JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Sport and Exercise Medicine

Guidance for training programme directors, supervisors and trainees

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Contents

Introduction

This guide for Sport and Exercise Medicine (SEM) is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the curriculum document itself. The curriculum, ARCP decision aid and this guide are available on the JRCPTB website.

The Rough Guide has been put together by members of the SEM SAC with additional help from many external stakeholders especially trainees. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

What is different about the 2021 Sport and Exercise Medicine curriculum?

Background

There have been two major drives to the need for change. Firstly, the move away from the 'tick-box' approach associated with the current competency-based curricula to the holistic assessment of high level learning outcomes. The new curriculum has a relatively small number of 'capabilities in practice' (CIPs) which are based on the concept of entrustable professional activities (EPAs). Secondly, the GMC has mandated that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the Generic Professional Capabilities (GPC) framework..

Duration of training

Sport and Exercise Medicine (SEM) higher specialty training will usually be completed in four years of full-time training. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the indicative time. There may also be trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

The Sport and Exercise Medicine curriculum

The purpose of the curriculum is to produce doctors with the generic professional and specialty specific capabilities required to practice in SEM across 2 broad domains. Firstly, specialists in SEM will lead and deliver comprehensive musculoskeletal (MSK) services, managing school aged children, adults and older adults, including those with additional co-morbidities and a chronic disease burden. Secondly, SEM consultants will have the knowledge and the understanding of the practical application of exercise medicine in the prevention and management of chronic disease at an individual and population level.

Once they have completed specialist training, SEM consultants will work in community and/or hospital based environments for MSK medicine and lead on embedding exercise

medicine and physical activity within clinical pathways for the prevention and management of chronic disease. The curriculum needs to have sufficient flexibility to train doctors entering the programme following training in internal medicine, general practice and ACCS.

The curriculum for SEM has been developed with input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives, the Faculty of Sport and Exercise Medicine (FSEM) and SAC lay persons. This has been through the work of JRCPTB, the SEM Specialist Advisory Committee and the FSEM.

Doctors in training will learn in a variety of settings using a range of methods, including workplace-based experiential learning, formal postgraduate teaching and simulation-based education.

By the end of their final year of training, the trainee will receive a CCT in Sport and Exercise Medicine.

Capabilities in Practice (CiPs)

The **generic CiPs** cover the universal requirements of all specialties as described in the GPC framework. The generic CiPs are common across all physician specialties. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The **specialty CiPs** describe the overarching professional task or work within the scope of Sport and Exercise Medicine.

Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. The CiPs are expanded fully in the curriculum. Portfolio submissions can be linked to the CiPs.

By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice (level 4) in all specialty CiPs.

Capabilities in practice (CiPs)

Generic CiPs

1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focussed on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately

6. Acting as a clinical teacher and clinical supervisor to be assessed by DOPS

Specialty CiPs

1. Leading and managing a multi-disciplinary team
2. Ability to develop, lead and deliver a comprehensive musculoskeletal service that spans community and hospital settings for adults
3. Ability to develop, lead and deliver a comprehensive musculoskeletal service that spans community and hospital settings for adolescents and school aged children
4. Ability to deliver exercise medicine services for adults, encompassing both prevention and management of chronic disease
5. Ability to deliver exercise medicine services for adolescents and school aged children, encompassing both prevention and management of chronic disease
6. The ability to promote and support population health through physical activity
7. Delivering effective resuscitation and early management of the acutely injured and unwell patient in the pre-hospital and hospital environments, including sport related traumatic brain injury

Evidence of capability

The curriculum describes the evidence that can be used by the educational supervisor to make a judgement of the trainee's capability (see blueprint on page 12). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multidisciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

Presentations and Conditions

The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated (see curriculum add in link for list of presentations and conditions). The presentation and conditions listed in the curriculum are either common or serious and trainees will be expected to know about these but they will not need to be signed off for individual items.

Practical Procedures

The curriculum and ARCP decision aid list the practical procedures required and the minimum level of competency.

