Rough Guide to Implementation
Acute Internal Medicine Curriculum
Guidance for training programme directors,
supervisors and trainees

August 2022

Contents

Introduction

This guide for Acute Internal Medicine (AIM) 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 AIM 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 AIM 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.

A key change in the new Acute Internal Medicine (AIM) 2022 curriculum is the addition of bedside ultrasound competencies as a core part of the curriculum for all trainees. Other main differences include managing Acute Medical Units (AMUs) and Same Day Emergency Care (SDEC) areas.

Duration of training

AIM 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 2022 AIM curriculum

The purpose of the curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to manage patients presenting with a wide range of acute medical symptoms and conditions and to take responsibility of an acute medical service.

AIM focuses on the assessment and management of unselected medical patients, thus the scope of AIM requires diagnostic reasoning, the ability to manage uncertainty, to deal with comorbidities, and to recognise when input from another speciality may be required.

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 higher specialty training, the trainee will receive a dual CCT in AIM 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 physicianly 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 AIM.

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 the acute care of patients within a medical specialty service

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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

Specialty CiPs
1. Managing Acute Medicine Services
2. Delivering alternative patient pathways including medical same day emergency care
3. Prioritising and selecting patients appropriately according to the severity of their illness, including making decisions about appropriate escalation of care
4. Integrate with other specialist services including Intensive Care, Cardiology, Respiratory and Geriatric medicine
5. Managing the interface with community services including complex discharge planning at the front door
6. Developing a specialty skill within the domains of clinical, academic, research or practical skills

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 possible evidence shown 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. The presentation and conditions listed 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.

Bedside ultrasound has become one of the core practical procedures, and includes competencies in thoracic, abdominal / renal and DVT imaging, in addition to siting peripheral vascular access under ultrasound guidance. These competencies are summarised in the table below:

Body System	Core pathologies	Core skills
Thoracic	Pulmonary oedema Pneumonia Pleural effusion Pneumothorax	Site mark for drainage of pleural effusions (as per BTS guidance)
Abdominal / renal	Hydronephrosis Bladder distension Abdominal free fluid	Site mark for paracentesis / ascitic tap
Lower limb	DVT (rule in)	-
Peripheral vascular access	-	Ultrasound guided peripheral vascular access

These competencies can be achieved in a number of ways. Local training programmes can be developed, which should include an assessment process approved by the regional specialty training committee (STC). Alternatively, doctors in training can undertake one of the established training courses for initial acquisition of competence. To maintain competence an indicative one day per week should be utilised within the first two years of training to facilitate further development of competencies. At a local level the acute internal medicine trainers should forge links with radiology services so that trainees have regular access to sonographer or radiologist lists to help maintain competencies.

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 IM clinical and 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 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 and in the ARCP decision aid.

What the trainee needs to do

The requirements for an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs) are documented in the ARCP decision aid (see ARCP section below). 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 four 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 SCE when appropriate
- a discussion about which resources are available to help with the programme
- develop 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), who may be the same person as the ES, to discuss the opportunities in the current placement including;

- develop 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 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 progress 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 an individual trainee but also 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 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 is four per training year

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.

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

Speciality Certificate Examination

The Specialty Certificate Examination has been developed by the Federation of Royal Colleges of Physicians in conjunction with the Society for Acute Medicine. This examination is designed to be undertaken by the trainee in the second or third year of training and must be completed by CCT. The examination tests the extra knowledge base that the trainees have acquired since taking the MRCP(UK) diploma.

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.

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 assess 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 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
- 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 assess 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

The GMC's policy statement on the transition of learners to a new curriculum sets out the requirements for doctors in training who are working towards a CCT to move to the most recent GMC approved curriculum and programme of assessment. The transition should be completed as soon as it is feasibly possible, taking account of patient and trainee safety whilst also balancing the needs of the service.

