JRCPTB

Joint Royal Colleges of Physicians Training Board

Rough Guide to Internal Medicine Training

Guidance for training programme directors, supervisors and trainees

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

Contents

Introduction

This guide to the new curriculum for Internal Medicine Training stage 1 (IMTS1) is to help training programme directors (TPDs), supervisors, trainees and others with the practicalities of implementing IMTS1. It is intended to supplement rather than replace the curriculum document itself. It is appreciated that all regional schools of medicine will be issuing their own guidance to take account of local resources and constraints, but it was felt that central guidance would be helpful.

The Rough Guide has been put together by members of the Curriculum Development Committee at the JRCPTB 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.

Why IMT is different from CMT?

Background

There have been two major drives to the need for change; firstly the 'tick-box' mentality that has become associated with the present Core Medical Training (CMT) curriculum with the need to assess over 120 competences. This approach does not provide a holistic assessment of capability as a physician and research has demonstrated that a successful trainee will progress through levels of attainment whereby clinical activities could be entrusted to them. This has facilitated the development of a novel assessment process of 'capabilities in practice' (CIPs). Secondly, the GMC has mandated that all postgraduate curricula must be based on higher level learning outcomes and incorporate the GMC defined Generic Professional Capabilities (GPCs) which were published in May 2017.

Duration of training

IMTS1 will usually be completed in three years of full-time training. Duration of specialty training and completion of further Internal Medicine Training to CCT (Stage 2) will vary by specialty. There will be options for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities to complete training sooner than the current indicative time. Guidance on completing training in less than 36 months is available on the JRCPTB website and as development as an IM clinician requires a level of experience as well as specific training, it is unlikely that Stage1 IM could be completed in less than 30 months. There may also be a small number of trainees who develop more slowly and will require an extension of training as indicated in the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide).

The IM stage 1 curriculum

The purpose of the IM stage 1 curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to manage patients presenting with a wide range of general medical symptoms and conditions. They will be entrusted to undertake the role of the medical registrar in NHS district general and teaching hospitals and qualified to apply for higher specialist training.

IMTS1 will normally be a three-year programme that will include mandatory training in geriatric medicine, critical care and outpatients (this may include ambulatory care clinics).

There will be a critical progression point at the end of the second year (IMY2) to ensure trainees have the required capabilities and are entrusted to 'step up' to the medical registrar role in IMY3. Given the importance of this progression point, it is vital that the training programme gives all trainees the opportunity to take part in the acute take during the middle or latter part of IMY2. Most trainees will be entrusted to manage the acute unselected take and manage the deteriorating patient with indirect supervision in IMY3. A few will require an additional period of time in a supportive training environment with the supervising physician readily available.

There will be a further critical progression point at completion of IMTS1; trainees will be required to meet all curriculum requirements, including passing the full MRCP(UK) diploma examination by time of completion.

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.

IM stage 1 will be the first stage of training in internal medicine and the specialties managed by the Joint Royal College of Physicians Training Board (JRCPTB). Further training in internal medicine and a specialty will be required to achieve a CCT in internal medicine and specialty. A number of physician specialties in which consultants will not be expected to provide acute unselected care, will recruit trainees who have completed IMY1 and IMY2 (and have the full MRCP Diploma). The capabilities of trainees at this critical progression point are detailed in the IM stage 1 curriculum and will be defined in the relevant specialties' entry requirements.

Capabilities in Practice (CiPs)

The six generic CiPs cover the universal requirements of all specialties as described in the GPC framework. Assessment of the generic CiPs will be underpinned by the GPC descriptors. Satisfactory sign off will indicate that there are no concerns.

The eight clinical CiPs describe the clinical tasks or activities which are essential to the practice of internal medicine. The clinical CiPs have also 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 of performance expected for completion of this stage of internal medicine training, as defined in the curriculum.

The 14 CiPs describe the professional tasks or work within the scope of internal medicine. Each CiP has a set of descriptors associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made. By the completion of training and award of CCT, the doctor must demonstrate that they are capable of unsupervised practice in all generic and specialty CiPs.

Capabilities in practice (CiPs)

Generic CiPs

1. Able to successfully function within NHS organisational and management systems
2. Able to deal with ethical and legal issues related to clinical practice
3. Communicates effectively and is able to share decision making, while maintaining appropriate situational awareness, professional behaviour and professional judgement
4. Is focussed on patient safety and delivers effective quality improvement in patient care
5. Carrying out research and managing data appropriately
6. Acting as a clinical teacher and clinical supervisor to be assessed by DOPS

Clinical CiPs

1. Managing an acute unselected take
2. Managing an acute specialty-related take
3. Providing continuity of care to medical in-patients, 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

Annual Review of Competence Progression (ARCP) during Internal Medicine Training stage 1

Introduction

The ARCP is a procedure for assessing competence annually in all medical trainees across the UK. It is owned by the four Statutory Education Bodies (Health Education England, NHS Education for Scotland, Health Education and Improvement Wales and Northern Ireland Medical & Dental Training Agency) and governed by the regulations in the Gold Guide. The JRCPTB can therefore not alter the way in which an ARCP is run but can provide guidance for trainees and trainers in preparing for it and guide panel members on interpretation of both curricular requirements and the decision aid when determining ARCP outcomes. Although receiving a non-standard ARCP outcome (i.e. anything but an outcome 1 or 6) should not be seen as failure, we know that many trainees are anxious about such an outcome and everything possible should be done to ensure that no trainee inappropriately receives a non-standard outcome.

Internal Medicine Training Stage 1 (IMTS1)

The curriculum for IMTS1 has heralded the most major change in physician training since the introduction of Core Medical Training in 2007. It has replaced over 100 individual competencies with 14 Capabilities in Practice (CiPs) and this will have a major impact on how trainees are assessed and how they will progress through their ARCPs. We know that the majority of trainees in core medical training achieve a standard ARCP outcome and if that proportion decreases significantly with the introduction of IMTS1, this implies a failure of the training and supervisory framework rather than a sudden decrease in the overall capability of our trainees. It is vital we avoid this by helping trainees and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: "Overall, on reviewing the ePortfolio, including the Educational Supervisor report, the Multiple Consultant Reports, the Multi-Source Feedback and (if necessary) other information such as workplace based assessments, reflection etc, is there evidence to suggest that this trainee is safe and capable of progressing to the next stage of training?"

Relationship with Educational Supervisor (ES)

Each trainee should have an Educational Supervisor for a minimum of 12 months of IMTS1. In reality, it is ideal if the trainee has the same ES throughout the whole of IMTS1 but practical considerations (such as geographical locations) may sometimes mitigate against this. It is vital that the trainee and the ES develop a close working relationship and meet up as soon as possible after the start of training. At that meeting, the ES should discuss how the various curriculum requirements will be met (especially some of the mandatory learning experiences such as clinics and critical care) and how evidence will be recorded to ensure that it can be demonstrated that the Capabilities in Practice have been achieved at the appropriate level. This meeting

should also result in the production of a Personal Development Plan (PDP) consisting of a number of SMART objectives that the trainee should seek to achieve during that training year. The trainee should meet up with their ES on a number of other occasions during the training year so that the ES can be reassured that appropriate evidence is being accumulated to facilitate production of a valid ES report towards the end of the year and guide the trainee as to further evidence that might be required.

Clinical supervisor (CS)

The trainee should have a Clinical Supervisor for each attachment and once again the trainee should meet up with the CS at the start of the attachment. Similar discussions should be held with the CS as have been held with the ES and once again, a PDP with SMART objectives should be constructed for each attachment. At the end of the attachment, the CS should be well placed to complete a Multiple Consultant Report (MCR) detailing how the trainee has developed towards developing each CiP. The CS should also document the progress that the trainee has made towards completing all the objectives of the PDP.

The trainee should provide a MCR from each designated CS as they are best placed to provide such a report but in addition should approach other consultants with whom they have had a significant clinical interaction and ask them also to provide a MCR. The MCR asks consultants to comment on performance towards each CiP although supervisors are not required to assign a specific entrustment level to the clinical CiPs. Throughout the attachment the trainee should be having SLEs completed by both consultants and more senior trainees. The number of SLEs demanded by the decision aid should be regarded as an absolute minimum and additional ones should be sought because

- Although they are formative, not summative assessments, they do provide additional evidence to show that a trainee is acquiring clinical (and generic) capabilities
- They may give the trainee the opportunity to have additional one to one clinical teaching from a senior colleague
- They allow the excuse for trainees to receive targeted and constructive feedback from a senior colleague.