Once a trainee is competent to perform a procedure unsupervised (as evidenced by summative DOPS) there is no requirement for further assessment. It is a matter of professional insight and probity that a trainee should maintain their competency by carrying out the procedure when the opportunity arises. If a trainee has not performed a particular procedure for some time and no longer feels confident or competent to carry it out, then they should seek further training with appropriate supervision. Trainers should have

ongoing conversation with trainees about procedural competence and this should be documented.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below level expected for the current year of training. For the specialty CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). The levels expected are given in the grid below (page 12) and in the ARCP decision aid.

What the trainee needs to do

The trainee needs to ensure that the evidence they provide will give the ES sufficient information to make an entrustment decision for each of the generic and specialty CiPs.

SLEs: It is not about the number of SLEs but ensuring the evidence provided covers all the CiPs. The SLE's needs to be from a variety of assessors, review performance across all CiPs and spread out across the training year. There is not a minimum number of SLEs. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development. They should record how many clinics they have attended and detail the performance and learning form these clinics in the portfolio using SLEs, reflection and the summary of clinical activity form.

Membership exam: Trainees must have completed both part 1 and 2 of the Faculty of Sport and Exercise Medicine Membership exam by completion of training. It is recommended that Part 1 is passed by end of ST4 and Part 2 is passed by end of ST5. If either of these is not achieved on time, the ES (and TPD if required) should instigate a wider review of training progression. Extension to training may be required.

Consultant, MDT and patient feedback: Each trainee must ensure that they have acquired multi-source feedback (MSF) and patient survey feedback on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of 3 reports from consultants, (at least one of whom must be a SEM consultant). All must be familiar with the trainees work and these will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory

statement about the level at which they assess the trainee to be functioning for each clinical CiP.

Quality Improvement Work: There is a requirement for evidence of ongoing participation in quality improvement work throughout every year of training with a full QiPAT by the end of ST4. Evidence of leadership in quality improvement and audit is needed in ST5 and ST6.

MSK Clinics: There is an indicative minimum number of weekly MSK clinics that need to be attended; this is 1 per week for 18 out of the 24 months in ST3 and ST4 and 2 MSK clinics per week in ST5 and ST6.

Sport attachment: There is a minimum indicative time for longitudinal attachment with a sport National Governing Body or Home County Institute of 1 day per week for 6 months within ST5 or ST6.

Teaching: 75% attendance at local/regional teaching and national teaching is needed with evidence of reflection on teaching.

ARCP preparation: As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self-assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the exam
- a discussion about what resources are available to help with the programme
- a Personal Development Plans (PDP) for the training year (comprising a series of SMART objectives)
- a plan for using study leave
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including;

- a PDP including SMART objectives for the placement
- access to clinics and how to meet the learning objectives
- required course attendances

Depending on local arrangements there should be regular meetings (we recommend approximately one hour most weeks) for personalised, professional development discussions which will include;

- writing and updating the PDP
- reviewing reflections and SLEs
- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a physician and career goals
- discussing things that went well or things that went not so well

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process, it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum
- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

What the Educational Supervisor (ES) needs to do

The educational supervisor and trainee should meet beforehand to plan what evidence will need to be obtained. This can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP. Any aspects likely to result in a non-standard outcome at ARCP

should be made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following anchor statements:

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

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include;

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the **specialty CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

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

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Point

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP

- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Local Faculty Groups (LFG)

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of senior clinicians (medical and non-medical) who get together to discuss trainees' progress. The purpose is not only to make an assessment of a trainee but to determine and plan on-going training. It is recommended again as an optimal way of providing information about trainees' progress.

The LFG set-up will depend on the circumstances of the organisation. In smaller units the LFG make include all the physicians; while in larger units there may be several LFGs, each in a different department. In all circumstances, as a minimum, an LFG must be able to consider, direct and report on the performance of trainees.

The LFG should meet regularly to consider the progress of each trainee and identify training needs, putting in place direction as to how these needs are to be met. This should be documented and communicated to trainee's Educational Supervisor and hence to the trainee. A mechanism for this to happen should be established.

LFGs can be arranged alongside Specialty Training Committee meetings.

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. The MSF will be collated by the ES and then discussed with the trainee ahead of the ARCP and any actions added to the PDP. If a repeat MSF is required it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The ***minimum*** number of MCRs considered necessary is 3 per year and at least one of these needs to be a consultant in SEM. The trainees own ES cannot fill in a MCR. Senior allied health care professionals can complete MCRs if they are familiar with the trainee's practise.

