JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Implementation Geriatric Medicine Curriculum

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 Geriatric Medicine 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 Geriatric Medicine 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 2022 Geriatric 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

Geriatric Medicine higher specialty training will usually be completed in four years of full-time training. Trainees who wish to complete the full stroke sub-specialty programme will require to undertake an additional 6 months of dedicated stroke 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 Geriatric Medicine curriculum

The purpose of the curriculum is to produce doctors with the generic professional and specialty specific capabilities required to practice in Geriatric Medicine. Skills will be developed in the management of patients presenting with frailty, falls, dementia, delirium, stroke, declining mobility and functional impairment, polypharmacy and multiple co-morbidities, along with the ability to address the challenges of frailty, complex co-morbidity, different patterns of disease presentation, slower response to treatment, uncertain prognosis, end of life and requirements for rehabilitation or social support demanded by the

demographic changes of population ageing. Geriatricians have a wide variety of opportunities for research, and the training is designed to facilitate opportunities for academic careers.

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 dual CCT in Geriatric Medicine and Internal 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 **clinical CiPs** describe the capabilities required for Internal Medicine. The **specialty CiPs** describe the professional tasks or work within the scope of Geriatric 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.

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

Internal Medicine Clinical CiPs

1. Managing an acute unselected take
2. Managing an acute specialty-related take
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment

4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions
5. Managing medical problems inpatients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills

Geriatric Medicine Specialty CiPs

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. 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
3. Managing older people living with frailty in a hyper-acute (front door), in-patient, out-patient and community setting
4. Managing and leading rehabilitation services for older people, including stroke
5. Managing community liaison and practice
6. Managing liaison with other specialties, such as surgery, orthopaedics, critical care, oncology and old age psychiatry
7. Evaluating performance and developing and leading services with special reference to older people

Geriatric Medicine CiPs (themed for service)

Trainees will complete <u>one</u> additional higher-level outcome from the list below according to service theme:

1. Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatrics and bone health service
2. 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
3. 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
4. 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
5. 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 (see Stroke Medicine CiP)

Academic Geriatric Medicine is endorsed and encouraged in any of the above service themes, linked to a formal academic appointment or completion of a higher research degree or postgraduate certificate of education

Each of the CiPs is described in detail in the geriatric medicine curriculum.

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 (please see the CiPs tables and the assessment blueprint). The educational supervisor will make a holistic judgement based on the evidence provided, particularly the feedback from clinical supervisors and the multi disciplinary team. The list of evidence for each CiP is not exhaustive and other evidence may be equally valid.

Key presentations and conditions for Geriatric Medicine
The curriculum provides guidance on the presentations and conditions which form the clinical context in which the capabilities are demonstrated. In patients with multi-morbidity and frailty there will inevitably be a great deal of overlap between conditions and issues. For each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, pathophysiology, clinical features, investigation, management and prognosis, 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 the level expected for the current year of training. For the IM clinical and Geriatric Medicine 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 of these CiPs 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 and in the ARCP decision aid.

What the trainee needs to do

There is no major change in how the trainee needs to prepare for the ARCP. They still need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. 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 how many patients they have been involved with on the Acute Unselected Take in the summary of clinical activity form.

Each trainee must ensure that they have acquired multi-source feedback (MSF) 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 4 reports from consultants who are familiar with their work and who 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.

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 Geriatric Medicine Specialty Certificate Examination (SCE)
- a discussion about what resources are available to help with the programme
- developing a set of SMART Personal Development Plans (PDPs) for the training year
- 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;

- developing a PDP including SMART objectives for the placement
- access to clinics and how to meet the learning objectives
- expectations for medical on-call
- expectations for inpatient experience
- expectations to gain experience in subspecialty areas
- expectations for additional theme for service
- expectations for community experience
- expectations to gain experience in end-of-life care

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, with any aspects likely to result in a non-standard outcome at ARCP 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 **IM clinical** and **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 Points

- 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 might 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 in the acute medicine/on-call setting.

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.

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. Feedback should be discussed with the trainee. 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 for geriatric medicine is 4. This is in addition to those required for IM. 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.

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

Acute Care Assessment Tool (ACAT)

The ACAT is used to provide feedback on a trainee's performance when undertaking acute care, particularly the acute medical take. Its main focus is on multi- tasking, prioritisation and organisational skills. It should not be used to produce a "multiple Case Based Discussion". Each ACAT should cover the care of a minimum of five patients. Trainees in geriatric medicine may include patients seen on community wards and in care homes where acute care is provided.

