

Curriculum for Acute Internal Medicine Training

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1. Introduction

Training in Acute Internal Medicine (AIM) will take trainees who have completed IM stage 1 (or equivalent) to the level at which they have the capabilities required to acquire a certificate of completion of training (CCT) in Acute Internal Medicine and are thereby deemed capable of working as independent practitioners in this specialty. All trainees will undertake AIM training alongside training in Stage 2 of Internal Medicine.

This curriculum defines the purpose, content of learning, process of training and the programme of assessment for the Acute Internal Medicine training.

2. Purpose

Curriculum purpose

The purpose of the Acute Internal Medicine (AIM) curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to manage patients presenting with a wide range of medical symptoms and conditions. If they have completed training satisfactorily they will be eligible for a CCT (or CESR CP) and can be recommended to the GMC for inclusion on the specialist register. At this stage they will be regarded as capable of independent unsupervised practice and will be eligible for appointment as an NHS consultant.

AIM will be a 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.

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 Acute Internal Medicine 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 curriculum for AIM has been developed with the support and input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay people. This has been through the work of the AIM Specialist Advisory Committee and its subgroups and at stakeholder engagement events.

Scope of practice

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.

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.

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.

Competitive entry into AIM training will take place following successful completion of Internal Medicine Training (IMT) stage 1 or Acute Care Common Stem (Acute Medicine). AIM is a Group 1 speciality and will dual train with IM stage 2. The curriculum will be managed by the Joint Royal College of Physicians Training Board (JRCPTB).

The IM capabilities in practice (CiPs) will be shared across all physician curricula, supporting flexibility for trainees to move between the specialties. The generic capabilities and mapping of the curriculum to the GMC's Generic Professional Capabilities (GPC) framework will facilitate transferability of learning outcomes across other related specialties and disciplines.

Population and service need

The Shape of Training (SoT) review was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused, more general (especially in the early years) and

with more flexibility of career structure. For physician training, the views and recommendations of SoT were similar to those of the Future Hospital Commission and the Francis report. With a changing population, and both young and elderly patients exhibiting co-morbidities and increasing complexity, acute medical services need a different approach to training the physician of the future.

A further driver for change was the GMC's review of the curricula and assessment standards and introduction of the GPC framework. From May 2017, all postgraduate curricula should be based on higher level learning outcomes and must incorporate the generic professional capabilities. A fundamental component of the GPCs is ensuring that the patient is at the centre of any consultation and decision making. To this end, communication skills are emphasised throughout all the CiPs (see below) and evidenced through work based assessments (particularly the multi-source feedback (MSF) tool).

The JRCPTB, on behalf of the Federation of Royal Colleges of Physicians, has produced a model for physician training that consists of an indicative seven year (dual) training period leading to a CCT in a speciality and internal medicine. There will be competitive entry into AIM and internal medicine dual training programmes following completion of stage 1 training in internal medicine or Acute Care Common Stem (Acute Medicine), during which there will be increasing responsibility for the acute medical take and the MRCP(UK) Diploma will be achieved. An indicative 12 months of internal medicine will be integrated flexibly within the dual training programme. This will ensure that CCT holders are competent to practice independently at consultant level in both AIM and IM.

The AIM curriculum will produce a workforce that reflects the current trends of increasing patient attendances to both primary care and emergency departments and therefore increasing onward referrals to acute medicine. This workforce will be trained to manage complex multi-morbidity in an ageing population and be able to manage many conditions in an ambulatory capacity. There is a growing need from a service perspective for Acute Medicine consultants, with over 150 consultant posts advertised in 2016-17, but less than 50% of these posts were successfully appointed to. (Ref Focus on Physicians: Census of Consultant Physicians and Higher Speciality Trainees 2016-17).

Interdependencies

The AIM curriculum is designed to address the need to attract more trainees to the acute specialities. This is facilitated by the inclusion of training in a specialty skill relevant to AIM training. This is in keeping with the principles of integration with other professional groups, generalisability of skills, longer term sustainability of the workforce, and future service provision.

Flexibility and transferability

The curriculum incorporates and emphasises the importance of the generic professional capabilities (GPCs). GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty. In addition, the IM generic CiPs

will be shared across all physicianly curricula and the IM clinical CiPs will be shared across all group 1 specialities, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training.

The AIM curriculum is designed to facilitate less than full time (LTFT) training, and the speciality of AIM is very suitable for flexible and LTFT Consultant and trainee working due to its sessional basis.

High level outcomes; capabilities in practice

The AIM capabilities in practice (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 in all CiPs.

The CiPs have been mapped to the GPC domains and subsections to reflect the professional generic capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each of the CiPs, the doctor in training's performance meets or exceeds the minimum expected level for completion of training, as defined in the curriculum.

The AIM outcomes comprise six specialty CiPs, six generic CiPs which are shared across all physician specialties and eight IM clinical CiPs shared across all group 1 specialties.

The sixth specialty CiP involves the trainee choosing a specialty skill to develop during their AIM training. This is enabled by giving each trainee approximately on average one a day a week of time within their training to develop this skill. In the vast majority of cases this will not involve an increase in training time. Specialty skills are also an important part of preparing trainees in AIM to deliver key areas of service going forward, such as medical education, management and leadership, and research to develop the evidence base for AIM.

Learning outcomes – capabilities in practice (CiPs)
Generic CiPs
<ol style="list-style-type: none">1. Able to successfully function within NHS organisational and management systems2. Able to deal with ethical and legal issues related to clinical practice3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement4. Is focussed on patient safety and delivers effective quality improvement in patient care5. Carrying out research and managing data appropriately6. Acting as a clinical teacher and clinical supervisor

Clinical CiPs (Internal Medicine)
<ol style="list-style-type: none"> 1. Managing an acute unselected take 2. Managing the acute care of patients within a medical specialty service 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 in patients 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
<ol style="list-style-type: none"> 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

2.1 Development

This curriculum was developed by the Curriculum Development Committee under the direction of the Joint Royal Colleges of Physicians Training Board (JRCPTB). The members of the CDC have broad UK representation and include consultants who are actively involved in teaching and training, trainee representatives, service representatives and lay persons.