Consultant supervisors completing the MCR will use the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice. If it is not possible for an individual to give a rating for one or more area they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

Supervised Learning Events

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Workplace-Based Assessments

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.

Teaching Observation (TO)

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

Quality Improvement Project Assessment Tool (QIPAT)

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

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via this link.

Examination

Trainees must have completed both part 1 and 2 of the Faculty of Sport and Exercise Medicine Membership exam by completion of training. It is recommended that Part 1 is passed by end of ST4 and Part 2 is passed by end of ST5. If either of these is not achieved this should instigate a wider review of training progression with the ES, and TPD if required, and a plan put in place. Extension to training may be required.

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop

SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that trainees do not need to present every piece of evidence listed and the list is not exhaustive and other evidence may be equally valid.

Blueprint for WPBAs mapped to CiPs

Learning outcomes	**CbD**	**DOPS**	**MCR**	**Mini -CEX**	**MSF**	**PS**	**QIPAT**	**TO**	**MFSEM**
Generic CiPs									
Able to function successfully within NHS organisational and management systems			√		√				
Able to deal with ethical and legal issues related to clinical practice	√	√	√	√	√				
Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement			√		√	√			
Is focussed on patient safety and delivers effective quality improvement in patient care			√		√		√		
Carrying out research and managing data appropriately			√		√				
Acting as a clinical teacher and clinical supervisor			√		√			√	
Speciality CiPs									
Leading and managing a multi-disciplinary team.	√		√	√	√				
Ability to develop, lead and deliver a comprehensive musculoskeletal service that spans community and hospital settings for adults.	√	√	√		√	√	√		√
Ability to develop, lead and deliver a comprehensive musculoskeletal service that spans community and hospital settings for adolescents and school aged children.	√	√	√		√	√	√		√

Learning outcomes	CbD	DOPS	MCR	Mini -CEX	MSF	PS	QIPAT	TO	MFSEM
Ability to deliver exercise medicine services for adults, encompassing both prevention and management of chronic disease.			√		√		√		√
Ability to deliver exercise medicine services for adolescents and school aged children, encompassing both prevention and management of chronic disease.			√		√		√		√
The ability to promote and support population health through physical activity.		√	√		√				√
Delivering effective resuscitation and early management of acute injury and illness in the pre-hospital and hospital environments, including sports related mild traumatic brain injury	√		√		√				

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting the ES needs to review:

- Transfers of Information on the trainee
- Previous ES, ARCP etc. reports if available
- Agree with the placement CSs how other support meetings will be arranged. Including;
  - Arrangements for LFGs
  - Arrangements for local/regional teaching

At the meeting between ES and trainee the following need to be considered:

- Review the placements for the year
- Review the training year elements of the generic educational work schedule or its equivalent
- Construct the personalised educational work schedule for the year or its equivalent
- Construct the annual PDP and identify relevant training courses
- Discuss the trainee's career plans and help facilitate these
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs

- Discuss the teaching programme – local/regional and national. 75% attendance is required.
- Discuss procedural simulation if needed
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including the professional development meetings and the interaction with the placement CSs
- Planning of SLEs and WPBA
- Arrangements for MSF
- Review the ARCP decision aid
- Arrangements for Interim Review of Competence Progression (IRCP)
- Arrangements for ARCP and the writing and discussion of the ESR
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points for ES and trainee

- Prepare for the meeting
- Make sure that knowledge of the curriculum is up-to-date
- Set up a plan for the training year

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered by the CS;

- Review Transfers of Information on the trainee (this should be provided by the ES and or TPD)
- Review previous ES, ARCP etc. reports if available
- Arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- Review the training placement elements of the generic educational work schedule or its equivalent
- Construct the personalised educational work schedule for the placement or its equivalent

- Construct the set of placement-level SMART objectives in the PDP
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
- Arrangements for MSF
- Review the ARCP decision aid
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

Professional Development Meetings (Educational Meetings)

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the trainee's PDP
- Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- Provide support around other issues that the trainee may be encountering

Transition arrangements for trainees already in programme

The SEM training scheme is designed to be flexible. If trainees transition across from another training scheme then a process of reviewing curriculum progression and then a gap analysis will be undertaken by the ES and an estimated CCT date will be provided. This will be ratified at the first ARCP by the panel. The sharing of generic competencies between medical specialties makes this process simpler. General Professional Capabilities (GPCs) will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty.