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). At least one of the teaching observations should be performed for a teaching group including non-medical healthcare professionals (MDT)

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

Speciality Certificate Examination

The Specialty Certificate Examination assesses knowledge relevant for a consultant geriatrician and is designed to be undertaken prior to the end of the ST6 year. To gain a CCT in Geriatric Medicine the trainee must pass this examination and be able to demonstrate adequate application of this knowledge in the clinical setting.

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 (e.g.

attendance at training days, management meetings, teaching days, courses etc) 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.

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 review:

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Agree with the placement CSs how other support meetings will be arranged. Including;
    - Arrangements for LFGs or equivalent
    - Arrangements for professional development meetings

At the meeting 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 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
- Discuss procedural simulation
- 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 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

- 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;

- Review Transfers of Information on the trainee
- 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 personalized 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

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

All trainees will be required to move to the new curriculum unless in their final year of training (pro rata for those training less than full time). Evidence already collected will continue to be used in assessing levels of supervision for CiPs. There are only a small number of changes to the current syllabus and it is not envisaged that trainees should have difficulty in the transition between curricula. Each trainee should have an individualised 'gap analysis' undertaken by the TPD/ES to ensure that training rotations take account of individual training needs. It should be noted that the following are new requirements, and trainees should be supported to ensure that they are able to gain the relevant experience:

- Trainees must be able to perform the Dix-Hallpike test and Epley manoeuvre independently by the time of CCT
- Trainees must be able to perform bedside bladder ultrasound scans independently by the time of CCT
- Trainees must complete one additional theme for service by the time of CCT. Trainees should discuss with their TPD and ES which of these themes will be completed.

Further information about transferring curriculum is available on the JRCPTB website here.

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.

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.

Geriatric 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 Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. 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. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because:

- 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 allow the excuse 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 has been documented
- As a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has 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
- 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.

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)
Multiple consultant report (MCR)	An indicative minimum number. Each MCR is completed by a consultant who	4	4	4	4

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	has supervised the trainee's clinical work. The ES should not complete an MCR for their own trainee				
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	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	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)
exercise (mini-CEX)	assessors. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee				
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*

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
					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 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.	Indicative minimum 20 clinics to include some specialty areas (falls, syncope, continence, bone health, memory, movement disorders, stroke and TIA, heart failure, nutrition, tissue viability)	Indicative minimum 20 clinics to include some specialty areas (falls, syncope, continence, bone health, memory, movement disorders, stroke and TIA, heart failure, nutrition, tissue viability)	Indicative minimum 20 clinics to include some specialty areas (falls, syncope, continence, bone health, memory, movement disorders, stroke and TIA, heart failure, nutrition, tissue viability)	Indicative minimum total 80 clinics to include all specialty areas by the time of completion of specialty training 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),	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

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	orthogeriatrics, movement disorders and acute stroke, and must rotate to community settings during the training programme				
Teaching attendance	Indicative minimum hours per training year. Should include local training days in IM and geriatric medicine, national specialty meetings and other specific courses/CPD relevant to training. Summary of teaching attendance to be recorded in ePortfolio	50 hours teaching attendance to include minimum of 25 hours recognised for CPD points or organised/ approved by HEE local office or deanery	50 hours teaching attendance to include minimum of 25 hours recognised for CPD points or organised/ approved by HEE local office or deanery	50 hours teaching attendance to include minimum of 25 hours recognised for CPD points or organised/ approved by HEE local office or deanery	Total 200 hours teaching attendance to include minimum of 100 hours recognised for CPD 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).

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	

Training programme

Learning Outcomes

Geriatric Medicine Specialty CiPs
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. 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 3. Managing older people living with frailty in a hyper-acute (front door), in-patient, out-patient and community setting 4. Managing and leading rehabilitation services for older people, including stroke 5. Managing community liaison and practice 6. Managing liaison with other specialties, such as surgery, orthopaedics, critical care, oncology and old age psychiatry 7. Evaluating performance and developing and leading services with special reference to older people

Geriatric Medicine CiPs require the development of competencies in a variety of settings: in-patient, out-patient and community. Many aspects of the geriatric medicine curriculum will be covered throughout the training period, and in a number of rotations and units. The following provides a guide on how training programmes should be focussed in order for trainees to gain the experience and develop the capabilities to the level required.

Subspecialty areas require specific attachments to ensure that curricular requirements can be met.

- Psychiatry of old age (indicative 4 weeks wte)
- Palliative care (indicative 4 weeks wte)
- Orthogeriatrics
- Community liaison and practice
- Stroke
- Movement disorders
- Continence (attendance at dedicated continence clinics, attendance at urodynamics assessments, working with continence nurse specialist and physiotherapist, attendance at an education course)
- Additional theme for service (indicative 3 months wte)

Mandatory training

Acute medical take

Trainees should be involved in the acute unselected medical take as required by the IM Stage 2 curriculum

Inpatients
Trainees in Geriatric Medicine will require to rotate through units which provide 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.

Community settings
Trainees in Geriatric Medicine will be required to rotate to community settings to provide experience in undertaking comprehensive assessments and developing care plans in patients' own homes, care homes and in rehabilitation settings. They will be required to gain experience in working with community multidisciplinary teams and primary care teams to provide coordinated integrated case management.

Outpatients
Trainees should attend a wide variety of clinics in order to gain sufficient competence in the following areas:

- Falls
- Syncope (including tilt testing)
- Continence (including urodynamics, urogynaecology, physiotherapy)
- Osteoporosis and bone health
- Memory clinic or other clinic with a focus on dementia
- Movement disorders
- Stroke and TIA
- Heart failure and other cardiovascular diseases
- Nutrition (including dietetics)
- Tissue viability (including leg ulceration, vascular surgery, diabetes podiatry}

Reflecting changes in clinical practice, some of this training could be provided as community experience, virtual clinics and work in ambulatory settings. The choice of clinic / experience should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor, with the educational objectives as set out in the teaching and learning methods section.

Liaison experience
Trainees in Geriatric Medicine will be expected to gain experience and training in liaison work with other specialties, particularly old age psychiatry, surgery, orthopaedics, critical care, oncology, and palliative medicine. This may most commonly be achieved through sessional attachment and should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor, with the educational objectives as set out in the teaching and learning methods section

Research and quality improvement

Academic Geriatric Medicine is crucial to maintaining clinical excellence in an ageing population, and older people remain under-represented in the evidence base for clinical practice.
Trainees will be expected to be competent in basic research methodology, ethical principles of research, performing a literature search, and critical appraisal of medical literature (see Generic CiP 5). Trainees in Geriatric Medicine must be able to demonstrate application of the above principles with regard to older people living with frailty. Trainees will be expected to have completed a research methodology course and a Good Clinical Practice course and should gain experience of recruiting participants to clinical studies.
Trainees will be expected to be competent in principles of audit and quality improvement methodology (see Generic CiP 4), to have personal experience of involvement in quality improvement, and to have completed a quality improvement project. Trainees should have completed a formal study course on Quality Improvement.

Medical education
Trainees will be expected to demonstrate that they are competent in teaching and training, and in providing effective feedback (see Generic CiP 6). Trainees in geriatric medicine will be expected to demonstrate competence in teaching or mentoring a wide variety of healthcare professionals who form part of the multi-disciplinary team. Trainees will be expected to have completed an appropriate teaching skills course.

Leadership and management
Trainees will be expected to demonstrate competence in understanding of NHS management and clinical governance structures (see Generic CiP 1). In addition, trainees in Geriatric Medicine will be expected to demonstrate competence in leadership and management specifically relating to older people (see Specialty CiP 7). Trainees will be expected to have completed a Leadership and Management course.

Additional theme for service
Trainees must complete one additional theme for service from a choice of five. Additional 'themes for service' capabilities will be integrated into the final 3 years of Geriatric Medicine training and should consist of an indicative 3 months whole time equivalent dedicated experience in the chosen field. Each theme has been selected to ensure service needs are met, including the needs of stroke medicine. Newly appointed consultants may be required to take on a role as a service lead and a dedicated focus on one of the specific service areas will equip trainees at CCT to be able to do this. Trainees are required to be able to demonstrate a greater depth of experience and level of competence than required by the core syllabus.

Learning Outcomes: Geriatric Medicine CiPs (themed for service)

Geriatric Medicine CiPs (themed for service)
Trainees will complete <u>one</u> additional higher-level outcome from the list below according to service theme:

1. Able to manage older patients presenting with fracture and is able to provide a comprehensive orthogeriatrics and bone health service
2. 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
3. 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
4. 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
5. 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 (see Stroke Medicine CiP)

Training resources links

Trainee Curriculum FAQs | British Geriatrics Society (bgs.org.uk)

Training requirements for higher specialist trainees in geriatric medicine: Palliative and end of life care | British Geriatrics Society (bgs.org.uk)

Training requirements for higher specialist trainees: Community liaison and practice | British Geriatrics Society (bgs.org.uk)

Training requirements for higher specialist trainees: Tissue viability | British Geriatrics Society (bgs.org.uk)

JRCPTB Geriatric Medicine webpage

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
BGS	British Geriatrics Society
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
GPC	Generic Professional Capabilities
GMC	General Medical Council
JRCPTB	Joint Royal Colleges of Physicians Training Board
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MMC	Modernising Medical Careers
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
PS	Patient Survey
SCE	Specialty Certificate Examination
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