JRCPTB

Joint Royal Colleges of Physicians Training Board

Geriatric Medicine ARCP Decision Aid 2022

This decision aid provides guidance on the requirement to be achieved for a satisfactory ARCP outcome at the end of each training year. The training requirements for Internal Medicine (IMS2) are set out in the IMS2 ARCP decision aid . The ARCP decision aids are available on the JRCPTB website https://www.jrcptb.org.uk/training-certification/arcp-decision-aids

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Educational supervisor (ES) report	One to cover the training year since last ARCP (up to the date of the current ARCP)	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms meeting or exceeding expectations and no concerns	Confirms performance is at the level appropriate for completion of specialty training and award of CCT
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. Trainees should complete self-rating for each CiP, which must be discussed with, and confirmed by, ES	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 expectations for completion of specialty training and award of CCT
Specialty capabilities in practice (CiPs)	See grid below for minimum levels expected for each year of training. Trainees should complete self-rating for each CiP, which must be discussed with, and confirmed by, ES.	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm trainee is performing at or above the level expected for all CiPs	Trainee must meet expectations for completion of specialty training and award of CCT (Level 4 for all specialty CiPs)

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Multiple consultant report (MCR)	An indicative minimum number. Each MCR is completed by a consultant who has supervised the trainee's clinical work. The ES should not complete an MCR for their own trainee	4	4	4	4
Multi-source feedback (MSF)	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM. An indicative 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	1 *(During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context)*	1 *(During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context)*	1 *(During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context)*	1 *(During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context)*
Patient survey	Indicative minimum of 20 responses required. Should be completed by ST6 but can be done earlier. ES should complete patient survey summary form and provide feedback to trainee			1	

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Supervised learning events (SLEs): Acute care assessment tool (ACAT)	An indicative minimum number to be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are identified. Each ACAT must include a minimum of 5 cases. ACATs should be used to demonstrate global assessment of trainee's performance on take or presenting new patients on ward rounds **(including community and care homes**), encompassing both individual cases and overall performance (e.g. prioritisation, working with the team).	4	4	4	Indicative minimum total 16 by the time of completion of specialty training
Supervised Learning Events (SLEs): Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)	An indicative minimum number to be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are identified. SLEs should be undertaken throughout the training year by a range of assessors. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee	8	8	8	Indicative minimum total 32 by the time of completion of specialty training

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
SCE in geriatric medicine	Trainees are encouraged to attempt the SCE in ST4/ST5			SCE attempted	SCE passed
Advanced life support (ALS)		Valid	Valid	Valid	Valid
Quality improvement (QI) project	Project to be assessed with quality improvement project tool (QIPAT).	Evidence of participation in quality improvement and leadership in QI activity (eg supervising another healthcare professional)	Evidence of participation in quality improvement and leadership in QI activity (eg supervising another healthcare professional)	Evidence of participation in quality improvement and leadership in QI activity (eg supervising another healthcare professional)	At least 1 specialty related QI project to be completed and assessed with QIPAT by the time of completion of specialty training *(In addition, at least 1 IM related QI project to be completed and assessed with QIPAT)*
Teaching observation (TO)	Indicative minimum number to be completed. At least one of the teaching observations should be performed for a teaching group including non-medical healthcare professionals (MDT)	1	1	1	Indicative minimum total 4 by the time of completion of specialty training *(1 TO to be carried out for IM teaching delivered by end of IMS2)*
Clinical activity: Outpatients	Trainees should attend a wide variety of clinics or alternatives (community experience, virtual clinics and work in ambulatory settings) in order to gain sufficient	Indicative minimum 20 clinics to include some specialty areas (falls, syncope, continence, bone health, memory,	Indicative minimum 20 clinics to include some specialty areas (falls, syncope, continence, bone health, memory,	Indicative minimum 20 clinics to include some specialty areas (falls, syncope, continence, bone health, memory,	Indicative minimum total 80 clinics to include all specialty areas by the time of completion of specialty training