Completing reports

When completing reports, all consultants should do more than just tick a box and make some generic comment such as “good trainee”. It is important that they make meaningful comments about why they have assigned that particular level of performance/behaviour to that particular trainee. In doing this, the descriptors assigned to each CiP should be especially useful as an *aide-memoire*. They should specifically not be used as a tick list that requires a comment for each descriptor but should just allow the senior doctor completing the report to reflect on what comments would be helpful to the ES for completion of their report and to the ARCP

panel in determining whether the trainee can progress to the next year of training. Constructive comments are also of course valued by the trainee. It is very helpful if the trainee can have constructive comments if they are progressing along the "normal" trajectory and especially if they are exceeding expectations either globally or in certain areas. If a trainee is performing below expectations then it is absolutely mandatory that meaningful, insightful and precise comments are provided.

ARCP preparation

As the ARCP approaches, it is essential that the trainee reviews their ePortfolio and ensures that all requisite information is available in a logical and accessible format. In particular they should ensure that:

- All appropriate certificates (ALS, MRCP etc) have been uploaded to the personal library and are clearly signposted
- An appropriate amount of reflection has been documented
- As a bare minimum (see comments above), the requisite number of SLEs (as demanded by the annual decision aid) has been completed and recorded in the ePortfolio (it is especially important to ensure that the mandated number has been performed by consultant assessors)
- MSF has been completed and the results released by the ES. It is critical that appropriate discussion/reflection has occurred and been recorded in response to the MSF
- MCR has been completed by each CS and additional ones have been completed by any supervisor with whom the trainee has had significant clinical/educational interaction
- They have self-rated themselves for each CiP on the curriculum page
- The SMART objectives documented in their PDP have either been achieved fully and the evidence for that achievement has been clearly documented. If any objectives of the PDP have not been fully achieved, then the reasons for that have been clearly documented and evidenced.
- An appointment has been made with their ES to discuss the annual ES report that will inform the ARCP panel

The ES should review the portfolio to ensure that all the above requirements have been met and record a final rating for each CiP on the curriculum page. The ES should meet up with the trainee to discuss the ESR so that there are no surprises.

The ARCP

At the ARCP, the panel should review the ePortfolio and in particular it should focus on the ESR report but also review the MCRs, the MSF, the PDPs and reflection. It should also reassure itself that all the mandatory courses and exams have been attended/passed (eg ALS, MRCP etc). If members of the panel have any concerns that the trainee under review is not eligible for a standard outcome (outcome 1 or outcome 6) then they should "drill down" deeper into the portfolio and review more of the SLEs and other subsidiary information. Once again it is stressed that the

general default is towards a standard outcome and trainees should not be turned down for this just because (for example) 1 SLE is deficient in some way.

The ARCP process in 2020 has been affected by the COVID-19 pandemic and the approach to evaluating trainee progress has been modified. Guidance on the revised ARCP process is available on the JRCPTB website page www.jrcptb.org.uk/covid-19.

Assessment: What is required from trainees and trainers?

Introduction

Decisions about a trainee's competence progression will be based on an assessment of how they are achieving their CiPs. For the generic CiPs it will be a straightforward statement as to whether they are operating at, above, or below their anticipated performance for the current year/level of training. However, for the clinical IM CiPs there will be a judgement made at what level of supervision they require (i.e. unsupervised or with direct or indirect supervision). For each clinical IM CiP there is a level that is to be achieved at the end of each year in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). This level is specified in the curriculum and therefore can only be altered with the agreement of the GMC.

What the trainee needs to do

For IMT, there is no major change in what the trainee needs to do in preparing for their ARCP. They still need to do an appropriate number of supervised learning events (SLEs) and workplace based assessments (WPBAs). The requirements are documented in the ARCP decision aid (see ARCP section below) but it should be appreciated by trainer and trainee that the decision aid sets out the absolute minimums. SLEs and formative DOPS are not pass/fail summative assessments but should be seen by both trainer and trainee as learning opportunities for a trainee to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Trainees should therefore be seeking to have SLEs performed as often as practical. They also must continue to attend and document their teaching sessions and must continue to reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development. They should record how many clinics they have attended and how many patients they have been involved with on the Acute Unselected Take in the summary of clinical activity form.

Each trainee must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their Educational Supervisor (ES) and prompted appropriate reflection. They also need to ensure that they have received a minimum of four reports from consultants who are familiar with their work and who will contribute to the Multiple Consultant Report (MCR). Each consultant contributing to the MCR will give an advisory statement

about the level at which they assess the trainee to be functioning for each clinical CiP.

As the ARCP approaches, trainees need to arrange to see their ES to facilitate preparation of the ES report (ESR). They will have to self-assess the level at which they feel they are operating at for each CiP. In an analogous fashion to the MSF, this self- assessment allows the ES to see if the trainee's views are in accord with those of the trainers and will give an idea of the trainee's level of insight.

Interaction between trainer and trainee

Regular interaction between trainees and their trainers is critical to the trainee's development and progress through the programme. Trainees will need to engage with their clinical and educational supervisors.

At the beginning of the academic year there should be a meeting with the ES to map out a training plan for the year. This should include;

- how to meet the training requirements of the programme, addressing each CiP separately
- a plan for taking the various stages of the MRCP diploma
- a discussion about what resources are available to help with the programme
- develop a set of SMART Personal Development Plans (PDPs) for the training year
- a plan for using study leave
- use of the various assessment/development tools

The trainee should also meet with the clinical supervisor (CS) to discuss the opportunities in the current placement including;

- develop a PDP including SMART objectives for the placement
- access to clinics and how to meet the learning objectives
- expectations for medical on-call
- expectations for in-patient experience
- expectations to gain experience in end-of-life care

Depending on local arrangements there should be regular meetings (we recommend approximately one hour most weeks) for personalised, professional development discussions which will include;

- writing and updating the PDP
- reviewing reflections and SLEs
- reviewing MCR and other feedback
- discussing leadership development
- discussing the trainee's development as a physician and career goals
- discussing things that went well or things that went not so well

Self-assessment

Trainees are required to undertake a self-assessment of their engagement with the curriculum and in particular the CiPs. This is not a 'one-off' event but should be a continuous process from induction to the completion of the programme and is particularly important to have been updated ahead of the writing of the ES report and subsequent ARCP. Self-assessment for each of the CiPs should be recorded against the curriculum on the trainee's ePortfolio account.

The purpose of asking trainees to undertake this activity is:

- To guide trainees in completing what is required of them by the curriculum and helping to maintain focus of their own development. To initiate the process it is important that the induction meeting with a trainee's ES reviews how the trainee will use the opportunities of the coming academic year to best advantage in meeting the needs of the programme. It will allow them to reflect on how to tailor development to their own needs, over-and-above the strict requirements laid out in the curriculum
- To guide the ES and the ARCP panel as to how the trainee considers they have demonstrated the requirements of the curriculum as set out in the Decision Aid and where this evidence may be found in the trainee's portfolio. This will help the ARCP panel make a more informed judgement as to the trainee's progress and reduce the issuing of outcome 5s as a result of evidence not being available or found by the panel

What the Educational Supervisor (ES) needs to do

IMT has a new requirement of how trainees and supervisors should interact, with the need to plan evidence to be acquired across the training year that can be used by the ES to write an important and substantial ES report (ESR).

The ESR will be the central piece of evidence considered by the ARCP Panel when assessing whether the trainee has attained the required standard as set out in the Decision Aid. As such, both time and planning will need to be given to writing it; this process will need to start at the beginning of the training year.

Educational Supervisor Report (ESR)

The ESR should be written ahead of the ARCP and discussed between the supervisor and the trainee before the ARCP, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report documents the entrustment decisions made by the supervisor for all the CiPs set out in the curriculum. The decisions should be based on evidence gathered across the training year as planned at the Induction Meeting with the trainee and modified through subsequent, regular, professional development meetings. The evidence should be gathered from several sources as appropriate for the particular CiP.

In completing the ESR, assessments are made for each **generic CiP** using the following anchor statements:

Below expectations for this year of training; may not meet the requirements for critical progression point
Meeting expectations for this year of training; expected to progress to next stage of training
Above expectations for this year of training; expected to progress to next stage of training

Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include;

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

For the **clinical CiPs**, the ES makes a judgement using the levels of entrustment in the table below.