Trainees who have come from alternative entry pathways

The SEM training scheme is suitable for entry from IMT, GP and ACCS training and it is therefore recognised that trainees will enter with a degree of varied experience. The scheme is an indicative 4 years in length and some flexibility in tailoring training based on prior experience should be possible within the wider training scheme. SEM training requires broad and extensive skills across primary and secondary care and population health.

For example, trainees from General Practice will have more experience in community MSK problems and chronic disease management, whereas those from internal medicine will have more experience of acute medical conditions but may need additional training in MSK medicine. A trainee coming from any background will still typically require the indicative 4 years of training to develop skills and competencies across the full breadth of the curriculum. It is a competency based curriculum so all trainees could theoretically complete in an accelerated time and assessment of this will be at the annual review (ARCP).

There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training faster than the current indicative time although it is recognised that longitudinal clinical experience and experiential learning is a fundamental aspect of development as a good physician (guidance on completing training early will be available on the JRCPTB website). There may also be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)[1].

Annual Review of Competence Progression (ARCP)

Introduction

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

[1] A Reference Guide for Postgraduate Specialty Training in the UK

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum.

The trainee should aim to have achieved part 1 of the membership exam by the end of ST4 to enter ST5 and both parts by the end of ST5 to enter ST6. Part 2 ideally should have been attempted by the end of ST5 even if not passed. A CCT cannot be awarded without the full FSEM membership exam.

Sport and Exercise Medicine training and the ARCP

The change from the tick-box style competencies to the high-level Capabilities in Practice (CiPs) will have a major impact on how trainees are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in trainees failing to achieve a standard ARCP outcome by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: "Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?"

Relationship with Educational Supervisor (ES)

It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Clinical supervisor (CS)

The trainee should have a named Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. The CS may be the same person as the ES. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a

Multiple Consultant Report (MCR). The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. The ARCP decision aid states a minimum of 3 MCRs per year, of which one must be from a consultant in SEM.

Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. There is no specific number of SLEs demanded by the decision aid as the aim of the SLEs is to provide evidence across the curriculum to facilitate the ES to make entrustment decisions about the trainee.

- Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- They provide the opportunity for trainees to receive targeted and constructive feedback from a senior colleague.

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the “normal” trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations, then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

- All appropriate certificates have been uploaded to the personal library and are clearly signposted
- An appropriate amount of reflection that supports the educational and teaching opportunities that have been accessed has been documented

- An appropriate number of SLEs that support the generic and specialty CiPs have been completed and recorded in the ePortfolio
- MSF has been completed and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF
- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction; a minimum of 3 and one SEM consultant included
- The trainee has self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have either been achieved fully and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed. If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should examine more detail in the ePortfolio and review more of the SLEs and other subsidiary information.

ARCP Decision Aid for Sport and Exercise Medicine

The Sport and Exercise Medicine ARCP decision aid documents the targets to be achieved for a satisfactory ARCP outcome at the end of each training year. This document is available on the JRCPTB website.

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
Educational supervisor (ES) report	One per year to cover the training year since last ARCP (up to the date of the current ARCP). NB if more than one post needs one ES report per post.	Confirms meeting or exceeding expectations and no concerns. If a trainee is considered as potentially meeting the criteria for being exceptional then this should be highlighted within the report.	Confirms meeting or exceeding expectations and no concerns.	Confirms meeting or exceeding expectations and no concerns.	Confirms meeting or exceeding expectations and no concerns.
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP.	ES to confirm trainee meets expectations for level of training.	ES to confirm trainee meets expectations for level of training.	ES to confirm trainee meets expectations for level of training.	ES to confirm trainee meets all generic CiPs.
Speciality capabilities in practice (CiPs)	See grid below of levels expected for each year of training. Trainees must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each individual speciality	ES to confirm trainee is performing at or above the level expected for all speciality CiPs.	ES to confirm trainee is performing at or above the level expected for all speciality CiPs.	ES to confirm trainee is performing at or above the level expected for all speciality CiPs.	ES to confirm trainee meets all speciality CiPs.

