JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Implementation
Internal Medicine Stage 2 Curriculum
Guidance for training programme directors, supervisors, and trainees

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ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Contents

Introduction

This guide for Internal Medicine Stage 2 (IMS2) is to help training programme directors (TPDs), Educational Supervisors (ES), Clinical Supervisors (CS), trainees, and others with the practicalities of implementing the new curriculum. It is intended to supplement rather than replace the IMS2 curriculum document. It is appreciated that regional Schools of Medicine are responsible for implementation and will need to take account of local resources and constraints, but trainees and many involved in the delivery of training have said that central guidance would be helpful. 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 General Internal Medicine SAC with additional help from many external stakeholders, especially trainees. It is intended to be a 'living document' and we value feedback via curriculum@jrcptb.org.uk.

The Internal Medicine Stage 2 curriculum

The IMS2 curriculum replaces the GIM curriculum for higher specialty trainees in stand alone GIM programmes and in group 1 specialties.

Reasons for change

There have been three main drivers of the need to change higher specialist training in General Internal Medicine. Firstly, the Shape of Training review (ref) was a catalyst for reform of postgraduate training of all doctors to ensure it is more patient focused and more general. Secondly, there is a desire to move away from the 'tick-box' approach associated with the current competency-based curricula to the holistic assessment of high-level learning outcomes, leading this new curriculum to have a relatively small number of 'capabilities in practice' (CIPs) which are based on the concept of entrustable professional activities (EPAs). Thirdly, 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.

The purpose of IMS2 training

The purpose of the IMS2 curriculum is to produce doctors with broad experience and the generic professional and clinical capabilities needed to manage patients presenting with a wide range of general medical symptoms and conditions. They require particular skill in diagnostic reasoning, differential diagnosis, management of co-morbidities, dealing with uncertainty, recognising when specialist care would (or would not) be appropriate, and determining when care should be palliative.

A doctor who has completed training in IMS2 must be capable of independent unsupervised practice as an NHS consultant doing an acute unselected medical take in a district general or

teaching hospital, managing care of such patients after their admission, and integrating as part of a care team.

What does good IMS2 training look like?

An IMS2 training programme must provide a trainee with experience and training to achieve the required standard for completion of IMS2, with the trainee's e-Portfolio including sufficient evidence in the form of Supervised Learning Events (SLE's) and reflective notes to allow their ES to make justifiable statements about their capabilities. These will be reviewed at the trainee's ARCP, where the panel will determine the trainee's annual training outcome.

A good IMS2 training programme will produce doctors who have a wide general medical knowledge and skills base, considerable experience and expertise in caring for patients with a broad range of medical problems, and who are enthusiastic to continue practising general medicine.

Capabilities in Practice (CiPs)

The **generic CiPs** underpin the practice of medicine, are common across all physician specialties, and cover the universal requirements of all specialties as described in the GPC framework. The IMS2 **clinical CiPs** describe the clinical capabilities required. Each CiP has a set of descriptors associated with that activity or task (see IMS2 Curriculum), which 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 generic and clinical 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 Stage 2 Clinical CiPs

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 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

Evidence of capability

The IMS2 curriculum describes the evidence that can be used by the Educational Supervisor to make a judgement of the trainee's capability and will make a holistic judgement based on the evidence provided, particularly the feedback from Clinical Supervisors and multi-disciplinary team.

Presentations and Conditions

The IMS2 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. Whilst trainees will be expected to know about them, sign off for individual items is not required.

Practical Procedures

The curriculum and ARCP decision aid list the IMS2 practical procedures and minimum level of competency required.

Once a trainee is competent to perform a procedure unsupervised (as evidenced by summative DOPS and signed off during IMS2 or any other recognised training programme) there is no requirement for further assessment. It is a matter of professional insight and probity that a doctor should recognise limits to their competency, and a trainee should seek further training with appropriate supervision if they (or their Educational Supervisor) feel that they are no longer confident or competent to carry out a practical procedure (e.g. because they have not performed it for a long time). In recent feedback on implementation of the new IMS2 curricula, many trainees, across all Group 1 specialties, reported a lack of access to procedures. Improvements have been made in access to simulation courses and training but concerns remain. It has been noted that some of the concerns arise because trainees lack confidence in performing some of the procedures rather than not having adequate training opportunities. We are also aware of the impact of Physician Associates (PAs) and Clinical Fellows upon access to procedural skills in the ward setting.
.JRCPTB encourages ES to put more emphasis on procedural shortfalls and arrange appropriate training, possibly in the skills-lab or simulation setting. Re-acquisition of skills should continue to be monitored through the ARCP process

Duration of training

Most trainees will train in IMS2 in combination with another (Group 1) medical specialty, when training in both specialties will usually be completed in four years of full-time training and the trainee will be awarded a dual Certificate of Completion of Training (CCT). Training in IMS2 as a single specialty (i.e. General Internal Medicine), followed by award of a CCT, will usually take three years. Trainees who demonstrate exceptionally rapid development and acquisition of capabilities may complete training sooner than these indicative times. Trainees who develop more slowly may require an extension of training under the provisions of the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