Level 1: Entrusted to observe only – no provision of clinical care
Level 2: Entrusted to act with direct supervision: The trainee may provide clinical care, but the supervising physician is physically within the hospital or other site of patient care and is immediately available if required to provide direct bedside supervision
Level 3: Entrusted to act with indirect supervision: The trainee may provide clinical care when the supervising physician is not physically present within the hospital or other site of patient care, but is available by means of telephone and/or electronic media to provide advice, and can attend at the bedside if required to provide direct supervision
Level 4: Entrusted to act unsupervised

Only the ES makes entrustment decisions. Detailed comments must be given to support entrustment decisions that are below the level expected. As above, it is good practice to provide a narrative for all ratings given.

Important Points

- Plan the evidence strategy from the beginning of the training year
- Write the report in good time ahead of the ARCP
- Discuss the ESR with the trainee before the ARCP
- Give specific, examples and directive narration for each entrustment decision

Types of Evidence

Local Faculty Groups (LFG)

This type of group has been recommended in training previously but is not universally implemented. If available this should be a group of senior clinicians (medical and non-medical) who get together to discuss trainees' progress. The purpose is not only to make an assessment of a trainee but to determine and plan on-going training. It is recommended again as an optimal way of providing information about trainees' progress.

The LFG set-up will depend on the circumstances of the organisation. In smaller units the LFG make include all the physicians; while in larger units there may be several LFGs, each in a different department. In all circumstances, as a minimum, an LFG must be able to consider, direct and report on the performance of trainees in the acute medicine/on-call setting.

The LFG should meet regularly to consider the progress of each trainee and identify training needs, putting in place direction as to how these needs are to be met. This should be documented and communicated to trainee's Educational Supervisor and hence to the trainee. A mechanism for this to happen should be established.

Multi-Source Feedback (MSF)

The MSF provides feedback on the trainee that covers areas such as communication and team working. It closely aligns to the Generic CiPs. Feedback should be discussed with the trainee. If a repeat MSF is required it should be undertaken in the subsequent placement.

Multiple Consultant Report (MCR)

The MCR captures the views of consultant (and other senior staff) based on observation of a trainee's performance in practice. The MCR feedback gives valuable insight into how well the trainee is performing, highlighting areas of excellence and areas of support required.

The ***minimum*** number of MCRs considered necessary is four (three of which should reflect performance in the acute take setting). It is advised that more should be obtained to support the entrustment decisions made by the ES especially if the trainee is struggling. All those formally appointed as CS should complete a MCR but any other consultant with whom the trainee has had significant interaction can also complete one.

In completing the MCR assessments are made for each CiP using the global anchor statements [meets, below or above expectations]. If it is not possible for an individual to give a rating for one or more of the CiPs they should record 'not observed'. Comments must be made, as a minimum, for any rating of below expectation. It is good practice to narrate all decisions. The narration should include:

- Source of the evidence and its context, outlining contradicting evidence if appropriate
- Examples (of statements)
- Direction for future development/improvement

Supervised Learning Events

Acute Care Assessment Tool (ACAT)

The ACAT is used to provide feedback on a trainee's performance when undertaking acute care, particularly the acute medical take. Its main focus is on multi- tasking, prioritisation and organisational skills. It should not be used to produce a "multiple Case Based Discussion". The Decision Aid requires a minimum of 4 per year undertaken by consultant assessors, each of which should cover the care of a minimum of five patients.

Case based Discussion (CbD)

This tool is designed to provide feedback on discussions around elements of the care of a particular patient. This can include elements of the particular case and the general management of the condition. It is a good vehicle to discuss management decisions.

Mini-Clinical Evaluation (mini-CEX)

This tool is designed to allow feedback on the directly observed management of a patient and can focus on the whole case or particular aspects.

Workplace-Based Assessments

Direct Observation of Procedural Skill (DOPS)

This tool is designed to give feedback and assessment for trainees on how they have undertaken a procedural skill. This may be in a simulated or real environment. Formative DOPS may be undertaken as many times as the trainee and supervisor feel is necessary. A trainee can be signed off as able to perform a procedure unsupervised using the summative DOPS.

Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competences at teaching. The TO form can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on a review of quality improvement documentation or on a presentation of the quality improvement project at a meeting. If possible, the trainee should be assessed on the quality improvement project by more than one assessor.

Guidance on how to assess QI skills and behaviours has been developed by the Academy of Medical Royal Colleges and is available via this link.

Reflection

Undertaking regular reflection is an important part of trainee development towards becoming a self-directed professional learner. Through reflection a trainee should develop SMART learning objectives related to the situation discussed. These should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help trainees deal with challenging situations.

It is important to reflect on situations that went well in addition to those that went not so well. Trainees should be encouraged to reflect on their learning opportunities and not just clinical events

Suggested evidence for each CiP

The suggested evidence to inform entrustment decisions is listed for each CiP in the curriculum and ePortfolio. However, it is critical that trainers appreciate that they do NOT have to supply evidence under each category listed. This list merely suggests the sort of information that could be used to evidence each CiP. For clinical CiP 2 in IM stage 1 it is accepted that experience of the management of specialty patients who have been admitted acutely is more likely than managing an acute specialty take itself. Training programmes will vary but all should offer the trainees an opportunity to work within a specialty that admits patients acutely. This should be possible in most hospitals as the consultants in the majority of medical wards have a specialty in addition to internal medicine. Such experience should be counted towards the achievement of clinical CiP 2.

Induction Meeting with ES: Planning the training year

Writing the ESR essentially starts with the induction meeting with the trainee at which the training year should be planned. The induction meeting between the ES and the trainee is pivotal to the success of the training year. It is the beginning of the training relationship between the two and needs both preparation and time. The induction meeting should be recorded formally in the trainee's ePortfolio. The meeting should be pre-planned and undertaken in a private setting where both can

concentrate on the planning of the training year. This is also a time for ES and trainee to start to get to know each other.

Ahead of the meeting review:

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

At the meeting the following need to be considered:

- Review the placements for the year
- Review the training year elements of the generic educational work schedule or its equivalent
- Construct the personalized educational work schedule for the year or its equivalent
- Construct the set of year-level SMART PDPs to include;
    - MRCP PDP
    - QI PDP
    - ALS
    - Career taster days
- Discuss the trainee's career plans and help facilitate these
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss the teaching programme
- Discuss procedural simulation
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including the professional development meetings and the interaction with the placement CSs
- Planning of SLEs and WPBA
- Arrangements for MSF
- Review the ARCP decision aid
- Arrangements for Interim Review of Competence Progression (IRCP)
- Arrangements for ARCP and the writing and discussion of the ESR
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

At the end of the meeting the trainee should have a clear plan for providing the evidence needed by the ES to make the required entrustment decisions.

Important Points

- Prepare for the meeting
- Make sure that knowledge of the IMTS1 curriculum is up-to-date
- Set up a plan for the training year

Induction Meeting with Clinical Supervisor (CS)

The trainee should also have an induction meeting with their placement CS (who may also be their ES). The meeting should be pre-planned and undertaken in a private setting where both can concentrate on the planning of the placement. This is also a time for CS and trainee to start to get to know each other.

Ahead of the meeting review the following should be considered;

- Review Transfers of Information on the trainee
- Review previous ES, ARCP etc. reports if available
- Arrangements for LFGs or equivalent

The following areas will need to be discussed, some of which will reinforce areas already covered by the ES but in the setting of the particular placement:

- Review the training placement elements of the generic educational work schedule or its equivalent
- Construct the personalized educational work schedule for the placement or its equivalent
- Construct the set of placement-level SMART objectives in the PDP
- Discuss the use of reflection and make an assessment of how the trainee uses reflection and dynamic PDPs
- Discuss procedural skill consolidation
- Discuss arrangements for LTFT training if appropriate
- Plan additional meetings including professional development meetings and the interaction with the placement CSs (depending on whether the ES or CS will be undertaking these)
- Arrangements for MSF
- Review the ARCP decision aid
- Pastoral support
- Arrangements for reporting of concerns
- Plan study leave

Professional Development Meetings

Trainers and trainees need to meet regularly across the training year. The GMC recommend an hour per week is made available for this activity. While it is not expected or possible for it to be an hour every week, the time not used for these meetings can be used to participate in LFG and ARCPs etc.