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
	CiP and overall global rating of progression.				
Multiple consultant report (MCR)	Minimum number 3 clinicians to complete including minimum 1 SEM consultant. Each MCR is completed by a consultant who has supervised the trainee's clinical work. If 3 SEM consultants are not available then other relevant speciality consultants or other senior HCPs may complete the MCR if they have regularly supervised the trainee's work. The ES should not complete an MCR for their own trainee.	1 x MCR (completed by minimum 3 clinicians including 1 SEM consultant).	1 x MCR (completed by minimum 3 clinicians including 1 SEM consultant).	1 x MCR (completed by minimum 3 clinicians including 1 SEM consultant).	1 x MCR (completed by minimum 3 clinicians including 1 SEM consultant).
Multi-source feedback (MSF)	Minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical). MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF. There should be evidence of development points from each	1	1	1	1

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
	MSF and reflection on how these have progressed each year.				
Patient survey (PS)	Minimum response 20 patients. PS report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat PS. There should be evidence of development points from each PS and reflection on how these have progressed each year.	1	1	1	1
Membership Exam of the Faculty of Sport and Exercise Medicine			Recommended to have passed Part 1	Recommended to have passed Part 1 and Part 2	Passed Part 1 and Part 2
Advanced life support (ALS)		Valid	Valid	Valid	Valid
Level 3 Pitchside Trauma Course			Valid	Valid	Valid

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
Safeguarding	Level 3 for children and young people, and adults	Valid	Valid	Valid	Valid
Supervised Learning Events (SLEs): Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)	Formative and summative assessments, aligned to the level indicators for generic and specialty CiPs and to the trainee's PDP. Should also encompass reviews of patient correspondence and assessment of performance over whole clinics and their associated administration. Structured feedback should be given and reflected on by the trainee. Where an SLE outcome is 'below the level expected' further SLEs should be undertaken to show an attempt to progress in this area. SLEs must be undertaken throughout the training year and by a range of assessors, including supervisory consultants. There is no minimum number of SLEs. Instead, sufficient should be undertaken to demonstrate the above criteria.	Sufficient number of formative and summative SLEs undertaken throughout the training year to demonstrate performance at the target level descriptors for generic and speciality CiPs and accompanied by trainee reflection.	Sufficient number of formative and summative SLEs undertaken throughout the training year to demonstrate performance at the target level descriptors for generic and speciality CiPs and accompanied by trainee reflection.	Sufficient number of formative and summative SLEs undertaken throughout the training year to demonstrate performance at the target level descriptors for generic and speciality CiPs and accompanied by trainee reflection. Must include assessment of performance over a whole clinic and its associated administration.	Sufficient number of formative and summative SLEs undertaken throughout the training year to demonstrate performance at the target level descriptors for generic and speciality CiPs and accompanied by trainee reflection. Must include assessment of performance over a whole clinic and its associated administration.

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
Audit and/or Quality improvement (QI) project	Audit or QI project plan and report completed. QI project to be assessed with quality project tool (QIPAT).	Participating in QI activity (eg project plan or audit).	1 project completed with QIPAT or audit loop closed (including re-audit) and presentation of results.	Demonstrating leadership in QI activity; eg supervising another HCP, novel project development	Demonstrating leadership in QI activity, includes on-going evaluation and reflection on impact.
Clinical activity: MSK clinics	See curriculum for definition of clinics and educational objectives. SLEs to be used to give structured feedback with evidence of reflection and engagement in formative learning. Includes general adult, adolescent and paediatric MSK clinics.	Indicative minimum 1 general MSK clinic per week for 18 months of ST3 and ST4 training period. Other clinics as required to align to development of the target level descriptors for speciality CiPs.	Indicative minimum 1 general MSK clinic per week for 18 months of ST3 and ST4 training period. Other clinics as required to align to development of the target level descriptors for speciality CiPs.	Indicative minimum 2 general MSK clinics per week for whole training year. Other clinics as required to align to development of the target level descriptors for speciality CiPs.	Indicative minimum 2 general MSK clinics per week for whole training year. Other clinics as required to align to development of the target level descriptors for speciality CiPs.
Clinical activity: Team & event medicine	See curriculum for definition of clinics and educational objectives. Mini CEX / CbD to be used to give structured feedback.		UKAD anti doping advisor accreditation.	Longitudinal sport or institute attachment during ST5 or ST6. Indicative minimum time 1 day/week for 6 months. Valid UKAD anti-doping advisor accreditation.	Longitudinal sport or institute attachment during ST5 or ST6. Indicative minimum time 1 day/week for 6 months. Valid UKAD anti-doping advisor accreditation.
Teaching attendance	Summary of teaching attendance and reflection on learning to be recorded in ePortfolio.	Minimum 75% attendance at local/regional teaching. Minimum 75% attendance at national training days.	Minimum 75% attendance at local/regional teaching. Minimum 75% attendance at national training days.	Minimum 75% attendance at local/regional teaching. Minimum 75% attendance at national training days.	Minimum 75% attendance at local/regional teaching. Minimum 75% attendance at national training days.