Academic training

Over recent years, there have been regular meetings between JRCPTB and the Academic medical community. There is understanding that IMS2 can pose particular problems for academic trainees who require to develop skills not only in GIM and specialty but also pursue academic activities including research projects, clinical lectureships and through national academic programmes.
Trainees in general have reported more reluctance to follow an academic pathway in Group 1 specialties now that they must complete IM capabilities and those already in academic pathways experience difficulties in achieving capabilities within standard training time. JRCPTB are continuing to work with relevant organisations in regard to trainees who wish to pursue a career in academic medicine. Various guidance documents have been developed (acceleration of training, identifying exceptionality) and it is hoped that supported trainees will be able to progress as swiftly as those undertaking academic training in previous years. With emphasis on capability acquisition for all trainees and less attention paid to the amount of time spent in any particular area of training this should be possible. JRCPTB will continue to monitor this area and work with the academic community to ensure no trainees are disadvantaged.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's progression through the stages of IMS2 training will be based on an assessment of how they are achieving their CiPs. Key to the quality of training and decision making is a supportive relationship between the trainee and their ES, formed at the initial induction meeting and re-enforced in subsequent meetings to adjust / adapt the individual training strategy. The ES should know their trainee well, and will consider information from Supervised learning events (SLE), Workplace-based assessments (WPBA), Multi-source feedback (MSF), Multiple Consultant Reports (MCR), other evidence in the trainee's e-Portfolio (e.g. reflective notes and the trainee's self-rating of their own performance), to produce an ES report (ESR) for every year of training.

It is acknowledged that there is tension between specialty and IM. This was particularly noted in the procedural specialties where trainees did not feel that they have enough time to attend procedural based training sessions. It is accepted that there is geographical variation and it must be acknowledged that the curricula have only been operational for 1 year and must be continued to be monitored. All Group 1 specialties are reminded that IM can be completed in blocks as has been introduced for the new Group 1 specialties. This can protect specialty time and the GIM SAC will produce more specific advice on how IM capabilities can be achieved without impacting specialty training. However, the need to maintain experience in the acute take indicates that 'keeping in touch' sessions should be undertaken at an average of one day per month during specialty training. These days can be taken individually but to maximise educational value they may be aggregated into a series of days every few months. This should therefore minimise the impact on specialty training. It ahould also be remembered that experience of in-patient management on a specialty ward can and should count towards GIM experience when the patients are suffering from, and managed with, conditions considered disparate from the primary specialty.

What the trainee needs to do

Arrange meetings with their Educational Supervisor in a timely manner

All trainees must have an ES, who will normally act in this role for at least the whole of a training year. There must be both an Educational Supervisor for Internal Medicine and Specialty (though, where appropriate, this can be the same individual)
As a minimum, the trainee should arrange meetings with their ES at the start (induction appraisal, within 4 weeks of commencement unless there are exceptional circumstances) and end (within 4 weeks, unless there are exceptional circumstances) of each new placement. Other meetings during the placement can be organised at the request of the trainee or their ES. When a trainee is moving from one placement to another but maintaining the same ES, a single meeting can be used for the end of attachment appraisal of one placement and the induction appraisal of the other.
From the recent survey of IMS2 implementation, trainees have reported that they are not meeting with educational supervisors as often as they would like/need. It is acknowledged that ES do not have enough time in their jobs for their role as ES however JRCPTB acknowledge their role in supporting supervisors and trainees in this area
JRCPTB will continue to produce training materials to support ESs in the role and provide specific ES training for IM Stage 2. JRCPTB will work with the 4 nations (via the CIMC) to ensure delivery of training.

Arrange meetings with their Clinical Supervisor in a timely manner

All trainees must have a CS for every placement, who may also be their ES. The trainee should arrange meetings with their CS at the start and end of each placement.

Accrue evidence of their training experience and performance

The trainee needs to engage with the mechanisms used to evidence their training and performance (e.g. organise SLEs, MSFs and MCRs; document teaching attendance) as specified in the ARCP Decision Aid (see below), and keep their e-Portfolio up to date. In doing so they will provide their ES with the evidence that they require to make entrustment decisions.

In the ARCP Decision Aid all times (e.g. days, months, years) and numbers (e.g. of patients, of clinics, of assessments) are to be understood as 'indicative'. This means that the view of the JRCPTB is that the time or number specified is that required by most trainees to acquire the capability and there to be adequate evidence to allow an ES to make a judgement about their trainee's performance. The ES and ARCP panels will use expert judgement to review whether more rapid progression through training will be possible, with adequacy of evidence is crucial to this type of decision making.

Use of the GIM Summary of Training calculator is recommended for recording an estimate for each ARCP of the numbers of patients seen on acute unselected take. Completion of a GIM PYR [Penultimate Year Report] trainee report and GIM Summary of Training calculator is required before a trainee's penultimate IM ARCP, unless alternative arrangements are advised by the local GIM TPD.

SLEs are a vehicle for feedback which a trainee can use to improve. Whilst some SLEs are needed to provide evidence for the ES to make a judgement about progression in relation to the Generic and Clinical CiPs, the trainee should recognise that they are an opportunity to receive one-to-one teaching and they should therefore be seeking to have SLEs performed as often as practical.

Trainees should attend and document teaching sessions and record their reflections on these and on clinical incidents and any other situations that would aid their professional development. In doing so they will provide their ES with the evidence that they require to make entrustment decisions.

As the ARCP approaches, trainees need to arrange one of their ES meetings to facilitate provision and discussion of the necessary ESR. In preparation for this they must self-assess the level at which they feel they are operating at for each CiP, and self-assess their performance using the MSF questionnaire. These self-assessments allow the ES to see if the trainee's views are in accord with those that others have of them.

What the Educational Supervisor needs to do

Prepare for meeting with the trainee

Before their induction meeting with a trainee the ES should:

- Review previous ESR, ARCP outcomes etc (if available)
- Ensure that they are up to date and familiar with the requirements specified in the IMS2 ARCP Decision Aid.
- Liaise with the trainee's CSs about particular training opportunities that are available in their placements, e.g. observation of management meetings, ongoing QI projects, ongoing research, involvement with palliative care.

Document meetings with the trainee on e-Portfolio

The induction and end-of-placement meetings should always be recorded formally in the trainee's ePortfolio. Other meetings should be recorded if appropriate.

Complete an Educational Supervisor's report before the trainee's ARCP

The ES's report (ESR) is the most important 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.

An ESR is required for every trainee before every ARCP. Best practice is for it to be built across the year and finalised ahead of the ARCP. Key elements in writing a good ESR include:

Consideration of all appropriate sources of information

Those required are specified in the ARCP Decision Aid (see below) and include MSF, MCRs, SLEs and WPBAs, which should be discussed with the trainee to highlight positive feedback and allow exploration of any concerns raised.

Undertaking regular reflection is an important part of being a self-directed professional learner, and trainees should reflect (without giving any patient-identifiable detail in their e-Portfolio) on situations that went well in addition to those that did not. A good ESR should comment on a trainee's reflections, made during meetings with their ES or recorded in their e-Portfolio, to comment on their ability to reflect and learn from experience.

Other sources of information about a trainee may be available, e.g. from local faculty groups where a group of senior clinicians within a service get together to discuss trainees' progress, with the collective opinions documented and communicated to the ES, who should discuss such feedback with the trainee and use it to inform their ESR.

Whenever any information is used by the ES to inform the ESR it is essential that it is discussed with the trainee and that such discussion is recorded in e-Portfolio.

In group 1 specialties there must be an ESR completed for both Internal medicine and for the trainee's other specialty. However, if the ES is the same for both specialties completion of one form to cover both specialties will suffice.

Generic CiPs

The ES must assess for each CiP with reference to 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

It is good practice to provide a narrative for all ratings given, but detailed comments must be made for any rating of below expectation, including source of the evidence and its context, with examples (e.g. of statements made in MCRs, MSF or SLEs).

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.

Clinical CiPs

Only the ES makes entrustment decisions

The ES must make a judgement for each CiP with reference to the following levels of entrustment:

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

It is good practice to provide a narrative for all ratings given, but detailed comments must be given to support entrustment decisions that are below the level expected for the stage of training (see IMS2 Decision Aid, below).

Adequate narrative

The ESR should comment on the trainee's experience, training and performance in the previous year with regard to clinical activity (acute unselected take, continuing ward care, outpatient), other elements specified in the Decision Aid (ALS, QI involvement, simulation training, teaching, practical procedural skills), and markers of good practice (palliative and end of life care experience, working with primary care and the community, and [for final year trainees] working in the manner of a consultant).

Adequate discussion with the trainee

The ES should discuss the ESR with the trainee before the ARCP. It is essential that such conversation occurs and is clearly documented when any aspects could result in a non-standard outcome at ARCP.

What the Clinical Supervisor needs to do

A trainee's training aims for the year are agreed in discussion with their ES. How these are to be achieved in practice is to be agreed in discussion with their CS for each placement.

Prepare for meeting with the trainee

Before their induction meeting with a trainee the CS (who may also be the trainee's ES) should:

- Review previous ESR, ARCP outcomes etc. (if available)
- Ensure that they are up to date and familiar with the requirements specified in the IMS2 ARCP Decision Aid.
- Liaise with the trainee's ES about which particular training opportunities that are available in their placement would be most valuable in terms of the trainee's overall training plan for the year, e.g. observation of management meetings, ongoing QI projects, ongoing research, involvement with palliative care.

Document meetings with the trainee on e-Portfolio

The induction and end-of-placement meetings should always be recorded formally in the trainee's ePortfolio. Other meetings should be recorded if appropriate.

Complete a Multiple Consultant Report form

MCR's are key evidence that the ES considers when making entrustment decisions, and at the end of each placement the CS should expect to complete a MCR for their trainee. These require the global anchor statements [meets, below or above expectations] to give feedback on areas of clinical practice that have been observed. It is good practice to provide a narrative for all ratings given, but detailed comments must be made for any rating of below expectation, including source of the evidence and its context, with examples. For instance, considering an ST6 dual trainee with a training plan to complete IMS2 Stage 2 by the end of ST7:
At least 2 of the MCRs in GIM must be from Consultants working with the trainee on the Acute Unselected Take

Domain	Expectations	Comment

Diagnostic skills, investigation and management of patients	Above	In the acute take setting, I and other consultant colleagues have observed Dr X to reliably make accurate diagnoses and implement clear plans for investigation and management, even of complex cases
	Meets	In the acute take setting, I and other consultant colleagues have observed Dr Y to make accurate diagnoses and implement appropriate plans for investigation and management of most patients, although they still require assistance with complex cases
	Below	In the acute take setting, I and other consultant colleagues have observed that Dr Z struggles to make accurate diagnoses and implement clear plans for investigation and management, even of straightforward cases

What supervising consultants need to do

Trainees may ask consultants (other than their ES and CS) who they work with to complete a MCR form, which they should do in the manner described above.

Meetings of trainees and their Educational Supervisors

These should take place in private settings, preferably without interruption.

Agree timeline of training

At the beginning of their IMS2 training the trainee needs to discuss and agree the time course of their training in IM with their ES and (if necessary) their specialty TPD. All parties need to understand the planned timeline for delivery of the three stages of IM training, e.g. will they complete Stage 1 of IMS2 by the end of ST4 or ST5 etc (see ARCP Decision Aid, below). This timeline to be confirmed at the trainee's ST4 ARCP and reviewed at subsequent ARCPs if required.

Planning and review of training

The induction meeting of the trainee and their ES at the beginning of each training year should:

- Allow the trainee to inform the ES of how they think their training is progressing – what, with reference to the IMS2 curriculum and ARCP Decision Aid, have they had plenty of experience and training in? What do they think they particularly need over the next 12 months? What, if they know, are their long-term career goals?
- Allow the ES, having reviewed the trainee's e-Portfolio, to make any observations they think relevant regarding the trainee's experience / training and its documentation.
- Review the placements for the year ahead.

- Consider elements of experience or training that require specific planning, e.g. procedural skills, simulation training, management experience.
- Lead to the development of a Personal Development Plan (PDP) for the training year, which should be framed in terms of SMART (Specific, Measurable, Attainable, Relevant, Time-bound) objectives linked to the curriculum, e.g. QI project, teaching observation, X outpatient clinics in Specialties A and B, mechanism for obtaining management experience.
- Develop a plan for using study leave.
- Provide pastoral support when required.
- Consider any other matter the trainee or ES wishes to discuss.

At the end of the induction meeting the trainee should have a clear plan for their training for the year and know what evidence the ES will need to make the required entrustment decisions when they complete the trainee's ESR before their ARCP.

Subsequent meetings of the trainee and their ES during the training year should:

- Review progress – what has gone well? What could have gone better? Does the PDP need to be updated?
- Review any feedback (e.g. MSF, MCR) received.
- Review e-Portfolio – is it up to date?
- Provide pastoral support when required.
- Consider any other matter the trainee or ES wishes to discuss.
- Before the ARCP – ensure that the ES has all information necessary to complete the ESR.

Whilst a minimum number of pre-arranged and documented meetings of a trainee and their ES are needed to plan and provide evidence of training, other meetings at short notice should be requested by either the trainee or the ES as needed.

Meetings of trainees and their Clinical Supervisors

These should take place in private settings, preferably without interruption.

The induction meeting of the trainee and their CS at the beginning of each placement should:

- Allow the trainee to inform the CS of their PDP, which they have agreed in discussion with their ES, including SMART objectives that they hope to achieve during the placement.
- Allow the CS to inform the trainee of the experience and training opportunities available, including clinical experience and other opportunities linked to the curriculum (e.g. observation of management meetings, ongoing QI projects, ongoing research, involvement with palliative care) and confirm which of these the trainee will pursue (if any).

- Agree which elements of experience or training that require specific planning will be obtained during the placement, e.g. procedural skills, simulation training, management experience.
- Agree arrangements for study leave.
- Confirm the personalized educational work schedule for the placement, which is a documentation of the points above.
- Provide pastoral support when required.
- Consider any other matter the trainee or CS wishes to discuss.

The meeting of the trainee and their CS at the end of each placement should:

- Review the trainee's progress – what has gone well? What could have gone better?
- Allow the trainee to provide the CS with feedback about the post – which elements of training have been good? What could be improved?
- Provide pastoral support when required.
- Consider any other matter the trainee or CS wishes to discuss.

Whilst a minimum number of pre-arranged and documented meetings of a trainee and their CS are needed to plan and support training, other meetings at short notice should be requested by either the trainee or the CS as needed.

Annual Review of Competence Progression (ARCP)

Introduction

The ARCP is an annual procedure for assessing the competence of all medical trainees across the UK, giving a summative judgement about whether the trainee can progress into the subsequent year of training (outcome 1) or successfully complete training if in the final year (outcome 6).

Before the ARCP panel

The trainee needs to make sure that their e-Portfolio is up to date such that it properly describes their experience, training, assessments and reflections over the previous year. Details of requirements are described in the ARCP Decision Aid (see below).

The ES needs to make sure that the trainee's e-Portfolio is properly completed, best practice being that they conduct a 'mock ARCP' with the trainee a month or so before the (real) ARCP to illuminate any deficiencies whilst there is time to address them. They should also complete an ESR, as described above.

Conduct of the ARCP panel

In some Deaneries specialty and IM training are assessed by separate ARCP panels, and in others a single ARCP panel assesses both. When a single panel is assessing progress in both

training programmes it is essential that a nominated member of the panel takes responsibility for assessing the trainee's progress in IM.

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?"

The requirements for an ARCP panel member to lead assessment of IM training are that they must:

- Practise Internal Medicine, including care of patients admitted on acute unselected take.
- Be familiar with the IMS2 curriculum and ARCP Decision Aid.
- Have reviewed the trainee's IM e-Portfolio in advance of the panel meeting, especially the ESR, MCRs and MSF.
- Be aware that completion of a <GIM PYR [Penultimate Year Report] trainee report> and <GIM Summary of Training calculator> (Firth calculator) is required before a trainee's penultimate IM ARCP, unless alternative arrangements are advised by the local GIM TPD.
- Have determined how the trainee's progress compares with that expected.
- Lead discussion of the trainee's IM training at the panel meeting.
- Give the panel's decision to the trainee and explain it to them when necessary.
- Document the panel's decision by completing an e-Portfolio IM ARCP outcome form (which is separate from the specialty outcome form).

ARCP Decision Aid for Internal Medicine Stage 2 (IMS2)

This ARCP decision aid documents the targets to be achieved for a satisfactory ARCP outcome for IMS2. It sets out the requirements for CCT and provides guidance on the evidence expected in training years where IM training is undertaken. The GMC requires an ARCP training outcome to be given for both IMS2 and the specialty for every year of training in Group 1 specialties. For years where no IM training takes place the ARCP panel should record this.

Progression through training is by acquisition of capabilities. In this Decision Aid all times (e.g. days, months, years) and numbers (e.g. of patients, of clinics, of assessments) are to be understood as 'indicative'. This means that the view of the JRCPTB is that the time or number specified is that required by most trainees to acquire and demonstrate the capability and for there to be adequate evidence to allow an Educational Supervisor (ES) to make a judgement about their trainee's performance. In addition to providing formative feedback to trainees, another purpose of SLEs is to provide evidence to inform the ES report. ARCP panels should make decisions based on holistic review of the trainee's progress and be proportionate in their requirements, e.g. if the only IM training that a trainee undertakes in a particular year is in outpatients, they should only require evidence related to Clinical CiP4 (managing patients in an outpatient clinic). The ES and ARCP panels will use their judgement to review whether more rapid progression through training will be possible, with adequacy of evidence being crucial to this type of decision making.

Evidence	**ST4**	**ST5**	**ST6 (final year of training for single specialty GIM trainees)**	**ST7 (final year of training for most Group 1 trainees)**	**ST8 (final year of training for some Group 1 trainees)**	**Indicative minimum by CCT**
Educational supervisor (ES) report	One to cover the training year since last ARCP (up to the date of the current ARCP)	One to cover the training year since last ARCP (up to the date of the current ARCP)	One to cover the training year since last ARCP (up to the date of the current ARCP)	One to cover the training year since last ARCP (up to the date of the current ARCP)	One to cover the training year since last ARCP (up to the date of the current ARCP)	Confirms performance is at the level appropriate for completion of IMS2 and award of CCT

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
Generic capabilities in practice (CiPs)	Trainees should complete self-rating for each CiP, which must be discussed with and confirmed by ES	Trainees should complete self-rating for each CiP, which must be discussed with and confirmed by ES	Trainees should complete self-rating for each CiP, which must be discussed with and confirmed by ES	Trainees should complete self-rating for each CiP, which must be discussed with and confirmed by ES	Trainees should complete self-rating for each CiP, which must be discussed with and confirmed by ES	Trainee must meet expectations for completion of IMS2 and award of CCT
Clinical capabilities in practice (CiPs)	In any year during which a trainee is training in IM, the trainee should complete self-rating for each CiP, which must be discussed with and confirmed by ES. See grid below for minimal levels expected during IMS2	In any year during which a trainee is training in IM, the trainee should complete self-rating for each CiP, which must be discussed with and confirmed by ES. See grid below for minimal levels expected during IMS2	In any year during which a trainee is training in IM, the trainee should complete self-rating for each CiP, which must be discussed with and confirmed by ES. See grid below for minimal levels expected during IMS2	In any year during which a trainee is training in IM, the trainee should complete self-rating for each CiP, which must be discussed with and confirmed by ES. See grid below for minimal levels expected during IMS2	In any year during which a trainee is training in IM, the trainee should complete self-rating for each CiP, which must be discussed with and confirmed by ES. See grid below for minimal levels expected during IMS2	Trainee must meet expectations for completion of IMS2 and award of CCT (Level 4 for all clinical CiPs)
Multiple consultant report (MCR)	In any year during which a trainee is training in IM, 2 MCRs that provide feedback on IM CiPs to be completed by consultants who have supervised the	In any year during which a trainee is training in IM, 2 MCRs that provide feedback on IM CiPs to be completed by consultants who have supervised the	In any year during which a trainee is training in IM, 2 MCRs (3 if final year of training) that provide feedback on IM CiPs to be completed by	In any year during which a trainee is training in IM, 2 MCRs (3 if final year of training) that provide feedback on IM CiPs to be completed by	During final year of IM training, 3 MCRs that provide feedback on IM CiPs to be completed by consultants who have supervised the trainee in the clinical	3 MCRs in final year confirming performance is at the level appropriate for completion of IMS2 and award of CCT

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
	trainee in the clinical CiPs in which they have been training	trainee in the clinical CiPs in which they have been training	consultants who have supervised the trainee in the clinical CiPs in which they have been training	consultants who have supervised the trainee in the clinical CiPs in which they have been training	CiPs in which they have been training	
Multi-source feedback (MSF)	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM (if IM training is taking place that year). During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM (if IM training is taking place that year). During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM (if IM training is taking place that year). During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM (if IM training is taking place that year). During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM (if IM training is taking place that year). During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context	One MSF must be completed each training year to cover the generic and clinical capabilities required for both HST and IM (if IM training is taking place that year). During a year that IM training occurs then at least 4 raters should come from those who have worked with the trainee in an IM context
Patient survey						At least 1 to be completed by end of IMS2

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
Supervised learning events (SLEs): **Acute care assessment tool (ACAT)**	If training in CiP1, 4 ACATs to be carried out by consultants supervising in the acute unselected take/post take setting. Each ACAT must include a minimum of 5 cases and should be used for 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)	If training in CiP1, 4 ACATs to be carried out by consultants supervising in the acute unselected take/post take setting. Each ACAT must include a minimum of 5 cases and should be used for 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)	If training in CiP1, 4 ACATs to be carried out by consultants supervising in the acute unselected take/post take setting. Each ACAT must include a minimum of 5 cases and should be used for 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)	If training in CiP1, 4 ACATs to be carried out by consultants supervising in the acute unselected take/post take setting. Each ACAT must include a minimum of 5 cases and should be used for 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)	If training in CiP1, 4 ACATs to be carried out by consultants supervising in the acute unselected take/post take setting. Each ACAT must include a minimum of 5 cases and should be used for 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)	4 ACATs in final year of IMS2 training to be carried out by consultants supervising in the acute unselected take/post take setting. Each ACAT must include a minimum of 5 cases and should be used for 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)

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
Supervised Learning Events (SLEs): **Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)**	In any year during which a trainee is training in IM, 3 SLEs (CbDs and/or mini-CEXs) to be carried out by consultants supervising in IM	In any year during which a trainee is training in IM, 3 SLEs (CbDs and/or mini-CEXs) to be carried out by consultants supervising in IM	In any year during which a trainee is training in IM, 3 SLEs (CbDs and/or mini-CEXs) to be carried out by consultants supervising in IM	In any year during which a trainee is training in IM, 3 SLEs (CbDs and/or mini-CEXs) to be carried out by consultants supervising in IM	In any year during which a trainee is training in IM, 3 SLEs (CbDs and/or mini-CEXs) to be carried out by consultants supervising in IM	3 SLEs (CbDs and/or mini-CEXs) in final year of IMS2 training to be carried out by consultants supervising in IM
Advanced life support (ALS) or equivalent	Valid ALS certificate	Valid ALS certificate	Valid ALS certificate	Valid ALS certificate	Valid ALS certificate	Valid ALS certificate
Quality improvement (QI) project						At least one QI project to be completed in IMS2 and assessed with quality improvement project tool (QIPAT) or equivalent
Clinical activity: Outpatients	Record number of outpatient clinics in specialties other	Record number of outpatient clinics in specialties other	Record number of outpatient clinics in specialties other	Record number of outpatient clinics in specialties other	Record number of outpatient clinics in specialties other	Indicative minimum of 20 clinics in specialties other

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
(can include community experience, virtual clinics and work in ambulatory settings)	than the trainee's specialty	than the trainee's specialty	than the trainee's specialty	than the trainee's specialty	than the trainee's specialty	than the trainee's specialty by the end of IMS2
Clinical activity: Acute unselected take	Record estimate of number of patients presenting with acute medical problems that the trainee has been actively involved in caring for	Record estimate of number of patients presenting with acute medical problems that the trainee has been actively involved in caring for	Record estimate of number of patients presenting with acute medical problems that the trainee has been actively involved in caring for	Record estimate of number of patients presenting with acute medical problems that the trainee has been actively involved in caring for	Record estimate of number of patients presenting with acute medical problems that the trainee has been actively involved in caring for	Active involvement in the care of an 750 patients presenting with acute medical problems by the end of IMS2, with 100 patients in the final year of training
Clinical activity: Continuing ward care of patients admitted with acute medical problems	Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems*	Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems*	Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems*	Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems*	Record number of months of experience and training in continuing ward care of patients admitted with acute medical problems*	12 months of experience and training in continuing ward care of patients admitted with acute medical problems by end of IMS2, including 3 months in final year of IMS2 training*

