on the basis of their own direct observation of the doctor in the workplace. To do this, the trainer needs:

- *a working understanding of the Generic Professional Capabilities framework*
- *to be able to highlight specific examples where a trainee has shown excellence, targets for development, or concerns about performance in the language of the framework.*

These judgements should be supported by feedback from other senior doctors and any approved assessment tools specified within the curriculum.

Para 20 (page 13)

The educational supervisor will collate the information derived from the minimum dataset, multi-consultant and clinical supervisor reports, and review them as the first part of the annual review of competence progression (ARCP).

- *Trainee is felt to be progressing satisfactorily with professional capabilities on the basis of this dataset - no further assessments are mandated. The evidence of satisfactory progress will be supported by a structured report, which will be reviewed and documented at ARCP.*
- *There are concerns about lack of achievement of generic professional capabilities - training may need to be targeted, with delay in progression, even if the specialty outcomes have been achieved.*

Last, on page 17 in the guidance it states:

“Trainees will need to understand the priority of Generic Professional Capabilities in their training, including the use of self-assessment against the specialty-specific outcomes and the generic components.”

The great majority of the Generic Professional Capabilities Framework is closely allied to the six generic Capabilities in Practice within the curriculum. The syllabus contains advice on demonstrating capability in Domain nine.

Nevertheless, both trainees and trainers should be aware of domain nine of the framework [1] found on page 25. The statement and first six (of 17) bullet points are reproduced here:

“Doctors in training must demonstrate that they can:

- a) keep up to date with current research and best practice in the individual's specific area of practice, through appropriate continuing professional development activities and their own independent study and reflection*
- b) practise in line with the latest evidence*
- c) conduct literature searches and reviews to inform their professional practise*
- d) critically appraise academic literature*
- e) understand the role of evidence in clinical practice and demonstrate shared decision making with patients*
- f) locate and use clinical guidelines appropriately”*