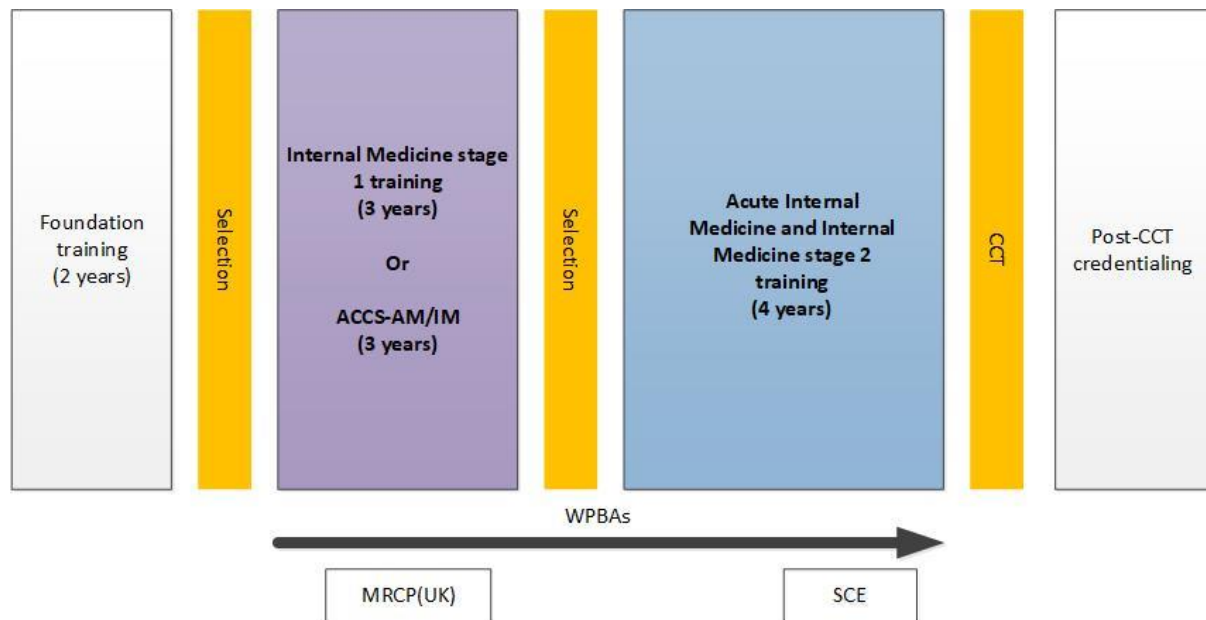
The model has been shared widely with numerous organisations including: councils of the three physician Royal Colleges and regional advisors, the trainees committees of the three colleges, the medical specialties board based in London, heads of school of medicine and the postgraduate deans. JRCPTB has held a series of consultation events with these stakeholders. In addition, podcasts have been available on YouTube and the JRCPTB website.

2.2 Training Pathway

Competitive entry into AIM training will take place following successful completion of Internal Medicine Training (IMT) stage 1 or Acute Care Common Stem (Acute Medicine). AIM is a Group 1 speciality and will dual train with IM stage 2.

Trainees in AIM will undertake an indicative four year training programme, which will include an indicative one year of IM stage 2 training. This will be integrated flexibly within the specialty training programme (some programmes will choose to run this as a separate year whilst others will integrate it within the specialty training). Internal medicine training will include supporting the acute unselected and the acute specialty take.

Training pathway – dual training with group 1 specialties



2.3 Duration of training

Training in AIM in combination with IM 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 more rapidly than the current indicative time although it is recognised that clinical experience is a fundamental aspect of development as a good physician (guidance on completing training early will be available on the [JRCPTB website](#)). There may also be a small number of trainees who develop more slowly and will require an extension of training in line with the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)¹.

2.4 Flexibility

GPCs will promote flexibility in postgraduate training as these common capabilities can be transferred from specialty to specialty, supporting flexibility for trainees to move between these specialties without needing to repeat aspects of training.

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

Specialty curricula will identify shared capabilities across relevant specialties and as curriculum become more modular we expect greater flexibility in higher specialty training.

2.5 Less than Full Time Training

Trainees are entitled to opt for less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

AIM as a speciality welcomes less than full time trainees and is entirely supportive of their development through our training programme.

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide.

2.6 Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic professional capabilities (GPC) framework² with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

² [Generic professional capabilities framework](#)

The nine domains of the GMC's Generic Professional Capabilities



Good medical practice (GMP)³ is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

The GPC framework describes nine domains with associated descriptor outlining the 'minimum common regulatory requirement' of performance and professional behaviour for those completing a CCT or its equivalent. These attributes are common, minimum and generic standards expected of all medical practitioners achieving a CCT or its equivalent.

The 20 domains and subsections of the GPC framework are directly identifiable in the AIM curriculum. They are mapped to each of the generic and specialty CiPs, which are in turn mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

This approach will allow early detection of issues most likely to be associated with fitness to practise and to minimise the possibility that any deficit is identified during the final phases of training.

³ [Good Medical Practice](#)

3 Content of Learning

The practice of Acute Internal Medicine requires the generic and specialty knowledge, skills, attitudes and procedural skills to manage patients presenting with a wide range of medical symptoms and conditions. It involves particular emphasis on diagnostic reasoning, managing uncertainty, dealing with comorbidities, and recognising when another specialty opinion or care is required.

The internal medicine curriculum is spiral and topics and themes will be revisited to expand understanding and expertise. The level of entrustment for capabilities in practice (CiPs) will increase as an individual progresses from 'competent' to 'expert'.

3.1 Capabilities in practice

3.2 Generic capabilities in practice

3.3 Clinical capabilities in practice

3.4 Specialty capabilities in practice

The six AIM clinical CiPs describe the clinical tasks or activities which are essential to the practice of Acute Internal Medicine. The clinical CiPs have been mapped to the nine GPC domains to reflect the professional generic capabilities required to undertake the clinical tasks.