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
Simulation	Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM	Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM	Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM	Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM	Record number of hours of simulation training to include recognition of human factors in interactions in any year during which a trainee is training in GIM	At least 12 hours of simulation training to include recognition of human factor in interactions during IMS2, including at least 4 hours in the final year of IMS2 training
Study Leave	Record number of hours of recognised IM study leave (CPD points and/or Deanery organised)	Record number of hours of recognised IM study leave (CPD points and/or Deanery organised)	Record number of hours of recognised IM study leave (CPD points and/or Deanery organised)	Record number of hours of recognised IM study leave (CPD points and/or Deanery organised)	Record number of hours of recognised IM study leave (CPD points and/or Deanery organised)	75 hours of recognised IM study leave (CPD points and/or Deanery organised) by end of IMS2, including 20 hours in final year of IMS2 training
Teaching experience						At least one Teaching Observation to be completed by end of IMS2
Practical procedures						Minimum level of competence required for

Evidence	ST4	ST5	ST6 (final year of training for single specialty GIM trainees)	ST7 (final year of training for most Group 1 trainees)	ST8 (final year of training for some Group 1 trainees)	Indicative minimum by CCT
						completion of IMS2 as shown in Table below
Notes: * Adequate experience and training in provision of continuity of care for medical inpatients cannot be provided by very short placements. Attachments of trainees to inpatient wards/services should generally be for periods of four weeks' duration or greater. Attachments of less than four weeks' duration will not normally allow Clinical Supervisors or Educational Supervisors to make a judgement about a trainee in relation to CiP3. A 4 week intensive placement in an acute medical until will be acceptable as an alternative to 3 months inpatients experience in the final year						

Practical procedural skills

Competence in the procedures below will have been achieved during IMS1 and should be maintained during IMS2 either by continued practice or skills lab training. When a trainee has been signed off as being able to perform a procedure independently they are not required to have any further assessment (DOPS) of that procedure unless they or their educational supervisor think that this is required (in line with standard professional conduct). This also applies to procedures that have been signed off during foundation training or in other training programmes (e.g. ACCS). 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.

Practical procedure	Minimum level of competence required in IMS2
Advanced cardiopulmonary resuscitation (CPR)	Leadership of CPR team
Ascitic tap	Competent to perform unsupervised

Practical procedure	Minimum level of competence required in IMS2
Direct current (DC) cardioversion	Competent to perform unsupervised
Lumbar puncture	Competent to perform unsupervised
Nasogastric (NG) tube	Competent to perform unsupervised
Pleural aspiration for fluid (diagnostic) It can be assumed that a trainee who is capable of performing pleural aspiration of fluid is capable of introducing a needle to decompress a large symptomatic pneumothorax	Competent to perform unsupervised
Abdominal paracentesis	Skills lab or satisfactory supervised practice
Access to circulation for resuscitation (femoral vein or intraosseous) The requirement is for a minimum of skills lab training or satisfactory supervised practice in one of these two mechanisms for obtaining access to the circulation to allow infusion of fluid in the patient where peripheral venous access cannot be established	Skills lab or satisfactory supervised practice
Central venous cannulation (internal jugular or subclavian)	Skills lab or satisfactory supervised practice
Intercostal drain for effusion*	Skills lab or satisfactory supervised practice
Intercostal drain for pneumothorax*	Skills lab or satisfactory supervised practice
Temporary cardiac pacing using an external device	Skills lab or satisfactory supervised practice

* Pleural procedures should be undertaken in line with the British Thoracic Society guidelines. Ultrasound guidance should be provided by a pleural-trained ultrasound practitioner

Outline grid of minimum level of entrustment expected for Internal Medicine clinical CiPs at the end of each year of IMS2 training – dual CCT (Group 1 specialty)

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

	Internal Medicine stage 2 + specialty training				CCT
Specialty CiP	**ST4**	**ST5**	**ST6**	**ST7**	**CRITICAL PROGRESSION POINT**
1. Managing an acute unselected take	**3**	**3**	**3**	**4**	
2. Managing the acute care of patients within a medical specialty service	**2**	**3**	**3**	**4**	
3. Providing continuity of care to medical inpatients	**3**	**3**	**3**	**4**	
4. Managing outpatients with long term conditions	**3**	**3**	**3**	**4**	
5. Managing medical problems in patients in other specialties and special cases	**3**	**3**	**3**	**4**	
6. Managing an MDT including discharge planning	**3**	**3**	**3**	**4**	
7. Delivering effective resuscitation and managing the deteriorating patient	**4**	**4**	**4**	**4**	
8. Managing end of life and applying palliative care skills	**3**	**3**	**3**	**4**	

Outline grid of minimum level of entrustment expected for Internal Medicine clinical CiPs at the end of each year of IMS2 training – single CCT