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
		Evidence of reflection.	Evidence of reflection	Evidence of reflection.	Evidence of reflection.
Teaching and supervision skills	Teaching observation, training courses, clinical supervisor training.	Evidence of participation in teaching of medical students, junior doctors and other AHPs in clinical and non clinical settings. Evidence may include; teaching observations, participant feedback, attendance at teaching courses, qualification in medical education.	Evidence of participation in teaching of medical students, junior doctors and other AHPs in clinical and non clinical settings. Evidence may include; teaching observations, participant feedback, attendance at teaching courses, qualification in medical education.	Evidence of participation in teaching of medical students, junior doctors and other AHPs in clinical and non clinical settings. Evidence may include; teaching observations, participant feedback, attendance at teaching courses, qualification in medical education. Completion of clinical supervisor training.	Evidence of participation in teaching of medical students, junior doctors and other AHPs in clinical and non clinical settings. Evidence may include; teaching observations, participant feedback, attendance at teaching courses, qualification in medical education. Evidence of CS role; this might include examples of SLE's completed and reflection on supervision experiences.
Research	Research, critical appraisal and evidence based practice.		Evidence of critical thinking related to clinical questions. Evidence might include; research proposal, formal written work, participation within an existing research group, literature review as	Evidence of developing research awareness and competence. Evidence might include; research proposal, participation in research group/study, literature review, presentation at research meeting.	Evidence of further developing research awareness and competence. Evidence might include; research proposal, participation in research group/study, literature review,

Evidence / requirement	Notes	SEM ST3	SEM ST4	SEM ST5	SEM ST6
			background to QUIP and audit projects.	Completion of 'Good Clinical Practice' module.	presentation at research meetings.
Management, leadership and service development		Participation and awareness of management structure and function within the NHS and leadership principles. Evidence of own working in MDTs and on projects; this may include reflection on PS, MSF, MCR, other SLEs, QUIPS and audit.	Developing participation and awareness of management and leadership principles. Evidence of own working in MDTs and on projects; this may include reflection on PS, MSF, MCR, other SLEs, QUIPS and audit. Reflection should demonstrate progression of awareness and ability from ST3.	Lead at least one project/initiative. Evidence of understanding of managerial structures in NHS and non NHS settings. Continued reflection of progression of leadership ability from ST4 including on SLEs, PS, MSF, MCR, QUIPS and audit. Reflection should demonstrate progression of awareness and ability from ST4. Completion of leadership and management course.	Lead at least one project/initiative. Evidence of leadership in NHS, non NHS, clinical and non clinical settings. This may include; reflective portfolio demonstration progression of awareness and ability from ST5, PS, MSF, MCR, other SLEs, QUIPS and audit.

Practical procedural skills

Trainees must be able to outline the indications for the procedures listed in the table below and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthesia, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the trainee must be able to appreciate and recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Please see table below for minimum levels of competence expected in each training year.