Satisfactory sign off will require educational supervisors to make entrustment decisions on the level of supervision required for each CiP and if this is satisfactory for the stage of training, the trainee can progress. More detail is provided in the programme of assessment section of the curriculum.

Specialty CiPs	
1. Managing Acute Medical Services	
Descriptors	Demonstrates knowledge, skills and attitudes that: <ul style="list-style-type: none">• Maximise the effectiveness of the Acute Medicine Unit (AMU)• Enables prompt decision making and patient communication in acute medical patients• Enables making multiple decisions or manage the care of multiple patients progressing in one time period• Enables care for patients with diagnostic uncertainty in the appropriate environment• Demonstrate ability to function well in situations with multiple and disparate demands on time

	<ul style="list-style-type: none"> • Deliver safe and effective handover • Demonstrate an advanced understanding of capacity and flow across the organisation • Ensure staffing and resources are optimal for delivery of care • Coordinate the multidisciplinary team (MDT) input into the care of patients in one environment to enable optimal use of resources to prevent duplication, replication or waste of resources • Enable the delivery of good quality education, supervision and training of the multidisciplinary team • Are responsive to patient feedback including from hard to reach groups such as adolescents and young adults, LGBTQ+, BAME groups and those with learning and neurodevelopmental difficulties when managing change on the AMU • Facilitate development of protocols and pathways • Reflect a knowledge of roles in multiprofessional interaction such as: Pharmacy e.g. Medicines reconciliation, Early supported discharge/intervention team
<p>GPCs</p>	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries <p>Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> • patient safety • quality improvement <p>Domain 7: Capabilities in safeguarding vulnerable groups</p>
<p>Evidence to inform decision</p>	<p>Educational supervisors report Patient feedback MCR MSF CbD ACAT Mini-CEX Reflection</p>

	Regional teaching
2. Delivering alternative patient pathways including Same Day Emergency Care (SDEC)	
Descriptors	<p>Promotes activity that facilitates:</p> <ul style="list-style-type: none"> • Interaction with community partners and the Emergency Department • Interaction with radiology • Development of ambulatory pathways • Development of pathways to optimise patient flow • Delivery of ambulatory procedures where appropriate • Identification of patients suitable for ambulatory management • Use of appropriate risk stratification tools where available to identify patients suitable for SDEC • Education of junior staff and other specialities in the role of SDEC • Assessment of the efficiency of the SDEC service • The identification of changes to work practices that can improve the efficiency of the care delivered • Equity of access, and a suitable environment for adolescents and young adults, LGBTQ+, BAME groups and those with learning and neurodevelopmental difficulties.
GPCs	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries <p>Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> • patient safety • quality improvement <p>Domain 7: Capabilities in safeguarding vulnerable groups Domain 8: Capabilities in education and training</p>
Evidence to inform decision	<p>Educational supervisors report Patient feedback MCR MSF CbD</p>

	ACAT Mini-CEX Reflection Regional teaching Audit or quality improvement project
3. Prioritising and selecting patients appropriately according to the severity of their illness, including making decisions about appropriate escalation of care	
Descriptors	Has developed knowledge, skills and attitudes that: <ul style="list-style-type: none"> • Demonstrate awareness of issues that can compromise patient safety • Identify the appropriate pathway for the management of the acutely unwell patient • Use and develop risk stratification tools to identify the best place for initial and ongoing management of patients • Provide assessment, stabilisation and management of an acutely unwell medical patient • Once the patient has been stabilised, to determine the most appropriate place for the ongoing management i.e. inpatient or outpatient • Identifies patients who are in the terminal phase of their life on presentation to prevent unnecessary harm to the patient and unnecessary use of resources
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) Domain 3: Professional knowledge <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement <ul style="list-style-type: none"> • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	Educational supervisors report Quality improvement project or audit MCR MSF

	<p>CbD ACAT Mini-CEX Reflection</p>
<p>4. Integrate with other specialist services including Intensive Care, Cardiology, Respiratory and Geriatric medicine</p>	
<p>Descriptors</p>	<p>Demonstrates knowledge, skills and attitudes that:</p> <ul style="list-style-type: none"> • Promote development of resilient relationships and communication with the Emergency Department, Intensive Care, and other Specialties including Cardiology, Respiratory and Geriatric medicine • Facilitate prompt risk stratification • Demonstrate airways management skills – up to and including supraglottic airway adjuncts • Demonstrate appropriate use of vasoactive and inotropic drugs • Demonstrate appropriate use of the various types of non-invasive respiratory support e.g. BiPAP, CPAP and high flow nasal cannula • Demonstrate knowledge of the appropriate methods for monitoring (invasive and non- invasive) the circulatory system • Provide advanced management for critically unwell patients in the first 72 hours of hospital stay • Facilitate treatment escalation planning, especially in the frail population • Co-ordinates the care of the acute unwell medical patient with critical care with effective handover
<p>GPCs</p>	<p>Domain 1: Professional values and behaviours Domain 2: Professional skills</p> <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries <p>Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> • patient safety • quality improvement <p>Domain 7: Capabilities in safeguarding vulnerable groups</p>

Evidence to inform decision	Educational supervisors report MCR MSF CbD ACAT Mini-CEX Reflection Regional teaching ALS course DOPS
5. Managing the interface with community services including complex discharge planning	
Descriptors	Has developed knowledge, skills and attitudes that: <ul style="list-style-type: none"> • Enable the co-ordination of the roles and duties of multiple and different professionals working on the AMU/SDEC unit to facilitate safe and effective discharge planning • Enable rapid resolution of clinical enquiries from primary care to facilitate patient flow and reduce unnecessary investigations and admission to secondary care • Optimise patient flow from the community and ED into AMU and then to the downstream wards and back to the community • Ensure that all clinicians involved in the care of complex patients receive adequate communication to ensure safe and effective discharge – including liaison with named lead clinician in adult and/or Older persons mental health services, CAMHS
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills <ul style="list-style-type: none"> • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) Domain 3: Professional knowledge <ul style="list-style-type: none"> • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement <ul style="list-style-type: none"> • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups

	Domain 8: Capabilities in education and training
Evidence to inform decision	Educational supervisors report Patient feedback MCR MSF CbD ACAT Mini-CEX Reflection Regional teaching
6. Developing a specialty skill within several broad domains. These are clinical, academic, research or procedural skills.	
Descriptors	<ul style="list-style-type: none"> Demonstrate the development of a specialty skill relevant to the practice of Acute Internal Medicine
GPCs	<p>Domain 1: Professional values and behaviours</p> <p>Domain 2: Professional skills</p> <ul style="list-style-type: none"> practical skills communication and interpersonal skills dealing with complexity and uncertainty clinical skills (<i>history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease</i>) <p>Domain 3: Professional knowledge</p> <ul style="list-style-type: none"> professional requirements national legislative requirements the health service and healthcare systems in the four countries <p>Domain 5: Capabilities in leadership and teamworking</p> <p>Domain 6: Capabilities in patient safety and quality improvement</p> <ul style="list-style-type: none"> patient safety quality improvement <p>Domain 8: Capabilities in education and training</p> <p>Domain 9: Capabilities in research and scholarship</p>
Evidence to Evidence to inform decision	Educational supervisors report <u>Evidence as per specialty skills part of the curriculum</u>

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	MRCP (UK)	Membership of the Royal Colleges of Physicians Diploma
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey

QIPAT	Quality improvement project assessment tool	TO	Teaching observation
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3.5 Presentations and conditions

3.6 Practical procedures

There are a number of procedural skills in which a trainee must become proficient.

Trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Trainees should receive training or refresher training in procedural skills in a simulated environment if required. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool. The table below sets out the minimum competency level expected for each of the practical procedures at the end of each year of training in AIM training. Trainees are expected to maintain procedural competences achieved during IM stage 1 training.

Obtaining independence in all these procedures is essential. Sites that require trainees to perform these procedures for service reasons will need to put in place mechanisms to provide training and assure competence for independent practice.

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).

Acute Internal Medicine practical procedures

	Acute Internal Medicine			
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) Check where this is in IM	Skills lab or satisfactory supervised practice	Competent to perform unsupervised	Maintain	Maintain

	Acute Internal Medicine			
Procedure	ST4	ST5	ST6	CCT
Intraosseous access to circulation for resuscitation	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
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 of ultrasound	Theoretical course attended	Signed off as competent in focused chest, abdominal and lower limb ultrasound	Maintain	Maintain

Notes

^a Pleural procedures should be undertaken in line with the British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended, except for large effusions. Ultrasound guidance should be provided by an appropriately trained pleural-trained ultrasound practitioner.

4 Learning and Teaching

4.1 The training programme

The organisation and delivery of postgraduate training is the responsibility of the Health Education England (HEE) and its Local Education and Training Boards (LETBs), NHS Education

for Scotland (NES), Health Education and Innovation Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA). A training programme director (TPD) will be responsible for coordinating the Acute Internal Medicine training programme. In England, the local organisation and delivery of training is overseen by a school of medicine.

Progression through the programme will be determined by the ARCP process (section 5.6) and the training requirements for each indicative year of training are summarised in the AIM ARCP decision aid (available on the [JRCPTB website](#)). The successful completion of AIM will be dependent on achieving the expected level in all CiPs, GPCs and procedural skills. The programme of assessment will be used to monitor and determine progress through the programme. Training will normally take place in a range of District General Hospitals and Teaching Hospitals.

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

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

When training in AIM stage all trainees will have an appropriate clinical supervisor (a consultant member of the team) and an appropriate educational supervisor in AIM. The clinical supervisor and educational supervisor may be the same person. It is mandatory for trainees in AIM to have an educational supervisor who practises AIM themselves.

4.1.1 Training

All training should be conducted in institutions which meet the relevant JRCPTB Quality Criteria, GMC standards for training and education and the relevant Health and Safety standards. Please see section 4.2 for guidance on methods of teaching and learning.

Acute Medical Unit training

An indicative 18 months of the indicative 48 months of dual AIM and IM training should be spent on an Acute Medicine Unit (AMU). During this period of training it is anticipated that the trainee will gain experience in the majority of the presentations and conditions detailed in Section 3.2.

The final year of training should include an indicative 6 months within an AMU that is led by an Acute Physician. This should include training in management and leadership skills as well as taking a more senior but supervised role within the running of the acute medical unit.

Acute Medicine should include training to support achieving the competencies detailed in the AIM CiPs, especially CiPs 1, 2, 3 and 5.

Inpatient training

At least 12 months of the 48 months of dual AIM and IM training should be spent in an indicative 4 month block attachments to each of Respiratory Medicine, Cardiology and Geriatric medicine.

Respiratory Medicine (indicative 4 months) should include training in:

- General respiratory outpatient clinics
- Assessment of new inpatient respiratory referrals
- Assessment of referrals of patients for non-invasive ventilation
- The operation of respiratory MDT meetings such as lung cancer

Cardiology (indicative 4 months) should include training in:

- General cardiology outpatient clinics
- Rapid Access chest pain clinics
- Assessment of patients on the Coronary Care Unit
- Assessment and selection of patients for interventional procedures
- Management of acute arrhythmias

Geriatric Medicine (indicative 4 months) should include training in:

- General geriatric outpatient clinics
- Assessment and management of frailty
- MDT meetings including complex discharge planning
- Assessment of new inpatient geriatric referrals

Outpatient training

During both the training on Acute Medicine Units and in Cardiology, Respiratory and Geriatric placements trainees will have access to training in outpatient settings. Reflecting changes in clinical practice, some of this training could be provided as community experience, virtual clinics and work in ambulatory settings.

In placements in Respiratory Medicine, Cardiology and Geriatric medicine trainees must have access to at least one clinic per week on average.

In placements in Acute Medicine trainees must have access to training in Same Day Emergency Care settings for a reasonable proportion of their time, equivalent to at least half a day a week.