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

	Internal Medicine stage 2			CCT
Specialty CiP	**ST4**	**ST5**	**ST6**	**CRITICAL PROGRESSION POINT**
9. Managing an acute unselected take	**3**	**3**	**4**	
10. Managing the acute care of patients within a medical specialty service	**2**	**3**	**4**	
11. Providing continuity of care to medical inpatients	**3**	**3**	**4**	
12. Managing outpatients with long term conditions	**3**	**3**	**4**	
13. Managing medical problems in patients in other specialties and special cases	**3**	**3**	**4**	
14. Managing an MDT including discharge planning	**3**	**3**	**4**	
15. Delivering effective resuscitation and managing the deteriorating patient	**4**	**4**	**4**	
16. Managing end of life and applying palliative care skills	**3**	**3**	**4**	

Training programme

Acute medical take
Trainees should be involved in the acute unselected medical take and they should be actively involved (have sufficient input for their involvement to be recorded in the patient's clinical notes) in the care of an indicative 750 patients presenting with acute unselected medical problems during the course of IM stage 2 training. Trainees will need to demonstrate they have the required capabilities to manage the acute unselected take at completion of training, hence it is required that they are involved in the acute unselected take for an indicative three months in the final year of training (e.g. three months of involvement with the acute unselected take as part of dual training with specialty; four weeks of attachment to an acute medicine service with no concurrent specialty duties), during which time they must be involved in the care of an indicative 100 patients presenting with acute unselected medical problems.

Care of medical specialty patients with acute illness
It is recognised that not all specialties will have an acute specialty take but all will receive patients in an unscheduled fashion. The trainee should be able to manage the specialty conditions with which the patient presents and provide management of co-existing acute medical illness.

Inpatients
Trainees in internal medicine must be entrusted to provide continuity of care to medical inpatients without supervision by completion of training (clinical CiP 3). Trainees will have had extensive experience and training in this capability during IM stage 1 and during IM stage 2 they should build on this by undertaking an indicative minimum of 12 months further experience and training in continuing ward care of patients admitted with acute medical problems. To confirm that trainees are confident and capable of unsupervised practice at the time of CCT an indicative minimum of three months of inpatient care should occur in the last year of training.

The inpatient setting should provide trainees with experience of the following:

- Assessment of patients during the course of acute medical illness
- Decision making during the course of acute medical illness
- Discussion with patients and relatives during the course of acute medical illness
- Management of the patient who is deteriorating, including decisions about and implementation of plans for escalation of care (to HDU, ICU) or move to palliative care
- Planning discharge of patients along with other members of the MDT.

In addition to the indicative minimum 12 months experience of inpatient care, trainees will acquire relevant skills, knowledge and behaviours (as detailed above and in the CiP descriptors) in specialty settings such as the acute take, outpatients, hospices, community and ambulatory care.

Outpatients
Trainees should attend and be actively involved in an indicative minimum of 20 clinics that occur outside of their main specialty. Reflecting changes in clinical practice, some of this training could be provided as community experience, virtual clinics and work in ambulatory settings. The choice of clinic / experience should be driven by the educational needs of the trainee, as identified by the trainee and their educational supervisor, with the educational objectives as set out in the teaching and learning methods section. Across all specialties, it has been widely reported that trainees are not consistently having clinics outside of their specialty timetabled and when they are, these are of limited value. It is still believed that attending clinics outside of the main specialty does increase breath of experience, however the recommended indicative number of 20 is not absolute and experience should be tailored for trainees to give direct benefit for their training.
It has been agreed to consult with group 1 SACs to determine a list of other speciality clinics that would most benefit trainees in their specialty. For example, renal trainees may benefit more from attending a diabetes clinic, rheumatology trainees may benefit from renal clinic etc.
Following consultation, a change request will be made to the GMC to remove this as a mandated requirement in the IM curriculum and this rough guide will be updated for each specialty to include more beneficial/quality clinic suggestions.

Simulation
Simulation teaching involving human factors and scenarios training should be carried out in IM stage 2 with refresher training for procedural skills where necessary
. Simulation can underpin assessment of the GPCs, for example, leadership and teamworking, communication skills and time management. particularly for those trainees experiencing difficulty in accessing procedures or who have specific need for updating skills.

Recommended training

Palliative and end of life care experience
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. Attachments with or experience of working with a palliative care team are strongly recommended.

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, admission avoidance clinics, and 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 three months of experience 'acting up' (with appropriate supervision) as a consultant in Internal Medicine.

Guidance for implementation of Internal Medicine Training during higher specialty training

Guidance has been produced on implementing IM training in group 1 specialties:

- **In new Group 1 specialties Lack of ability to get medical time for new group 1 specialty trainees (GUM, Neurology & Palliative Medicine)**
- **GIM TPDs will be encouraged to liaise with the specialty TPDs to arrange these blocks for trainees.**

- **In established Group 1 specialties**

Training resources links

JRCPTB Internal Medicine webpage

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
CiP	Capabilities in Practice
CbD	Case-based Discussion
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
ES	Educational Supervisor
GPC	Generic Professional Capabilities
GMC	General Medical Council
HoS	Head of School
ICU	Intensive Care Unit
IMY1-3	Internal Medicine Year 1-3
JRCPTB	Joint Royal Colleges of Physicians Training Board
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
Mini CEX	Mini Clinical Evaluation Exercise
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
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