A key requirement in the new Acute Internal Medicine (AIM) 2022 curriculum is to acquire bedside ultrasound competencies. A two-year transition period has been agreed with the GMC to allow current trainees with a CCT date prior to August 2024 to remain on the previous curriculum if it is not possible for them to transfer to the 2022 curriculum and acquire the bedside ultrasound competencies. If trainees with a CCT date prior to August 2024 wish to transfer to the 2022 curriculum this would be in discussion with their local training programme director to ensure that the relevant training in bedside ultrasound would be available within their current training time.

Doctors in their final year of training (pro rata for less than full time trainees), or for whom it would not be in the interests of patient safety or impractical to support to move to a new curriculum, will normally remain on the curriculum in place prior to the new approval.

Guidance for trainees transferring to the new curriculum:
- Transition should ideally be at the point at which a trainee progresses into the next training grade/level. Transfer will be to the 2022 curricula for AIM and Internal Medicine.
- Educational supervisors should agree individual transition plans with their trainees, with training programme directors providing guidance for this. The educational supervisor and trainee should review the new curriculum learning outcomes - 'capabilities in practice' - and identify any gaps that need to be addressed. This 'gap analysis' will help deaneries to tailor the training programme to ensure the trainee encounters relevant learning experiences. Any additional training time and change to the CCT date should be agreed by the first ARCP.
- A form will be provided on the ePortfolio to facilitate and record the curriculum transfer and gap analysis discussion.

- Trainees will not be required to re-link or transfer evidence from the previous curriculum and should start using the new curriculum in their ePortfolio account.

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.

Acute Internal 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.

Acute Internal Medicine 2022 ARCP Decision Aid

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	An indicative 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

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 - of which at least 3 MCRs completed by consultants who have personally supervised the trainee in an acute take/post-take setting	4 - of which at least 3 MCRs completed by consultants who have personally supervised the trainee in an acute take/post-take setting	4 - of which at least 3 MCRs completed by consultants who have personally supervised the trainee in an acute take/post-take setting	4 - of which at least 3 MCRs completed by consultants who have personally supervised the trainee in an acute take/post-take setting
Multi-source feedback (MSF)	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	1	1	1
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.	4	4	4	4

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
	ACATs should be used to demonstrate global assessment of trainee's performance on take or presenting new patients on ward rounds, encompassing both individual cases and overall performance (eg prioritisation, working with the team). It is not for comment on the management of individual cases				
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	4	4	4	4

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
SCE	Failure to pass AIM SCE Exam by the end of ST6 will result in a non-standard ARCP outcome		Attempted	Attempted	Passed
Advanced life support (ALS)		Valid	Valid	Valid	Valid
Clinical Governance Quality improvement (QI) project	Evidence of engagement with Quality Improvement and Clinical Governance required on a yearly basis	Evidence of involvement in answering complaints, Coroners referrals, Datixes, audit or QI	Evidence of involvement in answering complaints, Coroners referrals, Datixes, audit or QI	Evidence of involvement in answering complaints, Coroners referrals, Datixes, audit or QI	QI project plan and report to be completed. Project to be assessed with quality improvement project tool (QIPAT)
Simulation	All practical procedures should be taught by simulation as early as possible in ST4 Refresher training in procedural skills should be completed if required	Evidence of simulation training (minimum one day) including procedural skills			Evidence of simulation training including human factors and team-based scenario training
Teaching attendance	An indicative minimum hours per training year. To be specified at induction Summary of teaching attendance to be recorded in ePortfolio	50 hours teaching attendance to include minimum of 20 hours AIM teaching recognised for CPD points or organised/ approved by HEE local office/deanery	50 hours teaching attendance to include minimum of 20 hours AIM teaching recognised for CPD points or organised/ approved by HEE local office/deanery	50 hours teaching attendance to include minimum of 20 hours AIM teaching recognised for CPD points or organised/ approved by HEE local office/deanery	50 hours teaching attendance to include minimum of 20 hours AIM teaching recognised for CPD points or organised/ approved by HEE local office/deanery

Evidence / requirement	Notes	Year 1 (ST4)	Year 2 (ST5)	Year 3 (ST6)	Year 4 (ST7)
Teaching					Teaching assessment and evidence of teaching capability (eg formal teaching course)
Management					Evidence of management skills and knowledge (eg completion of a management course)
Specialty skill	See curriculum for list of specialty skills and guidance for training and assessment		Decide on specialty skill and commence attainment		Formal sign off of specialty skill as per curriculum

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. 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).