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.

Critical care training

It is mandatory for completion of AIM training that the trainee spends a minimum of 4 months in a critical care placement. Ideally critical care should not be the last attachment during AIM training.

This should include training in:

- Assessment of referrals for management at level 2 or 3 care
- Assessment for and use of vasoactive and inotropic medication
- The use of advanced invasive and non-invasive circulatory monitoring
- Airway management skills – up to and including supraglottic airway adjuncts

Point of Care Ultrasound training

It is mandatory for all AIM trainees to gain competencies in Point of Care Ultrasound. All trainees will need to meet competencies in focused chest, abdominal and lower limb ultrasound. Trainees will be supported to achieve this by having an indicative average of one day a week allocated to this over the first 18 to 24 months of their training.

Specialty skill training

All trainees must develop a specialty skill, as detailed in CiP 6 of the AIM curriculum. Trainees will be supported to achieve this by having an average of one day a week allocated to this training over the final 24 to 30 months of training, once competence in Point of Care Ultrasound is achieved.

It is understood that point of care ultrasound training and specialty skill training may occur alongside each other in the event of a trainee choosing to start training in their specialty skill in their first or second year.

Audit, Quality Improvement Projects and administration

All trainees should also have time to develop audit and quality improvement projects that are part of the curriculum, and also for non clinical administration. It is anticipated that this time will also be accounted for in the one day per week that is allocated to POCUS and the specialty skill.

Simulation training

Simulation training including non-technical skills/human factors and clinical scenarios should be carried out in AIM training programmes with training or refresher training for procedural skills where necessary.

4.1.2 Recommended experience

Palliative and end of life care

Trainees should be involved in the management of patients who are approaching the end of their lives and be able to demonstrate that they can recognise such patients and care for them and their families appropriately.

Working with primary care and the community

Trainees will need to demonstrate that they have an understanding of primary care and community services, and they should be able to interact with them appropriately and effectively. Experience of and training in working across the primary-secondary care divide (e.g. rapid access outpatient clinics, admissions' avoidance clinics, ambulatory care) will be markers of good practice.

Working in the manner of a consultant

At the completion of CCT doctors need to be able to function as independent consultant practitioners. It will be a marker of good practice for trainees in their final year to be given up to 3 months of experience 'acting up' (with appropriate supervision) as a consultant in Acute Internal Medicine.

4.2 Teaching and learning methods

The curriculum will be delivered through a variety of learning experiences and will achieve the capabilities described in the syllabus through a variety of learning methods. There will be a balance of different modes of learning from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to different learning methods may vary depending on the nature of the attachment within a rotation.

This section identifies the types of situations in which a trainee will learn.

Learning with peers - There are many opportunities for trainees to learn with their peers. Local postgraduate teaching opportunities allow trainees of varied levels of experience to come together for small group sessions. Examination preparation encourages the formation of self-help groups and learning sets.

Work-based learning - The content of work-based experiential learning is decided by the local faculty for education but includes active participation in:

- **Reviewing patients with consultants**

It is important that trainees have an opportunity to present at least a proportion of the patients whom they have admitted to their consultant for senior review in order to obtain immediate feedback into their performance (that may be supplemented by an appropriate WBA such as an ACAT, mini-CEX or CBD). This may be accomplished when working on a take shift along with a consultant or on a post-take ward round with a consultant.

- **Personal ward rounds and provision of ongoing inpatient clinical care**

Every patient seen, on the ward or in out-patients, provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. The

experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems.

- **Reverse ward rounds**

Trainees should have the opportunity to be directly observed by the consultant for all or part of a ward round, whether on an Acute Medical Unit or another in-patient area. In a 'reverse ward round' the consultant becomes part of the team (e.g. writing in the notes) while the trainee leads the ward round, taking on the usual role of the consultant. This is an opportunity to make decisions with feedback as part of a team.

- **Multi-disciplinary team meetings**

There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning.

Trainees have supervised responsibility for the care of in-patients. This includes day-to-day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

Formal postgraduate teaching

The content of these sessions are determined by the local faculty of medical education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching in the local postgraduate teaching sessions and at external regional, national and international meetings. Examples include: lunchtime teaching sessions, Grand Rounds, mortality and morbidity meetings, radiology meetings, journal clubs, ultrasound courses, Royal College of Physicians meetings and Society for Acute Medicine conferences.

Regional AIM training days

Training Programme Directors are responsible for ensuring that a minimum of 10 regional training days per year are available for AIM trainees to attend, and a register of attendance is kept. Attendance at regional training days is a mandatory requirement of the curriculum for trainees. The training days should cover the AIM syllabus over a 2-3 year period. Ideally the format should be a mixture of interactive and didactic. It should be case-based and include teaching on relevant guidelines and evidence-based practice. Training days should be geared towards preparation for the Specialty Certificate Examination in acute internal medicine, as well as covering a wider range of curriculum topics such as quality improvement, patient safety, ambulatory care, and non-technical skills.

Independent self-directed learning

Trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)

- audit, quality improvement and research projects
- reading journals
- achieving personal learning goals beyond the essential, core curriculum

Formal study courses

Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include management courses and communication courses.

4.3 Academic training

The four nations have different arrangements for academic training and doctors in training should consult the LETB or deanery for further guidance.

Trainees may train in academic medicine as an academic clinical fellow (ACF) or equivalent. Academic trainees can be recruited at any point in the Acute Internal Medicine training programme.

Some trainees may opt to do research leading to a higher degree without being appointed to a formal academic programme. This new curriculum should not impact in any way on the facility to take time out of programme for research (OOPR) but as now, such time requires discussion between the trainee, the TPD and the Deanery as to what is appropriate together with guidance from the appropriate SAC that the proposed period and scope of study is sensible.

5 Programme of Assessment

5.1 Purpose of assessment

The purpose of the programme of assessment is to:

- assess trainees' actual performance in the workplace
- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development
- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience
- demonstrate trainees have acquired the GPCs and meet the requirements of GMP
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme;
- inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme;
- identify trainees who should be advised to consider changes of career direction.