Practical procedures – minimum requirements	**ST3**	**ST4**	**ST5**	**ST6**
US**		Completion of theory via eIFH training (theory and physics of US and safe practice including governance, equipment, image acquisition, image storage, image reporting, artefacts and the relevance of other imaging modalities to MSKUS and incorporation into clinical presentation). **Observe only**	Supervised US lists with MSK radiologist or other FSEM accredited mentor for an indicative 12 months or 40 clinics. One US course in ST5 or 6 (not a PGCert or masters). Log book of US cases with the level of supervision documented (supervised, minimally supervised, not supervised) supported by formative and summative DOPS. **Able to perform the procedure under direct supervision**	
Joint injections – including all aspects of safe practice including indications, consent and complications			Evidenced by formative and summative DOPS	**Maintain**

Practical procedures – minimum requirements	ST3	ST4	ST5	ST6
			Competent to perform the procedure unsupervised	
Landmark soft tissue injections			Able to perform without supervision landmark injections of upper and lower limb soft tissues. Evidenced by formative and summative DOPS **Competent to perform the procedure unsupervised**	**Maintain**
CPET and interpretation – variation in delivery of individual training schemes may mean this competency is achieved at an earlier stage				Evidenced by formative and summative DOPS. **Competent to perform the procedure unsupervised**
Respiratory function testing and interpretation including EVH testing – variation in delivery of individual training schemes may mean this competency is achieved at an earlier stage				Evidenced by formative and summative DOPS.

Practical procedures – minimum requirements	ST3	ST4	ST5	ST6
				Competent to perform the procedure unsupervised

*When a trainee has been signed off as being able to perform a procedure independently they are not required to have any further assessment (DOPS) of that procedure unless they or their educational supervisor think that this is required (in line with standard professional conduct). This also applies to procedures that have been signed off during foundation training or in other training programmes (e.g. ACCS).
** See FSEM UK MSK US Guidelines May 2019 for further guidance.

Levels to be achieved by the end of each training year speciality CiPs

Level descriptors
Level 1: Entrusted to observe only – no provision of clinical care
Level 2: Entrusted to act with direct supervision
Level 3: Entrusted to act with indirect supervision
Level 4: Entrusted to act unsupervised

Speciality CiPs	**ST3**	**ST4**	**ST5**	**ST6**
1. Leading and managing a multi-disciplinary team.	**2**	**2**	**3**	**4**
2. Ability to develop, lead and deliver a comprehensive musculoskeletal service that spans community and hospital settings for adults.	**2**	**3**	**3**	**4**
3. Ability to develop, lead and deliver a comprehensive musculoskeletal service that spans community and hospital settings for adolescents and school aged children.	**2**	**2**	**3**	**4**
4. Ability to deliver exercise medicine services for adults, encompassing both prevention and management of chronic disease.	**2**	**2**	**3**	**4**
5. Ability to deliver exercise medicine services for adolescents and school aged children, encompassing both prevention and management of chronic disease.	**2**	**2**	**3**	**4**
6. The ability to promote and support population health through physical activity.	**2**	**3**	**3**	**4**
7. Delivering effective resuscitation and early management of the acutely injured or unwell patient in the pre-hospital and hospital environments, including sports related mild traumatic brain injury.	**2**	**3**	**3**	**4**

Training programme

The sequence of training should ensure appropriate progression in experience and responsibility. The training to be provided at each training site is defined to ensure that, during the programme, the curriculum requirements are met and also that unnecessary duplication and educationally unrewarding experiences are avoided.

The following provides a guide on how training programmes should be focussed in each training year in order for trainees to gain the experience and develop the capabilities to the level required.

The curriculum specifies the range of diseases, impairments and disabilities that must be seen; and the range of contexts that they must be seen in; and the range of problems and severities of those problems that must be seen. This section gives, in broad terms, the areas that should be included in any training programme. Training is organized by both underlying causative conditions, and by the setting where patients are seen.

It is expected that the following environments will be accessible for trainees during the course of the programme.

The core features that should be provided for any training programme to deliver this curriculum are:

Musculoskeletal Medicine

MSK disorders are some of the most common disabling conditions within a population, and although patients with these conditions rarely need inpatient services, they constitute the majority of community-based patients.

This experience includes:

- Consultant led out-patient clinics in intermediary and secondary care, general practice, and community services
- Clinical experience with chronic pain services, specialist orthopaedic and rheumatological services, and services for functional disorders such as fibromyalgia and hypermobility syndrome.
- Involvement with orthotics and podiatry services
- Consultant led paediatric and adolescent MSK, orthopaedic, rheumatology, metabolic bone health and pain clinics that have paediatrician input
- Rehabilitation clinics
- MDT meetings
- Sport specific clinics

The trainee should undertake regular MSK clinics throughout training; an indicative minimum of 1 MSK clinic per week for 18 months out of first 2 years of training (ST3 and ST4) and indicative minimum of 2 per week in ST5 and ST6.