These meetings are important and should cover the following areas. This list is not exhaustive. Meet away from the clinical area regularly to:

- Discuss cases
- Provide feedback
- Monitor progress of learning objectives
- Discuss reflections
- Provide careers advice
- Monitor and update the trainee's PDP

- Record meeting key discussion points and outcomes using the Educational Meeting form on the ePortfolio
- Record progress against the CiPs by updating the comments in the CiP section of the portfolio (this will make writing the ESR at the end of the year much easier)
- Provide support around other issues that the trainee may be encountering

At ARCP

The ARCP gives the final summative judgement about whether the trainee can progress into the subsequent year of training (or successfully complete training if in the final year). The panel will review the ePortfolio (especially the ES report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each CiP and that they are evidence based and defensible. The panel must also review the record of trainee experience to ensure that each trainee has completed (or is on track to complete over ensuing years) the various learning experiences mandated in the curriculum (e.g. outpatient clinics, critical care attachment, geriatrics and acute unselected take).

There are two critical progression points defined within the curriculum. One is the transition from IMY2 to IMY3 when the trainee advances into what was traditionally referred to as the 'medical registrar' role and the second is at the end of IMY3 when the trainee has completed IMT Stage 1 and is ready to progress into higher specialty training either in a Group 2 specialty alone or in Group 1 specialty when training will be integrated with IMT stage 2.

Progression from IMY2 to IMY3

The new GMC approved curriculum for internal medicine training (IMT) states that there is a critical progression point for trainees as they pass from IMY2 to IMY3. This is essentially because part of the trainees' progression is to the important role of the medical registrar, a move that is regarded as a step change in level of responsibility. Previously, when a trainee had successfully concluded CMT (including passing the whole of MRCP - a mandatory component of CMT completion) they were regarded

as suitable to apply for posts that would involve working as the medical registrar. In practice we know that

- A significant proportion of trainees (26% in 2017) do not pass the whole of MRCP during their two years of CMT
- In trainee surveys, even those who had passed the whole of MRCP and completed CMT did not always feel competent and confident to take on the role of medical registrar

Concern has been expressed that the new curriculum does not precisely define the mechanism by which trainees who have acquired the necessary capabilities to undertake the medical registrar role successfully may be identified. For Group 1 specialties in the new curriculum it is not mandatory to have completed MRCP by the end of IMY2 but rather it is "expected". Trainees who have not completed MRCP but who are otherwise continuing to make satisfactory progress will be able to pass into IMY3.

Some trainees, of course, will wish to enter a Group 2 specialty (one that is not involved in the care of acutely unwell patients) and they will be able to leave IM training on completion of IMY2. The entry criteria for Group 2 specialties will mandate successful completion of IMY2 with ARCP outcome 1, including level 3 (indirect supervision required) in clinical CiP 1 and full MRCP.

Accepted points

- It is essential from both a patient safety perspective and also for the educational needs and wellbeing of the trainee that only trainees who are competent so to do should lead the acute take.
- MRCP(UK) is not an exam that defines the ability of a doctor to lead the acute unselected take. It provides evidence for various underpinning skills and knowledge but in itself it is neither necessary nor sufficient.
- The summative judgement of whether a trainee is capable of leading the acute take (and therefore acting as medical registrar) is that they have achieved level 3 entrustment (entrusted with indirect supervision) in clinical CiP 1 managing an acute unselected take.
- The curriculum states that a trainee should expect to achieve level 3 in this CiP by the end of IMY2 allowing them to develop into the role of medical registrar with appropriate support during IMY3.
  As noted previously the training programmes must provide an adequate opportunity for trainees to acquire clinical CiP 1 by adequate exposure to the acute take within IM2.
- Like all CiPs, that judgement is firstly self-assessed by the trainee, then made by the ES in the ESR and finally scrutinized and ratified at the IMY2 ARCP. A number of information streams may feed into that entrustment decision including personal observation, informal intelligence from colleagues (which must be

documented in the ESR), formalised reporting in the form of the MCR, MSF, WPBAs/SLEs (especially ACATs), whether the trainee has undertaken a period of 'acting up' in the medical registrar role (in line with JRCPTB guidance) and the trainee's progress towards completing MRCP. If an ES feels that a trainee with MRCP is not at level 3 on clinical CiP 1 then they need specifically to explain and justify their reasoning. Equally, if an ES feels that a trainee who has attempted but NOT passed MRCP is at level 3 then they will need to justify that entrustment decision fully.

Sign off of Level 3 entrustment for clinical CiP 1: Managing the acute unselected take

The ESR will have a separate box where the ES specifically certifies that in their opinion the trainee has achieved (or by the end of IMY2, is expected to achieve) Level 3 in clinical CiP 1 and is therefore capable of leading acute unselected take with indirect supervision. There will be an explicit statement that this entrustment decision is made following formal consideration of a number of relevant factors:

1. At least 3 MCRs specifically commenting on acute care and confirming that the trainee is on (or ahead of) track to achieve level 3 in clinical CiP 1 (mandatory)
2. A satisfactory MSF that suggests no problems (mandatory)
3. Relevant ACATs (in line with the decision aid) that demonstrate progression and maturation in the assessment, investigation and treatment of patients with acute medical illness and with no serious concerns documented (mandatory)
4. Satisfactory 'acting up'. This must be performed in a planned mentored, supportive and closely supervised environment and not just for service delivery. It must be carried out in line with current JRCPTB guidance on acting up. Opportunities to act-up may not be available to all so it is not mandatory to have done this in order to achieve level 3 in clinical CiP 1.
5. Progress at achieving MRCP in line with the decision aid.

The first three conditions must all be met. Possession of full MRCP(UK) and periods of 'acting-up' are not mandatory but are important elements that must be taken into consideration when the overall entrustment recommendation is made.
Progress within the disparate elements of MRCP(UK) must however be demonstrated in line with the decision aid. Acting up will not be permitted within the IMY1 year and must only be undertaken by trainees in IMY2 who have assessed themselves as being able to undertake this duty as well as having this ability ratified by their ES (in line with current JRCPTB guidance).

This ES recommendation will then be scrutinized and ratified at the ARCP with reference to the ARCP decision aid but the ES should complete their report at whatever time is necessary to give employers notice about the anticipated status of

trainees with regard to progression from IMY2 to IMY3 and hence the availability of trainees to undertake the medical registrar role. This may be at a planned 'interim review'.

The requirement for 'enhanced supervision/mentoring' into the medical registrar role will be dependent on the trainee's progress towards acquisition of level 3 in clinical CiP 1 and the trainee's confidence in undertaking the role. It will not be predicated on the ARCP outcome. If they have achieved an ARCP outcome 1 by definition they are fit to be the medical registrar but they may have been given an outcome 2 (or possibly even a 3) on the basis of CiPs that have nothing to do with acute take and would then not require "enhanced supervision/mentoring" into the medical registrar role.

It is recognised that from an employment perspective, trainees will need to be provisionally allocated into IMY3 on the basis of anticipated level 3 entrustment three months before August. However, the final definitive allocation **can only** occur after the end of the ARCP process.

All trainees irrespective of their entrustment level in clinical CiP 1 must be mentored and supported into their medical registrar role and it is incumbent upon Heads of School (HoS), TPDs and educational and CSs to ensure that this takes place. It is essential that any trainee who feels unsupported in this role can discuss those concerns with their ES and escalate them as necessary via College Tutor (or equivalent), TPD, Head of School (HoS) or Director of Medical Education (DME).

For some trainees it will be unclear that they have achieved clinical CiP 1 level 3 and some may have personal concerns about their medical registrar role. This is the **most important** group for the ARCP panel to consider in detail. The key decision is between progression to IMY3 with enhanced supervision and mentoring or remaining at IMY2. For example it may be appropriate for them to progress to IMY3 but only to lead the acute take during the working day when direct senior supervision is available. This will necessarily limit their time in IMY3 to develop the appropriate skills to complete IMT and it will only be very borderline cases that are likely to progress to IMY3. No trainee should be made to progress to IMY3 if, in their own assessment, they are not ready to take on the medical registrar role. The uncertainty that these trainees express should be explored in detail and arrangements made for mentoring and probably extra time in training so that confidence for the role can be acquired.