Procedure	ST4	ST5	ST6	CCT
Advanced cardiopulmonary resuscitation (CPR)	Leadership of a cardiac arrest team	Maintain	Maintain	Maintain
Central venous cannulation (internal jugular and femoral)	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Intraosseus access to circulation	Skills lab or satisfactory supervised practice	Maintain	Maintain	Maintain
Intercostal drain for pneumothorax	Competent to perform unsupervised	Maintain	Maintain	Maintain
Intercostal drain for effusion [a]	Competent to perform unsupervised	Maintain	Maintain	Maintain
Knee aspiration	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain
Abdominal paracentesis	Competent to perform unsupervised	Maintain	Maintain	Maintain

Procedure	ST4	ST5	ST6	CCT
Setting up Non Invasive Ventilation or CPAP		Skills lab or satisfactory supervised practice	Maintain	Competent to perform unsupervised
Arterial line insertion		Competent to perform unsupervised	Maintain	Maintain
Point of care ultrasound	Theoretical course attended	Signed off as competent in focused chest, abdominal and lower limb ultrasound	Maintain	Maintain

Levels to be achieved by the end of each training year and at critical progression points for AIM specialty CiPs

Outline grids of levels expected for Acute Internal Medicine clinical CiPs at the end of each year of training

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 CiP	Acute Internal Medicine				CCT
	ST4	ST5	ST6	ST7	
1. Managing acute services	2	3	3	4	
2. Delivering alternative patient pathways including ambulatory care	2	3	3	4	
3. Prioritising and selecting patients appropriately according to the severity of their illness, including making decisions about appropriate escalation of care	2	3	3	4	
4. Integrate with other specialist services including Intensive Care, Cardiology, Respiratory and Geriatric medicine	2	3	3	4	
5. Managing the interface with community services including complex discharge planning	2	3	3	4	
6. Developing a specialty skill within several broad domains. These are clinical, academic, research or procedural skills	Skill chosen	Skill started	Skill development	Skill complete	

CRITICAL PROGRESSION POINT

Training programme

AIM will be an indicative four year programme in combination with Internal Medicine (IM) stage 2 training. The programme will include mandatory training placements in geriatric medicine, intensive care, respiratory medicine and cardiology, in addition to dedicated training on Acute Medicine Units and Ambulatory Care Units. There will be a critical progression point at the end of the training programme to ensure trainees have the required capabilities and are entrusted to undertake the role of the Acute Medicine consultant.

The model for physician training and the AIM curriculum will:
- Ensure trainee physicians can provide safe emergency and acute care during, and on completion of, their formal postgraduate training
- Ensure that AIM doctors develop and demonstrate a range of essential capabilities for managing patients with both acute and long-term conditions
- Ensure that trainee physicians can acquire and demonstrate all of the GMC mandated GPCs including communication skills
- Allow flexibility between specialties through GPCs and higher level learning outcomes
- Further develop the attributes of professionalism, particularly recognition of the primacy of patient welfare that is required for safe and effective care of those with both acute and long-term conditions
- Develop physicians who ensure patients' views are central to all decision making
- Provide the opportunity to develop leadership, team working and supervisory skills in order to deliver care in the setting of a contemporary multidisciplinary team and to work towards making independent clinical decisions with appropriate support
- Provide doctors with a variety of hospital, and academic workplace experience during their programme.

All doctors will have the opportunity to understand the interface with community care provision. The scope of AIM requires diagnostic reasoning and the ability to manage uncertainty, deal with comorbidities, and recognise when another speciality opinion or care is required. AIM focuses on the initial assessment and management of unselected medical patients.

Training in AIM produces clinicians who are comfortable managing a wide range of medical conditions, with a particular focus on risk assessment and ambulatory management. Critical care competencies form part of the programme and AIM trained clinicians will be able to manage critically unwell patients in conjunction with critical care teams. AIM trained clinicians will be able to understand the importance of flow through acute services and also the integration of these services within the wider health care community.

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.

Whilst in all AIM training programme placement the trainee should expect

- Educational Supervisor who is an Acute Physician
- 1 day per week non-clinical (or equivalent) for bedside ultrasound / specialist skill / audit / QIP
- Adequate opportunity for WPBAs
- Regular local teaching
- Allocated time for admin / clinic letters

In specific posts on the program the trainees should expect

On AMU placement
- Essential:
    - Exposure to AMU ward rounds ensuring trainee gets exposure to a wide variety of patients
    - Regular SDEC / Ambulatory care experience
    - Procedural exposure as per curriculum – paracentesis, chest drain and aspiration, knee aspiration and lumbar puncture
    - Adequate opportunity for WPBA – including 'reverse ward rounds'
- Desirable:
    - Able to achieve bedside ultrasound and exposure to focused echo if desired
    - Departmental US machine dedicated to the AMU (ideally with linear/curvilinear/phased array probes)
    - Opportunity to 'act up' where appropriate within training programme and stage of training

In Geriatric Medicine
- Essential:
    - Clinics – including falls, movement disorders, acute geriatrics
    - Supervised ward rounds
    - CGA (Comprehensive Geriatric Assessment) teaching and experience
    - Close liaison with MDT (including complex discharge planning)
    - Geriatric pharmacology, ethics and communication
- Desirable:
    - In reach to ED / acute frailty exposure
    - Elderly psychiatrist liaison attachment
    - Palliative care team exposure

In Respiratory Medicine
- Essential:
  - Clinics - including asthma, COPD, lung cancer, ILD, 'Hot services'
  - Supervised ward rounds
  - Inpatient referral experience including ESD support services
  - CPAP, NIV and Hi Flow Nasal Oxygen (advanced respiratory support) setup and management
- Desirable:
  - Pleural clinic, including thoracic ultrasound and procedural experience
  - Lung MDT experience (including presenting patients)
  - Respiratory radiology meetings

In Cardiology
- Essential:
  - Clinics – including rapid access chest pain, heart failure and arrhythmia
  - Supervised ward rounds
  - CCU ward rounds and experience
  - Inpatient referral experience including ESD services
- Desirable:
  - Heart failure ward rounds
  - DCCV +- pericardiocentesis experience
  - Opportunity to accredit in focussed echo +- attend echo meetings
  - Catheter lab exposure including primary PCI experience

In Intensive Care
- Essential:
  - Ward rounds (supervised where possible)
  - Inpatient referral experience (i.e. utreach) including ICU admission criteria
  - Experience of surgical complications / medical problems in surgical patients, airway compromise, the 'emergency presentations'
  - Experience of airway management using adjuncts and bag valve and mask
  - Experience with NIV – settings and monitoring
  - Renal replacement therapy indications and options
  - Procedural exposure as per curriculum: CVC insertion, arterial line insertion, femoral line insertion.
  - Medicolegal, ethics, organ donation and communication aspects of Intensive Care Medicine
- Desirable:
  - Bedside ultrasound +- focussed echo experience
  - Basic principles of managing brain injury

- Exposure to brain stem testing

For speciality skills please see the curriculum. Please note not every location will be able to deliver every possible skill. It is suggested that the trainee approaches this with their ES over the ST4 year to be in a position to start them in ST5/6.

Training resources links

JRCPTB webpage for Acute Internal Medicine
Society for Acute Medicine
Information regarding FAMUS (with subsequent links to learning resources)

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
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
FAMUS	Focused acute medicine ultrasound
FUSIC	Focused ultrasound for intensive care
GPC	Generic Professional Capabilities
GMC	General Medical Council
IMY1-3	Internal Medicine Year 1-3
JRCPTB	Joint Royal Colleges of Physicians Training Board
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
POCUS	Point of Care Ultrasound
PS	Patient Survey
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