General Practice
The SEM trainee should spend the full time equivalent of an indicative 3-6 months in General Practice.

Population and Public Health
The SEM trainee should spend the full time equivalent of an indicative 6 months undertaking work specifically related to population health competencies over the duration of the training program

Accident and Emergency
The SEM trainee should spend an indicative 3-6 months full time equivalent in an Emergency Medicine setting

Sport National Governing Body and Home Institutes (English Institute of Sport, Scottish Institute of Sport)
Exposure to the high volume of sport specific conditions provides key learning opportunities that cannot be provided at the same level within the NHS. The training in these organisations will enable the SEM consultant to be the expert on these conditions within the NHS. The MDT environment of sport provides directly transferable skills to the NHS and the opportunity to work closely with a wider group of allied health professionals. This placement should give exposure to team, contact, disability and endurance sport.

Specialist Medical Departments

- Cardiology including adult and paediatric congenital heart disease, arrhythmias, exercise testing and ischaemic heart disease
- Respiratory including adult and paediatric asthma, COPD, breathlessness clinics
- Endocrinology including adult and paediatric diabetes and obesity clinics
- Disease specific rehabilitation services
- MDT pain services for both adults and children/adolescents

Simulation
Some of the practical procedures in the SEM curriculum should be taught by simulation in ST3 and ST4 if required. Further years should include refresher training for procedural skills where necessary. Other procedures, for example exercise testing, can only be performed in the clinical setting, so a mix of learning environments is necessary.

Musculoskeletal Ultrasound
The Faculty of Sport and Exercise Medicine (FSEM), in collaboration with the British Society of Skeletal Radiologists (BSSR), have produced a framework for SEM doctors who practice MSK ultrasound (MSKUS). This is a framework that recognises that MSKUS is a skill that develops over many years of practice. The majority of this will therefore be post CCT training but the basic skills and knowledge is embedded into

the curriculum. Using this framework, the training scheme will provide the following training in a mentored environment:

- An understanding of the theory and physics of MSKUS and safe practice including governance, equipment, image acquisition, image storage, image reporting, artefacts and the relevance of other imaging modalities to MSKUS
- Incorporation of MSKUS findings into the clinical presentation

These proficiencies will be achieved via:

- Theory and physics of MSKUS (elfH training modules), which should take place before attendance at US lists
- Attendance at US lists with an MSK radiologist or SEM mentor (who fulfil the FSEM criteria for a mentor) for an indicative 12 months or 40 clinics –in ST5 and/or ST6, mandated by the end of ST6
- Log book of US cases with the level of supervision documented; supervised, minimally supervised, not supervised (personal library to be reviewed at ARCP from ST5 onwards)

This exposure and mentored training can be used towards competency aligned to the FSEM framework. Any part of the framework where competency has been achieved can be signed off by the mentor. This will be aligned to the most up to date syllabus for FSEM UK MSK Training; 2017 or later.

Training resources links

Moving Medicine
ARCP decision aid
Sport and Exercise 2021 Curriculum
JRCPTB Physician Trainer Resources

Glossary of abbreviations

ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
BSSR	British Society of Skeletal Radiologists
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
CBME	Competency Based Medical Education
DME	Director of Medical Education
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
EIS	English Institute of Sport
FSEM	Faculty of Sport and Exercise Medicine
GPC	Generic Professional Capabilities
GMC	General Medical Council
HCI	Home County Institute
HoS	Head of School
JRCPTB	Joint Royal Colleges of Physicians Training Board
LFG	Local Faculty Group
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
MFSEM	Membership of the Faculty of Sport and Exercise Medicine
Mini CEX	Mini Clinical Evaluation Exercise
MMC	Modernising Medical Careers
MSKUS	Musculoskeletal Ultrasound
MSF	Multi-Source Feedback
NGB	National Governing Body
NTN	National Training Number
PDP	Professional Development Plan
PS	Patient Survey
RCR	Royal College of Radiology
SIS	Scottish Institute of Sport
SLE	Supervised Learning Event
WPBA	Workplace Based Assessment

JRCPTB

Joint Royal Colleges of Physicians Training Board

ROYAL COLLEGE *of* PHYSICIANS *of* EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians