JRCPTB

Joint Royal Colleges of Physicians Training Board

Rehabilitation Medicine ARCP Decision Aid 2021 – updated June 2024

This decision aid provides guidance on the requirements to be achieved for a satisfactory ARCP outcome at the end of each training year. This document is available on the JRCPTB website https://www.jrcptb.org.uk/training-certification/arcp-decision-aids

Evidence / requirement	Notes	Year 1 (ST3)	Year 2 (ST4)	Year 3 (ST5)	Year 4 (ST6)
Educational supervisor (ES) report	One per year 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 will meet all requirements needed to complete training
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. 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 expectations for level of training
Specialty 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 CiP	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	ES to confirm level 4 in all CiPs by end of training
Multiple consultant report (MCR)	Indicative requirement. 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)	Minimum of 12 raters to include a mixture of staff with no more than 3 doctors. MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are	1	1	1	1

Evidence / requirement	Notes	Year 1 (ST3)	Year 2 (ST4)	Year 3 (ST5)	Year 4 (ST6)
	raised then arrangements should be made for a repeat MSF				
Supervised learning events (SLEs): **Case conference assessment tool (cCAT)**	Indicative requirement. This tool only applies to case conferences when the patient and family are present. A trainee should perform six in the first two years and six in the second two years. If possible, at least two should be undertaken in the first year. A consultant or other senior medical staff should assess the assessment and feedback.	6		6	
Supervised Learning Events (SLEs): **Case-based discussion (CbD) and mini-clinical evaluation exercise (mini-CEX)**	Indicative requirement. SLEs should be undertaken regularly throughout the training year (i.e. 4 every 4 months) and should cover a range of diseases, impairments, and contexts. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee	12 (to include minimum of 4 CbDs and 4 mini-CEX)	12 (to include minimum of 4 CbDs and 4 mini-CEX)	12 (to include minimum of 4 CbDs and 4 mini-CEX)	12 (to include minimum of 4 CbDs and 4 mini-CEX)
Quality improvement project (QIP)	Evidence of involvement in QI expected each year with completion of two QIPs assessed with QIP assessment tool (QIPAT) during training	Evidence of involvement in QIP	1 completed QiP with QIPAT	Evidence of involvement in QIP	1 completed QiP with QIPAT
Teaching observation (TO)	Indicative requirement. At least one TO per year to be completed by a consultant	1	1	2	3
Patient survey	Indicative minimum of 20 responses required. ES should complete patient survey summary form and provide feedback to the trainee	1		1	
Reflective entries	Evidence of reflective practice. There should be regular reflective entries, at least half being related to clinical events				

Practical procedural skills

Trainees must be able to outline the indications for the procedures 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. 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).

Practical procedure	Year 1 (ST3)	Year 2 (ST4)	Year 3 (ST5)	Year 4 (ST6)
Botulinum toxin injection for limb spasticity	Satisfactory supervised practice	Satisfactory supervised practice	Competent to perform unsupervised	Maintain

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Outline grid of levels expected for Rehabilitation Medicine specialty CiPs

Level descriptors

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

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