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	competence in the specialty areas detailed in the curriculum. The choice of clinic / experience should be driven by the educational needs of the trainee. Summary of clinic / experience to be recorded in ePortfolio. Structured feedback to be given via mini CEX / CbD. Patient survey and reflective practice recommended.	movement disorders, stroke and TIA, heart failure, nutrition, tissue viability)	movement disorders, stroke and TIA, heart failure, nutrition, tissue viability)	movement disorders, stroke and TIA, heart failure, nutrition, tissue viability)	At least 2 MCR should comment on outpatient capability *(IM stage 2 requires minimum 20 outpatient clinics in specialties other than the trainee's specialty)*
Clinical activity: Geriatric medicine specialty specific activity	Trainees in geriatric medicine will require to gain experience in the management of people living with frailty, comprehensive assessment of acutely ill older people, rehabilitation of older people (including stroke), orthogeriatrics, movement disorders and acute stroke, and must rotate to community settings during the training programme	Evidence of active involvement in the care of in-patients and / or community dwelling patients	Evidence of active involvement in the care of in-patients and / or community dwelling patients	Evidence of active involvement in the care of in-patients and / or community dwelling patients	Evidence of active involvement in the care of in-patients and community dwelling patients presenting with the full range of geriatric medical problems
Teaching attendance	Indicative minimum hours per training year. Should include local training days in IM and geriatric medicine, national specialty	50 hours teaching attendance to include minimum of 25 hours recognised for CPD	50 hours teaching attendance to include minimum of 25 hours recognised for CPD	50 hours teaching attendance to include minimum of 25 hours recognised for CPD	Total 200 hours teaching attendance to include minimum of 100 hours recognised for CPD

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	meetings and other specific courses/CPD relevant to training. Summary of teaching attendance to be recorded in ePortfolio	points or organised/ approved by HEE local office or deanery	points or organised/ approved by HEE local office or deanery	points or organised/ approved by HEE local office or deanery	points or organised/ approved by HEE local office or deanery by the time of completion of specialty training
Generic competencies	A number of generic competencies must be gained during specialty training, including research skills, quality improvement skills, leadership and management skills and effective teaching skills. These may be obtained by attendance at specific training courses or by demonstrating equivalent training	Evidence of knowledge in at least one of the following: research methodology and good clinical practice, quality improvement skills, effective teaching skills, leadership and management	Evidence of knowledge in at least two of the following: research methodology and good clinical practice, quality improvement skills, effective teaching skills, leadership and management	Evidence of knowledge in at least three of the following: research methodology and good clinical practice, quality improvement skills, effective teaching skills, leadership and management	Evidence of knowledge of research and good clinical practice, quality improvement methodology, effective teaching skills, leadership and management by the time of completion of specialty training

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 procedure	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Dix-Hallpike test and Epley manoeuvre				Competent to perform unsupervised by the time of completion of specialty training
Bladder scanning (bedside ultrasound procedure)				Competent to perform unsupervised by the time of completion of specialty training

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).

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Levels to be achieved by the end of each training year for Geriatric Medicine specialty CiPs

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

Geriatric Medicine Specialty CiP	IM Stage 2 + Specialty training				CCT
	ST4	ST5	ST6	ST7	
1. Performing a comprehensive assessment of an older person, including mood and cognition, gait, nutrition and fitness for surgery in an in-patient, out-patient and community setting	2	3	4	4	CRITICAL PROGRESSION POINT
2. Managing complex common presentations in older people, including falls, delirium, dementia, movement disorders, incontinence, immobility, tissue viability, and stroke in an in-patient, out-patient and community setting	2	2	3	4	
3. Managing older people living with frailty in a hyper-acute (front door), in an in-patient, out-patient and community setting	2	3	3	4	
4. Managing and leading rehabilitation services for older people, including stroke	2	2	3	4	
5. Managing community liaison and practice	2	2	3	4	
6. Managing liaison with other specialties such as surgery, orthopaedics, critical care, oncology, cardiology, old age psychiatry	2	3	3	4	
7. Evaluating performance and developing and leading services with special reference to older people	2	2	3	4	
8. Specialty theme for service (ONE ONLY) a) Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatrics and bone health service b) Able to assess patients with urinary and faecal incontinence and is able to provide a continence service for a specific patient group in conjunction with specialist nursing, therapy and surgical colleagues c) Able to manage ill or disabled older people in a hospital at home, intermediate care and community setting and is able to provide a comprehensive community geriatric medicine service d) Able to manage patients with a wide range of movement disorders at any stage and is able to develop a specialist movement disorders service for older people e) Able to assess patients presenting acutely with stroke and TIA including suitability for cerebral reperfusion treatments and their subsequent ongoing medical management within an organised stroke service	2	2	3	4	