5.2 Programme of Assessment

Our programme of assessment refers to the integrated framework of exams, assessments in the workplace and judgements made about a learner during their approved programme of training. The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance at critical progression points in, and to demonstrate satisfactory completion of training as required by the curriculum.

The programme of assessment is comprised of several different individual types of assessment. These include the Speciality Certificate Examination in Acute Internal Medicine, summative and formative assessments. A range of assessments is needed to generate the necessary evidence required for global judgements to be made about satisfactory performance, progression in, and completion of, training. All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (eg through the blueprinting of assessment system to the stated curricular outcomes).

The programme of assessment emphasises the importance and centrality of professional judgment in making sure learners have met the learning outcomes and expected levels of performance set out in the approved curricula. Assessors will make accountable, professional judgements. The programme of assessment includes how professional judgements are used and collated to support decisions on progression and satisfactory completion of training.

The assessments will be supported by structured feedback for trainees. Assessment tools will be both formative and summative and have been selected on the basis of their fitness for purpose.

Assessment will take place throughout the training programme to allow trainees continually to gather evidence of learning and to provide formative feedback. Those assessment tools which are not identified individually as summative will contribute to summative judgements about a trainee's progress as part of the programme of assessment. The number and range of these will ensure a reliable assessment of the training relevant to their stage of training and achieve coverage of the curriculum.

Reflection and feedback should be an integral component to all WBPAs. In order for trainees to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently. Feedback should be of high quality and should include an action plan for future development for the trainee. Both trainees and trainers should recognise and respect cultural differences when giving and receiving feedback.

5.3 Assessment of CiPs

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical supervisors and others contributing to assessment will provide formative feedback to the trainee on their performance throughout the training year. This feedback will include

a global rating in order to indicate to the trainee and their educational supervisor how they are progressing at that stage of training. To support this, workplace based assessments and multiple consultant reports will include global assessment anchor statements.

Global assessment 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

Towards the end of the training year, trainees will make a self-assessment of their progression for each CiP and record this in the ePortfolio with signposting to the evidence to support their rating.

The educational supervisor (ES) will review the evidence in the ePortfolio including workplace based assessments, feedback received from clinical supervisors (via the Multiple Consultant Report) and the trainee’s self-assessment and record their judgement on the trainee’s performance in the ES report, with commentary.

For **specialty CiPs** the ES will make an entrustment decision for each CiP and record the indicative level of supervision required with detailed comments to justify their entrustment decision. The ES will also indicate the most appropriate global anchor statement (see above) for overall performance.

Entrustability scales are behaviourally anchored ordinal scales based on progression to competence and reflect a judgment that has clinical meaning for assessors⁵.

Level descriptors for clinical CiPs

Level	Descriptor
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

⁵ [Entrustability Scales: Outlining Their Usefulness for Competency-Based Clinical Assessment](#)

The ARCP will be informed by the ES report and the evidence presented in the ePortfolio. The ARCP panel will make the final summative judgement on whether the trainee has achieved the generic outcomes and the appropriate level of supervision for each CiP. The ARCP panel will determine whether the trainee can progress to the next year/level of training in accordance with the Gold Guide. ARCPs will be held for each training year. The final ARCP will ensure trainees have achieved level 4 in all CiPs for the critical progression point at completion of training.

5.4 Critical progression points

There will be a key progression point on completion of AIM training. Trainees will be required to be entrusted at level 4 in all CiPs in order to achieve an ARCP outcome 6 and be recommended for a CCT in AIM.

The educational supervisor report will make a recommendation to the ARCP panel as to whether the trainee has met the defined levels for the CiPs and acquired the procedural competence required for each year of training. The ARCP panel will make the final decision on whether the trainee can be signed off and progress to the next year/level of training [see section 5.6].

The outline grid below sets out the expected level of supervision and entrustment for the specialty CiPs and the critical progression points for the whole of AIM training

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	CRITICAL PROGRESSION POINT
Managing acute services	2	3	3	4	
Delivering alternative patient pathways including ambulatory care	2	3	3	4	
Prioritising and selecting patients appropriately according to the severity of their illness, including making decisions about appropriate escalation of care	2	3	3	4	
Integrate with other specialist services including Intensive Care, Cardiology, Respiratory and Geriatric medicine	2	3	3	4	
Managing the interface with community services including complex discharge planning	2	3	3	4	
Developing a specialty skill within several broad domains. These are clinical, academic, research or procedural skills	Skill chosen	Skill started	Skill developing	Skill complete	

5.5 Evidence of progress

The following methods of assessment will provide evidence of progress in the integrated programme of assessment. The requirements for each training year/level are stipulated in the ARCP decision aid (www.jrcptb.org.uk).

Summative assessment

Examinations and certificates:

- Advanced Life Support Certificate (ALS)
- Specialty Certificate Examination in Acute Medicine (SCE)

Workplace-based assessment (WPBA):

- Direct Observation of Procedural Skills (DOPS) – summative

Point of Care Ultrasound:

- Competence demonstrated through completion of a recognised training programme, such as FAMUS or appropriate FUSIC modules

Formative assessment

Supervised Learning Events (SLEs):

- Acute Care Assessment Tool (ACAT)
- Case-Based Discussions (CbD)
- mini-Clinical Evaluation Exercise (mini-CEX)

WPBAs:

- Direct Observation of Procedural Skills (DOPS) - formative
- Multi-Source Feedback (MSF)
- Patient Survey (PS)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)

Supervisor reports:

- Multiple Consultant Report (MCR)
- Educational Supervisor Report (ESR)

These methods are described briefly below. More information and guidance for trainees and assessors are available in the ePortfolio and on the JRCPTB website (www.jrcptb.org.uk).