ARCP outcomes

- Trainees who have achieved the appropriate level in all CiPs, including entrustment level 3 in clinical CiP 1, have MRCP and have otherwise fulfilled all criteria for progression will be awarded an ARCP outcome 1
- If a trainee at the end of IMY2 has achieved the appropriate levels for all CiPs but has not achieved full MRCP then they will be given an ARCP outcome 2 to make the point that full MRCP should be obtained as soon as possible

- If a trainee at the end of IMY2 has not achieved all the appropriate levels but it is felt that they will catch up in IMY3 then they should be given an outcome 2
- If a trainee at the end of IMY2 is likely to need additional time in training then they should be given an outcome 3 (again irrespective of whether or not they have MRCP and/or have achieved entrustment level 3 in clinical CiP 1)
- Trainees with an outcome 1 after IMY2 can take a break from training for a maximum of three years and then apply for specialty training in a group 2 specialty. This will mean they can still get a CCT by completing the curriculum defined training in the specialty of their choice. For trainees who wish to apply to a group 1 specialty they would have to return to training and complete IMY3 before they can apply to that specialty
- A trainee who wishes to leave training after IMY2 and has not achieved an ARCP outcome 1 may leave on an outcome 2 or 3
- There should also be the possibility of a routine ARCP after 6/12 for all those who received an outcome 3 and remained in IMY2. This would allow mid-year progression to IMY3 and the potential to complete IMY3 without the necessity for additional training time

Summary of IMY2 ARCP outcomes

3 main groups:

1. On track, no problems: ARCP 1 - progress to IMY3
2. Some concerns, around clinical CiP 1 in particular, from ES or trainee. Careful and detailed decision making and planning by ARCP panel: ARCP 2 or 3
3. More concerns. Remain at IMY2 for at least 6 months: ARCP 3

What are the training opportunities for trainees who have completed CMT/ ACCS-AM or BBT?

Any CMT who has completed core medical training (CMT), Acute Care Common Stem – Acute Medicine (ACCS-AM) or Broad Based Training (BBT) with a satisfactory ARCP outcome is guaranteed an IMY3 post in the school/deanery of their original training **up to three years after exiting the programme.**

This means that trainees who have completed CMT in August 2019 would be guaranteed an IMY3 post commencing August 2021 or August 2022, noting that IMY3 posts will not have commenced by August 2020 and ST3 specialty recruitment will be available that year. **There will be very limited ST3 recruitment into group 1 specialties in August 2021.**

Therefore, trainees who have completed CMT in Aug 2019 will have two years to obtain a guaranteed IMY3 post. However, from Aug 2023 onwards, they will not be eligible for ST4 specialty recruitment unless they have completed an equivalent IMY3 training.

Trainees completing CMT in August 2020 will have three years to obtain a guaranteed IMY3 post commencing August 2021, August 2022 or August 2023. However, from Aug 2024 onwards, they will not be eligible for ST4 specialty recruitment unless they have completed an equivalent IMY3 training.

From August 2024 onwards, there will be no guarantee of IMY3 posts as, by that year, we will be four years from the final cohort completing CMT and all trainees will have progressed through the new IMT stage 1 curriculum.

The table below summarises the opportunities to enter group 1 specialties in each year. Group 2 specialties will continue to recruit at ST3 and will not require completion of IMY3.

	Aug 2019	Aug 2020	Aug 2021	Aug 2022	Aug 2023	Aug 2024
	IMY1 starts	*IMY2 starts*	*IMY3 starts*	*IM stage 2 starts*		
Year completing CMT ⇩	*ST3 recruitment*	*ST3 recruitment*	***Limited group 1 ST3 recruitment***	*ST4 recruitment*	*ST4 recruitment*	*ST4 recruitment*
Aug 2019	Eligible for ST3 recruitment	Eligible for ST3 recruitment	**Guaranteed IMY3**	**Guaranteed IMY3**	-	-
Aug 2020	-	Eligible for ST3 recruitment	**Guaranteed IMY3**	**Guaranteed IMY3**	**Guaranteed IMY3**	-

Practical Procedural Skills

The development of practical procedural skills has always been integral to the training of medical registrars. The procedures that are required and the way in which they are performed is continuously evolving as new techniques (especially around imaging) become available to improve patient safety and comfort. Some procedures that were traditionally carried out by a general medical registrar are now frequently performed by specialist services (e.g. temporary transvenous cardiac pacing, pleural drainage etc). It has therefore been difficult to define exactly what procedural skills are required by a trainee in Internal Medicine.

It is felt that the position adopted in the present IMT curriculum represents a reasonable compromise between those individuals who feel that IM trainees do not need to develop and demonstrate any procedural skills and those who feel that a medical registrar should be competent to carry out unsupervised, all procedures required in previous medical curricula. The situation is compounded by the fact that

all the procedures listed may have to be performed out of normal working hours as an emergency or urgent necessity and therefore there is a service need as well as a training requirement. There has been concern that IM trainees may be placed under pressure to perform procedures for which they are not adequately trained. The Federation has therefore produced a statement for all Medical Directors stressing that they ensure there is a robust and safe mechanism to carry out these essential procedures. This states that this is the Trusts' responsibility as a clinical governance issue and is not the remit of training organisations. It is noted in the decision aid table below that several procedures only need to be performed in a skills laboratory as a minimum. This is important so that a trainee at least knows the basics of the procedure and should be able to upskill readily when they are in a post where there are opportunities to learn how to perform the procedure in patients with appropriate supervision and progress to being able to perform independently.

It is stressed that the level of competence for each procedure, defined in the curriculum and decision aid, is the minimum required to achieve a standard ARCP outcome for each year and trainees should take every opportunity to increase their level of skill in each procedure and if possible, become capable of performing them unsupervised. There is no longer a distinction made in the curriculum between life-threatening and routine procedures. This is because it has become appreciated that there is significant morbidity and potential mortality from some of the procedures previously designated as routine and therefore the somewhat arbitrary distinction serves no useful purpose in maintaining patient safety. Trainees now only need a single summative DOPS assessment in order to be regarded as competent at the appropriate level. They are encouraged to carry out a number of supervised procedures in the way of formative DOPS before submitting themselves for a summative assessment. Trainers need to have a documented, ongoing conversation with trainees about procedures, their practice in them and when they should be undertaking the summative DOPS for each procedure. These conversations should be documented within the portfolio in additional meetings and appraisals.

Maintenance of competence

This is also a controversial area. Once a trainee has achieved an appropriate assessment via a summative DOPS, there is no requirement for further assessment. It is a matter of professional insight and probity that a trainee should maintain their competency by carrying out the procedure when the opportunity arises. If a trainee has not performed a particular procedure for some time and no longer feels confident and/or competent to carry it out, then they should seek further training/experience either in a skills lab or on patients with appropriate supervision. Their level of skill may be informed by formative DOPS, but there is no requirement for a further sign off by way of a summative DOPS. Trainers need to have a documented, ongoing conversation with trainees about procedures and the trainee's maintenance of competence in them.

Trainees must be able to outline the indications for the procedures listed in the decision aid 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 (this may include seeking assistance from colleagues in other specialties when necessary). Please see the decision aid below for minimum levels of competence expected in each training year.

Internal Medicine Training (IMT) Stage 1 ARCP Decision Aid

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

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)
Educational supervisor report (ESR)	One per year to cover the training year since last ARCP (up to the date of the current ARCP)	Confirms meeting or exceeding expectations and no concerns	Confirms will meet the critical progression point and can progress to IMY3 and act as medical registrar	Confirms will meet the critical progression point criteria and complete IM stage 1
Generic capabilities in practice (CiPs)	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. Trainees should record self-rating to facilitate discussion with ES. ES report will record rating for each generic CiP	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training	ES to confirm trainee meets expectations for level of training
Clinical capabilities in practice (CiPs)	See grid below of levels expected for each year of training. Trainees must complete self-rating to facilitate discussion with ES. ES report will confirm entrustment level for each individual CiP and overall global rating of progression	ES to confirm trainee is performing at or above the level expected for all CiPs	ES to confirm expected levels achieved for critical progression point at end of IMY2	ES to confirm expected levels achieved for critical progression point at end of IMY3
Multiple consultant report (MCR)	Minimum number. Each MCR is completed by a consultant who has supervised the trainee's clinical work. The ES should not complete an MCR for their own trainee	4	4 - of which at least **3** MCRs written by consultants who have personally supervised the trainee in an acute take/post-take setting	4 - of which at least **3** MCRs written by consultants who have personally supervised the trainee in an acute take/post-take setting

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)
Multi-source feedback (MSF)	Minimum of 12 raters including 3 consultants and a mixture of other staff (medical and non-medical) Replies should be received within 3 months (ideally within the same placement). MSF report must be released by the ES and feedback discussed with the trainee before the ARCP. If significant concerns are raised then arrangements should be made for a repeat MSF	1	1	1
Supervised learning events (SLEs): Acute care assessment tool (ACAT)	Minimum number to be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are identified. Each ACAT must include a minimum of 5 cases. ACATs should be used to demonstrate global assessment of trainee's performance on take or presenting new patients on ward rounds, encompassing both individual cases and overall performance (eg prioritisation, working with the team). It is not for comment on the management of individual cases	4	4	4
Supervised Learning Events (SLEs):	Minimum number to be carried out by consultants. Trainees are encouraged to undertake more and supervisors may require additional SLEs if concerns are	4	4	4

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)
Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX)	identified. SLEs should be undertaken throughout the training year by a range of assessors. Structured feedback should be given to aid the trainee's personal development and reflected on by the trainee			
MRCP (UK)	Failure to pass full MRCP by the end of IMY2 will result in a non-standard ARCP outcome	Part 1 passed	Full MRCP(UK) diploma achieved	Full MRCP(UK) diploma achieved
Advanced life support (ALS)		Valid	Valid	Valid
Quality improvement (QI) project	QI project plan and report to be completed. Project to be assessed with quality improvement project tool (QIPAT)	Participating in QI activity (eg project plan)	1 project completed with QIPAT	Demonstrating leadership in QI activity (eg supervising another healthcare professional)
Clinical activity: Outpatients	See curriculum for definition of clinics and educational objectives. mini CEX / CbD to be used to give structured feedback. Patient survey and reflective practice recommended. Summary of clinical activity should be recorded on ePortfolio	Minimum 20 outpatient clinics by end of IMY1	Minimum 20 outpatient clinics in IMY2	Minimum 20 outpatient clinics in IMY3 and 80 outpatient clinics in total (IMY1-3)
Clinical activity: Acute unselected take	Active involvement in the care of patients presenting with acute medical problems is defined as having sufficient input for the trainee's involvement to be recorded in the patient's clinical notes	Evidence that trainee actively involved in the care of at least 100 patients presenting with acute medical problems in IMY1	Evidence that trainee actively involved in the care of at least 100 patients presenting with acute medical problems in IMY2. ES to confirm level 3 for clinical CiP 1	Evidence that trainee actively involved in the care of at least 100 patients presenting with acute medical problems in IMY3 and a minimum 500 patients in total (IMY1-3).

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)
				ES to confirm level 3 for clinical CiP 1
Clinical activity: Continuing ward care of patients admitted with acute medical problems	Trainees should be involved in the day-to-day management of acutely unwell medical inpatients for at least 24 months of IM stage 1			Minimum of 24 months by end of IM stage 1
Critical care	See curriculum for definition of critical care placements and learning objectives			Evidence of completion of minimum 10 weeks in critical care setting (ICU or HDU) in not more than two separate blocks by end of IM stage 1
Geriatric medicine				Evidence of completion of minimum of four months in a team led by a consultant geriatrician by completion of IM stage 1. At least one MCR to be completed by geriatrician during IM Stage 1
Simulation	All practical procedures should be taught by simulation as early as possible in IMY1. Refresher training in procedural skills should be completed if required	Evidence of simulation training (minimum one day) including procedural skills	Evidence of simulation training including human factors and scenario training	Evidence of simulation training including human factors and scenario training
Teaching attendance	Minimum hours per training year. To be specified at induction Summary of teaching attendance to be recorded in ePortfolio	50 hours teaching attendance to include minimum of 20 hours IM teaching recognised for CPD points or organised/	50 hours teaching attendance to include minimum of 20 hours IM teaching recognised for CPD points or organised/	50 hours teaching attendance to include minimum of 20 hours IM teaching recognised for CPD points or organised/

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)
		approved by HEE local office or deanery	approved by HEE local office/deanery	approved by HEE local office/deanery

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
Advanced cardiopulmonary resuscitation (CPR)	Skills lab or satisfactory supervised practice	Participation in CPR team	Leadership of CPR team
Temporary cardiac pacing using an external device	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Ascitic tap	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Lumbar puncture	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Nasogastric (NG) tube	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
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**. Pleural procedures should be undertaken in line with the British Thoracic Society guidelines[b]	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
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	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
for obtaining access to the circulation to allow infusion of fluid in the patient where peripheral venous access cannot be established			
Central venous cannulation (internal jugular or subclavian)	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Intercostal drain for pneumothorax	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Intercostal drain for effusion Pleural procedures should be undertaken in line with the British Thoracic Society guidelines [b]	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
Direct current (DC) cardioversion	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a]
Abdominal paracentesis	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice

[a] 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 ES 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).

[b] 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 a pleural-trained ultrasound practitioner.

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

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

Clinical CiP	IMY1	IMY2	CRITICAL PROGRESSION POINT	IMY3	CRITICAL PROGRESSION POINT
1. Managing an acute unselected take	**2**	**3**		**3**	
2. Managing an acute specialty-related take	**2***	**2***		**2***	
3. Providing continuity of care to medical in-patients	**2**	**3**		**3**	
4. Managing outpatients with long term conditions	**2**	**2**		**3**	
5. Managing medical problems in patients in other specialties and special cases	**2**	**2**		**3**	
6. Managing an MDT including discharge planning	**2**	**2**		**3**	
7. Delivering effective resuscitation and managing the deteriorating patient	**2**	**3**		**4**	
8. Managing end of life and applying palliative care skills	**2**	**2**		**3**	

* This entrustment decision may be made on the basis of performance in other related CiPs if the trainee is not in a post that provides acute specialty-related take experience.

Mandatory training requirements

Acute Take Medicine

Purpose
A major focus of the new IMT programme is equipping physicians with the capabilities to care for an acutely unwell patient (IM clinical CiP 7) and manage an acute unselected medical take (AUT) (CiP 1). It is therefore essential that trainees gain adequate supervised experience of the AUT throughout their programme. It is appreciated that different hospitals will vary dramatically in the number and grades of clinicians participating in AUT, the way the teams are deployed, the case mix of patients admitted and the numbers of patients admitted in a 24 hour period.

Learning outcomes
The principal learning outcomes for the periods participating in AUT are encapsulated in clinical CiP 7 (Delivering effective resuscitation and managing the acutely deteriorating patient) and clinical CiP 1 (Managing an acute unselected take). However, there will also be the opportunity to develop and demonstrate other capabilities such as team-working, communication etc.

Duration and form of AUT attachment
As noted above, each hospital will vary in the size, case mix and organisation of its AUT. It is hoped that a trainee will gain experience in a number of different scenarios such as a formal attachment to an acute medical unit and periods of being on call for acute medicine when attached to other teams (both at night and during the day). Additionally, they may gain skills and experience whilst working in ambulatory care units and in the emergency department. There may be some situations where specialties (such as cardiology for example) run an acute specialty take and remove those particular patients from the AUT. In those situations, it will be important that TPDs and ESs ensure that their trainees can still acquire the requisite exposure to that particular group of patients. As a general rule it is advised that trainees have at least one 4 month attachment to an acute medicine unit during IMY1 or IMY2.

Numbers
Trainees should be involved in the acute unselected medical take in each year of the IMT stage 1 programme, but it is recognised that this will not be a feature of all attachments, and that their greatest involvement will be in IMY3. In each year of the internal medicine stage 1 training programme they should be actively involved (have sufficient input for their involvement to be recorded in the patient's clinical notes) in the care of at least 100 patients presenting with acute medical problems, and at least 500 patients by the end of IMT stage 1.

Trainees need to see the number of AUT patients to achieve the learning outcomes described below and demonstrate that they have achieved the CiP level appropriate to their year of training.

It is therefore more important that every patient they see provides a good learning experience with appropriate feedback rather than they just see high absolute numbers of patients. However, it is felt that a certain minimum number of patients need to be seen in each year to ensure that the AUT experience is spread and maintained throughout all 3 years of IMT stage 1. There will be considerable variation in how much a trainee is involved in the management of any individual patient. In some cases, the patient may have been admitted/clerked by the trainee, in other cases a more senior trainee may have reviewed a patient who has been admitted by a nurse practitioner or a more junior doctor. Sometimes the trainee will receive direct feedback on their management from a more senior doctor (registrar or consultant) and occasionally there may be a more formal workplace based assessment such as an ACAT, mini-CEX or CbD. In other situations, a trainee may just hear about a patient case on a ward round (or more often on an office based ward round). For the purpose of counting numbers of AUT cases seen, the new IMT curriculum continues with the previous definition that a trainee's involvement with the patient be sufficient for their name to be recorded in the patient notes.

There is no requirement for actual numbers to be recorded for each AUT and of course no patient identifiable data must be recorded anywhere within the educational record (ePortfolio or elsewhere). However, a calculator will be available on the JRCPTB website to help estimate of the number of patients seen based on the number of months doing AUT, the number of shifts per month whilst doing AUT and the average number of patients seen per shift by a trainee doing AUT. The calculator will ask for the name of a supervising consultant who could support those figures if necessary. The estimated total number of patients can then be recorded in the summary of clinical activity and teaching attendance form on the ePortfolio.

The curriculum mandates that 100 patients should be seen (with the definition above of name recorded in the notes) during each year of training and that 500 should be seen in total over all 3 years. Given that most trainees would see at least 100 patients within a single 3 month attachment, it must be stressed that these numbers are minimum requirements and there must be no question of trainees' reducing their involvement in the AUT once that that figure has been met.

Clinical CiP 1: Managing an acute unselected take	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues

	• Appropriately selects, manages and interprets investigations • Recognises need to liaise with specialty services and refers where appropriate
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • 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 team working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF CbD ACAT MRCP(UK) Logbook of cases Simulation training with assessment

Continuing Care

Purpose

Trainees should be involved in the day-to-day management of acutely unwell medical inpatients for at least 24 months of the internal medicine stage 1 training programme.

Learning outcomes

The principal learning outcome for inpatients experience is covered in clinical CiP 3 (Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment). There will also be the opportunity to develop and demonstrate other capabilities such as team-working and communication.

Clinical CiP 3: Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills

	• Formulates an appropriate diagnostic and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Demonstrates appropriate continuing management of acute medical illness in patients admitted to hospital on an acute unselected take or selected take • Recognises need to liaise with specialty services and refers where appropriate Appropriately manages comorbidities in medial inpatients (unselected take, selected acute take or specialty admissions) • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • 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 team working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision	MCR MSF ACAT Mini-CEX DOPS MRCP(UK)

Achieving the skills

To achieve these outcomes, we recommend that trainees have four-month blocks of continuing care experience across IMY1 and IMY2. It is expected that these blocks will be specialty based but that individual programmes may vary. Trainees should have the opportunity to be based in a ward setting with a wide mix of patients. They should have the opportunity to attend senior-led ward rounds, manage the day-to-day running of a medical ward with support from Foundation doctors and nursing teams.

Trainees should receive an induction to in-patient work in each block. Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table above.

Outpatients

Purpose

The ability to practice medicine in an out-patient setting is a key skill for physicians in nearly all medical specialties. The skills required differ from those needed for in-patient care and are hence an important part of the IMT Stage 1 curriculum. A consultant physician may spend three half-days per week working in out-patients. The work involves dealing with new and follow-up patients, setting and amending treatment plans, interfacing with primary care and other specialties, good use of health-care resources, good time management and record keeping. Increasingly the work will also involve the skills around tele-medicine (especially in the light of the COVID-19 pandemic)

Learning Outcomes

The principal learning outcome for outpatients experience is detailed in clinical CiP 4 (Managing patients in an outpatient clinic, ambulatory or community setting). There will also be the opportunity to develop and demonstrate other capabilities such as teamworking and communication.

Clinical CiP 4: Managing patients in an outpatient clinic, ambulatory or community setting (including management of long-term conditions)	
Descriptors	• Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient centred care including shared decision making • Demonstrates effective consultation skills • Formulates an appropriate diagnostic and management plan, taking into account patient preferences • Explains clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately manages comorbidities in outpatient clinic, ambulatory or community setting • Demonstrates awareness of the quality of patient experience
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and team working
Evidence to inform decision	MCR ACAT

	mini-CEX PS MRCP(UK) Letters generated at outpatient clinics

Educational objectives

- To understand the management of chronic diseases
- Be able to assess a patient in a defined timeframe
- To interpret and act on the referral letter to clinic
- To propose an investigation and management plan in a setting different from the acute medical situation
- To review and amend existing investigation plans
- To write an acceptable letter back to the referrer
- To communicate with the patient and where necessary relatives and other health care professionals.

For those that participate in virtual outpatient clinics (via video or telephone consultation) the following additional educational objectives also apply:

- To understand specific aspects of confidentiality and privacy associated with remote consultation and practical aspects including the organisation of relevant tests
- To understand the decision making involved in virtual outpatient clinics, including the need for and place of review
- To be able to manage unexpected events within a remote consultation e.g. unexpected symptoms or signs
- To be able to communicate and empathise with patients in a virtual/remote setting.

Achieving the skills

To achieve these outcomes, we recommend that trainees undertake an indicative number of 80 clinics across the IMT stage 1 programme. Clinics should be undertaken in a number of different settings which may include remote video consultations and ambulatory or community settings. Trainees should receive an induction to outpatient work. They should have the opportunity to observe consultations but must be able to undertake their own consultations when they are either directly observed or receive individual feedback on the cases they see. Trainees should receive feedback on the notes they make in clinic and on the letters they write to GPs.

Demonstration of achieving the required CiP level may be shown using a mixture of the evidence given in the CiP table above.

Geriatric Medicine

Purpose

The purpose of the IMT stage 1 curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to manage patients presenting with a wide range of general medical symptoms and conditions. Training in geriatric medicine is listed as mandatory in the internal medicine curriculum.

Learning Outcomes

- Managing long term conditions and promoting patient self-care
    - To work with patients and use their expertise to manage their condition collaboratively and in partnership, with mutual benefit
    - To pursue a holistic and long-term approach to the planning and implementation of patient care, in particular to identify and facilitate the patient's role in their own care
    - To be able to manage long term conditions supporting and enabling patient independence
- To have the knowledge and skills to lead a multidisciplinary team providing care to an older patient in an inpatient, outpatient or community-based setting, and when to refer for further specialist advice.
- To have the knowledge and skills to plan the successful transfer of care or discharge of frail older patients
- To have the knowledge and skills required to assess and manage patients with life limiting diseases (malignant and non-malignant) across all health care settings, in conjunction with other health care professionals.

In addition, the IMT stage 1 curriculum lists a variety of conditions in which trainees should be able to demonstrate CiPs and GPCs. Trainees will need to become familiar with these conditions and presentation. The curriculum specifically states that the scope of internal medicine is broad and cannot be encapsulated by a finite list. However, the specific geriatric medicine pathological conditions listed in the curriculum are as follows:

Presentation	**Conditions/Issues**
Delirium	Continence –faecal and urinary
Deterioration in mobility	Dementias
Falls	Depression
Fragility fractures	Malnutrition
Frailty	Movement disorders
Hypothermia	Osteoporosis
Incontinence	Pharmacology
Memory loss	Subarachnoid haemorrhage
Unsteadiness / balance disturbance	Stroke
	Transient ischaemic attack
	Pressure ulcers

Achieving the skills

To achieve these outcomes, we consider (and the curriculum mandates) that a four-month attachment to a team lead by a consultant geriatrician during the training programme is an absolute minimum.

Critical Care

Purpose

The ability to assess, recognise and care for an acutely unwell patient is critical for a trainee physician. Whether or not the overall ambition is to practice in an acute environment it is well recognised that patients may experience an acute deterioration in their condition and require that this acted upon including involving colleagues from the critical care department when necessary. Training in critical care is thus mandatory in the internal medicine curriculum.

It is accepted that for a trainee physician to be able to recognise, assess and care for an acutely unwell patient they need a significant experience in a critical care environment and the learning objectives for such an experience are detailed below. Discussions with trainees and the Faculty of Intensive Care Medicine would suggest that the optimum method of achieving these learning objectives would be by a 3-month attachment to an intensive care unit where the trainee is fully integrated within all aspects of the ICU team's work including the delivery of out of hours care. Ideally this attachment should occur within IMY2 as the trainee will have acquired an appropriate level of medical skills to maximise their learning opportunities and will be able to enter IMY3 with the confidence to manage acutely unwell patients.

It is recognised that such an ideal experience may not be immediately implementable within all LEPs and therefore the curriculum mandates a 10-week minimum period of placement in a of critical care (ICU or mHDU) settings over the 3 years in not more than two separate blocks.

Learning outcomes

The principal learning outcome for critical care experience is covered in clinical CiP 7 (Delivering effective resuscitation and managing the acutely deteriorating patient). There will also be the opportunity to develop and demonstrate other capabilities such as team-working and communication.