Assessment should be recorded in the trainee's ePortfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

SLEs

Acute Care Assessment Tool (ACAT)

The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT. This tool can also be used to assess other situations where a trainee is interacting with a number of different patients (eg in a day hospital or a business ward round)

Case-based Discussion (CbD)

The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, discharge summary). A typical encounter might be when presenting newly referred patients in the out-patient department.

mini-Clinical Evaluation Exercise (mini-CEX)

This tool assesses part of a clinical encounter (history, physical examination, explanation and counselling) with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee is observed and receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

WPBAs:

Direct Observation of Procedural Skills (DOPS)

A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative assessment). A trainee can be regarded as competent to perform a procedure independently after they have been signed off as independent and able to deal with complications by the required number of appropriate assessors (summative assessment).

Multi-source feedback (MSF)

This tool is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and include doctors, administrative staff, and other allied professionals. Raters should be agreed with the educational supervisor at the start of the training year and the trainee should also complete a self-assessment. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the Educational Supervisor.

Patient Survey (PS)

The PS addresses issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

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 review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the same quality improvement project by more than one assessor.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO can be based on any instance of formal teaching by the trainee which has been observed by the assessor.

Supervisor reports:

Multiple Consultant Report (MCR)

The MCR captures the views of consultant supervisors based on observation on a trainee's performance in practice. The MCR feedback and comments received give valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the trainee and contribute to the educational supervisor's report.

Educational supervisors report (ESR)

The ES will periodically (at least annually) record a longitudinal, global report of a trainee's progress based on a range of assessment, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESR can incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

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 third or fourth year of training prior to the year of CCT. The examination tests the extra knowledge base that the trainees have acquired since taking the MRCP(UK) diploma. The knowledge base itself must be associated with adequate use of such knowledge and passing this examination must be combined with satisfactory progress in workplace based assessments for the trainee to successfully reach the end of training and be awarded the CCT in Acute Internal Medicine

5.5 Decisions on progress (ARCP)

The decisions made at critical progression points and upon completion of training should be clear and defensible. They must be fair and robust and make use of evidence from a range of assessments, potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise or experience. They can also incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Periodic (at least annual) review should be used to collate and systematically review evidence about a doctor's performance and progress in a holistic way and make decisions about their progression in training. The annual review of progression (ARCP) process supports the collation and integration of evidence to make decisions about the achievement of expected outcomes.

Assessment of CiPs involves looking across a range of different skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks, as do decisions about the satisfactory completion of presentations/conditions and procedural skills set out in this curriculum. The outline grid in section 5.4 sets out the level of supervision expected for each of the specialty CiPs. The table of practical procedures sets out the minimum level of performance expected at the end of each year or training. The requirements for each year of training are set out in the ARCP decision aid (www.jrcptb.org.uk).

The ARCP process is described in the Gold Guide. LETBs/deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's ePortfolio.

As a precursor to ARCPs, JRCPTB strongly recommend that trainees have an informal ePortfolio review either with their educational supervisor or arranged by the local school of medicine. These provide opportunities for early detection of trainees who are failing to gather the required evidence for ARCP.

In order to guide trainees, supervisors and the ARCP panel, JRCPTB has produced an ARCP decision aid which sets out the requirements for a satisfactory ARCP outcome at the end of each training year and critical progression point. The ARCP decision aid is available on the JRCPTB website www.jrcptb.org.uk.

5.6 Assessment blueprint

The table below show the possible methods of assessment for each CiP. It is not expected that every method will be used for each competency and additional evidence may be used to help make a judgement on capability.

Blueprint for WPBAs mapped to CiPs

Learning outcomes	ACAT	Cbd	DOPS	MCR	Mini-CEX	MSF	PS	QIPAT	TO
Generic CiPs									
Able to function successfully within NHS organisational and management systems				√		√			
Able to deal with ethical and legal issues related to clinical practice		√	√	√	√	√			
Communicates effectively and is able to share decision making, while maintaining appropriate situational behaviour and professional judgement				√		√	√		
Is focussed on patient safety and delivers effective quality improvement in patient care				√		√		√	
Carrying out research and managing data appropriately				√		√			
Acting as a clinical teacher and clinical supervisor				√		√			√
Clinical CiPs									
Managing an acute unselected take	√	√		√		√			
Managing an acute specialty-related take	√	√		√		√			
Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment	√		√	√	√	√			
Managing patients in an outpatient clinic, ambulatory or community setting, including management of long term conditions	√			√	√		√		
Managing medical problems in patients in other specialties and special cases	√	√		√					
Managing a multi-disciplinary team including effective discharge planning	√			√		√			
Delivering effective resuscitation and managing the acutely deteriorating patient	√		√	√		√			
Managing end of life and applying palliative care skills		√		√	√	√			
Practical procedural skills			√						
Specialty CiPs									
Managing acute services	√	√		√		√			
Delivering alternative patient pathways including ambulatory care	√	√		√		√	√		
Appropriate patient selection for pathways and prioritisation of care	√		√	√	√	√			
Integration with other specialist services including Intensive Care, Cardiology, Respiratory and Geriatric medicine	√			√	√		√		
Integration with community service including complex discharge planning	√	√		√					

Learning outcomes	ACAT	CbD	DOPS	MCR	Mini-CEX	MSF	PS	QIPAT	TO
Development and integration of a specialty skill	√			√		√			
Practical procedural skills			√						

KEY

ACAT	Acute care assessment tool	CbD	Case-based discussion
DOPS	Direct observation of procedural skills	Mini-CEX	Mini-clinical evaluation exercise
MCR	Multiple consultant report	MSF	Multi source feedback
PS	Patient survey	QIPAT	Quality improvement project assessment tool
TO	Teaching observation		

6 Supervision and feedback

This section of the curriculum describes how trainees will be supervised, and how they will receive feedback on performance. For further information please refer to the AoMRC guidance on Improving feedback and reflection to improve learning⁶.

Access to high quality, supportive and constructive feedback is essential for the professional development of the trainee. Trainee reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two way dialogue. Effective feedback is known to enhance learning and combining self-reflection to feedback promotes deeper learning.

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers. Trainees would also benefit from such training as they frequently act as assessors to junior doctors, and all involved could also be shown how best to carry out and record reflection.

6.1 Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. Outpatient and referral supervision must routinely include the opportunity to discuss all cases with a supervisor if appropriate. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

⁶ [Improving feedback and reflection to improve learning. A practical guide for trainees and trainers](#)

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. Depending on local arrangements these roles may be combined into a single role of educational supervisor. However, it is preferred that a trainee has a single named educational supervisor for (at least) a full training year, in which case the clinical supervisor is likely to be a different consultant during some placements.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training⁷.

Educational supervisor

The educational supervisor is responsible for the overall supervision and management of a doctor's educational progress during a placement or a series of placements. The educational supervisor regularly meets with the doctor in training to help plan their training, review progress and achieve agreed learning outcomes. The educational supervisor is responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.

Clinical supervisor

Consultants responsible for patients that a trainee looks after provide clinical supervision for that trainee and thereby contribute to their training; they may also contribute to assessment of their performance by completing a 'Multiple Consultant Report (MCR)' and other WPBAs. A trainee may also be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the trainee's training and progress during a particular placement. It is expected that a named clinical supervisor will provide a MCR for the trainee to inform the Educational Supervisor's report.

The educational supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the educational supervisor. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to deliver effective clinical governance through its management systems.

Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles⁸. It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards.

⁷ [Promoting excellence: standards for medical education and training](#)

⁸ [Recognition and approval of trainers](#)

Opportunities for feedback to trainees about their performance will arise through the use of the workplace-based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

Trainees

Trainees should make the safety of patients their first priority. Furthermore, trainees should not be practising in clinical scenarios which are beyond their experiences and competences without supervision. Trainees should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Trainees would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Trainees should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.5 Appraisal

A formal process of appraisals and reviews underpins training. This process ensures adequate supervision during training, provides continuity between posts and different supervisors and is one of the main ways of providing feedback to trainees. All appraisals should be recorded in the ePortfolio

Induction Appraisal

The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee's progress so far, agree learning objectives for the post ahead and identify the learning opportunities presented by the post. Reviewing progress through the curriculum will help trainees to compile an effective Personal Development Plan (PDP) of objectives for the upcoming post. This PDP should be agreed during the Induction Appraisal. The trainee and supervisor should also both sign the educational agreement in the e-portfolio at this time, recording their commitment to the training process.

Mid-point Review

This meeting between trainee and educational supervisor is not mandatory (particularly when an attachment is shorter than 6 months) but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed. The PDP can be amended at this review.

End of Attachment Appraisal

Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal then the programme director should be informed

7 Quality Management

The organisation of training programs for Acute Internal Medicine is the responsibility of HEE LETBs/local teams and the devolved nations' deaneries.

The LETBs/deaneries will oversee programmes for postgraduate medical training in their regions. The Schools of Medicine in England, Wales and Northern Ireland and the Medical Specialty Training Board in Scotland will undertake the following roles:

- oversee recruitment and induction of trainees from Foundation to Acute Internal Medicine
- allocate trainees into particular rotations for Acute Internal Medicine appropriate to their training needs
- oversee the quality of training posts provided locally
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across training programmes
- oversee the workplace-based assessment process within programmes
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training
- recognise the potential of specific trainees to progress into an academic career

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by LETBs/deaneries or by the colleges or both.

Development, implementation, monitoring and review of the curriculum are the responsibility of the JRCPTB via the SAC responsible for AIM. The committee will be formally constituted with representatives from each health region in England, from the devolved nations and with trainee and lay representation. It will be the responsibility of the JRCPTB to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

JRCPTB provide their role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges of Physicians in Edinburgh, Glasgow and London. Our SACs are actively involved in assisting and supporting LETBs/deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing

application for new post and programme, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

JRCPTB uses data from six quality datasets across its 30 physicianly specialties and three subspecialties to provide meaningful quality management. The datasets include the GMC National Training Survey (NTS) data, ARCP outcomes, MRCP(UK) exam outcomes, New Consultant Survey, Penultimate Year Assessments (PYA)/External Advisor reports and the monitoring visit reports.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by JRCPTB to improve the provision of training and ensure enhanced educational experiences. The principles of the quality criteria for CMT and GIM will be transferred to the IM curriculum to ensure this continues.

8 Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the Joint Royal Colleges of Physicians Training Board (JRCPTB) via the website www.jrcptb.org.uk.

Clinical and educational supervisors should use the curriculum and decision aid as the basis of their discussion with trainees, particularly during the appraisal process. Both trainers and trainees are expected to have a good knowledge of the curriculum and should use it as a guide for their training programme.

Each trainee will engage with the curriculum by maintaining an eportfolio. The trainee will use the curriculum to develop learning objectives and reflect on learning experiences.

Recording progress in the ePortfolio

On enrolling with JRCPTB trainees will be given access to the ePortfolio for IM stage 2. The ePortfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

The trainee's main responsibilities are to ensure the ePortfolio is kept up to date, arrange assessments and ensure they are recorded, prepare drafts of appraisal forms, maintain their personal development plan, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use ePortfolio evidence such as outcomes of assessments, reflections and personal development plans to inform appraisal meetings. They are also expected to update the trainee's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

Deaneries, training programme directors, college tutors and ARCP panels may use the ePortfolio to monitor the progress of trainees for whom they are responsible.

JRCPTB will use summarised, anonymous ePortfolio data to support its work in quality assurance.

All appraisal meetings, personal development plans and workplace based assessments (including MSF) should be recorded in the ePortfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the ePortfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other ePortfolio content should be used to provide evidence towards acquisition of curriculum capabilities. Trainees should add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, competency and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

9 Equality and diversity

The Royal Colleges of Physicians will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The Federation of the Royal Colleges of Physicians believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the Colleges, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as doctors in training and examination candidates.

LETBs/deaneries quality assurance will ensure that each training programme complies with the equality and diversity standards in postgraduate medical training as set by GMC. They should provide access to a professional support unit or equivalent for trainees requiring additional support.

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- LETBs/deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every 3 years

- LETBs/deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training (at least as an e-module) every 3 years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. LETBs/deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. LETBs/deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
- monitoring of College Examinations
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.