Clinical CiP 7: Delivering effective resuscitation and managing the acutely deteriorating patient	
Descriptors	• Demonstrates prompt assessment of the acutely deteriorating patient, including those who are shocked or unconscious • Demonstrates the professional requirements and legal processes associated with consent for resuscitation • Participates effectively in decision making with regard to resuscitation decisions, including decisions not to attempt CPR, and involves patients and their families • Demonstrates competence in carrying out resuscitation
GPCs	Domain 1: Professional values and behaviours

	Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and team working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision	MCR DOPS ACAT MSF MRCP(UK) ALS certificate Logbook of cases Reflection Simulation training with assessment

Educational objectives

- Prompt accurate assessment and management of the acutely ill and/or deteriorating patient including those who are shocked or unconscious.
- Has knowledge of, and is able to apply, clinical processes associated with resuscitation
- Has knowledge of, and is able to apply, legal processes associated with resuscitation, including do not actively resuscitate orders.
- Is able to recognise where the ceiling of care applies and is able to manage the needs of the dying patient
- Demonstrates the ability to be actively involved in critical clinical decision making including Involving the patients and carers in all decisions.
- Recognises the role of the broad MDT associated with a critical care setting including the role of human factors and use of technology
- Recognises the resources associated with critical care delivery and thus how patient prioritization is achieved
- Develop practical procedural skills such as central venous catheter insertion

Achieving the skills

Ideally trainees should be exposed to a 3 month attachment in a critical care unit where the trainee is fully integrated into all aspects of the ICU team's work including out of hours. If this is not possible in the short the minimum requirement is of an indicative 10 week period of placement within a critical care setting over the three years of the programme in no more

than two blocks. The critical care setting must be a defined intensive care unit or high dependence unit that manages a proportion of patients that have presented with an acute medical illness.

Palliative and end of life care

Purpose

It is necessary that trainees receive training on managing end of life and applying palliative care skills. Some may undertake a placement in a specialist palliative care environment (hospital advisory team, hospice or community) however majority of trainees will receive Palliative training in the acute care setting. Guidance on this is provided in the teaching and learning methods section below.

Learning outcomes

The principal learning outcome for palliative and end of life care experience is encapsulated in clinical CiP 8 (Managing end of life and applying palliative care skills). There will also be the opportunity to develop and demonstrate other capabilities such as team-working, communication.

Clinical CiP 8: Managing end of life and applying palliative care skills	
Descriptors	• Identifies patients with limited reversibility of their medical condition and determines palliative and end of life care needs • Identifies the dying patient and develops an individualised care plan, including anticipatory prescribing at end of life • Demonstrates safe and effective use of syringe pumps in the palliative care population • Able to manage non-complex symptom control including pain • Facilitates referrals to specialist palliative care across all settings • Demonstrates effective consultation skills in challenging circumstances • Demonstrates compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills *(history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease)* Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries
Evidence to inform decision	MCR CbD

	Mini-CEX MSF MRCP(UK) Regional teaching Reflection

Achieving the skills
The IMT stage 1 curriculum lists the presentations and conditions in which trainees should be able to demonstrate CiPs and GPCs. The curriculum specifically states that the scope of internal medicine is broad and cannot be encapsulated by a finite list. However, the specific palliative medicine conditions listed in the curriculum are given in the table below.

Presentation	Conditions/Issues
Pain Physical symptoms other than pain Psychosocial concerns including spiritual care and care of family The dying patient	Advanced malignancy End stage organ failure Frailty Multiple comorbidity

Simulation

Purpose
All practical procedures in the IMT stage 1 curriculum should be taught by simulation as early as possible in IMY1 with further simulation teaching involving human factors and scenarios training carried out in either IMY1 or IMY2. Further years should include refresher training for procedural skills where necessary.

The practical procedures and minimum levels of competency are set out in the ARCP decision aid.

Allocating IMY3 placements

All schools will have provided full rotation information for the first two years of the programme, including the hospital, specialty information and duration of each post and an indication of where IMY3 will be based geographically. There is some variation across the UK as to the structure of IMY3 posts. Our guidance is that the year should consist of two six month posts to include Acute Medicine/continuing GIM on-call. The curriculum mandates that posts in IMY3 are a minimum of six months' duration.

How will IMY3 allocations be made?

Each school will manage a locally run process for allocating rotations for IMY3.

- The TPD for Internal Medicine will hold interim reviews in IMY2 to gauge the trainee's (non-binding) intentions for plans to undertake IMY3

- Within each geographic region indicated for IMY3, the TPD and workforce team will request preferences for the available rotations from all trainees considering a progression into IMY3. Submission of preferences should include a short statement as to why the trainee has chosen the specialty or specialties. In writing the statement the trainee should be made aware that the specialty undertaken in IMY3 will not be taken into consideration in the selection process for ST4 higher specialty training and the person specification for higher specialty posts will also make this clear
- Trainees can use IMY3 as an opportunity to undertake a specialty complementary to any chosen career path
- Rotations for IMY1 and IMY2 should not include any repeat of specialty. In some programmes it may be possible to select an IMY3 rotation that includes a specialty already covered in IMY1 or IMY2; it will not be possible to stay in the same specialty for both IMY3 posts
- When finalising allocations, the TPD/s will take into account the learning needs of the trainee and the service provision requirements across the region
- The allocation of IMY3 posts will try to ensure that as many trainees as possible get their first choices
- Where possible the allocated IMY3 post will be in the same site as either the IMY1 or IMY2 rotation
- Trainees will have 10 working days to appeal the decision of the TPD. Appeals should be submitted to the Head of School (HoS); trainees should receive a response by email within 10 working days

Decision-making regarding allocation into IMY3 posts, where highly competitive, may include the following consideration of trainee performance within the programme:

- ARCP outcome at end of IMY1
- Progress in the MRCP Diploma
- Completion of a quality improvement project
- The reasons stated in the trainee's personal statement
- Recruitment score on entry to the programme

Important points to note

Changes in the number of trainees in the programme and service pressures mean that it is not possible to absolutely guarantee that advertised rotations and processes will not change. All regions will make efforts to ensure that any changes are minimised and managed as fairly as possible.

Acute Care Common Stem – Acute Medicine (ACCS-AM)

Trainees undertaking an ACCS acute medicine training programme who wish to apply to a group 1 specialty from 2022 will be required to complete IMY3. They will be offered a stand-alone IMY3 within the same region as their ACCS programme.

The process for allocating rotations will be managed locally by each region. Transition guidance will be provided by the JRCPTB.

Less than full time (LTFT) trainees / gaps in training / deferrals

Some trainees are working less than full time (LTFT) and will not be ready to progress into IMY3 at the same rate as other colleagues; other trainees may have chosen to defer their entry into IMY3 or had a gap in training. Each region is aware of these issues and will seek to work with trainees within the programme, to allow them to have an equal chance to select suitable rotations in IMY3. The JRCPTB will provide guidance to support this process.

IMY3 return to training - flexibility for trainees

It is likely that there will be some transitional challenges implementing the new Internal Medicine stage 1 curriculum starting in 2019 going through until at least 2023.

Flexibility for trainees

The main challenge will be for trainees who started and completed Core Medical Training (CMT), Acute Care Common Stem Acute Medicine (ACCS-AM) or Broad-Based Training (BBT) and have taken a longer training pathway or taken time out for any reason. This will include those who went out of programme, those who had extended maternity or sickness leave and those on academic programmes. We have already indicated that these doctors have an absolute right to an IMY3 year in the deanery they were originally appointed to, provided they were in good standing at the time they left CMT / ACCS-AM / BBT. Discussions have also clarified that these doctors would need a bespoke discussion and plan to enter IMY3 and some would need to go into the formal systems for returning to training.

It will be a requirement that no matter what route they have followed, they will not be able to complete IMY3 unless they have met all the CiPs at the level expected in the curriculum and passed all parts of MRCP(UK).

It is also considered to be ideal that they are offered the opportunity to meet the normal expected standards in areas specified in the curriculum, such as critical care, outpatients, geriatrics and simulation.

It is recognised that based on experience both in and out of training that this may not be required for all those who were in ‘old’ CMT / ACCS-AM / BBT training and there should be reasonable expectations of flexibility.

This will need to be agreed with the appropriate TPD but the following guidelines would be acceptable to JRCPTB:

- Simulation: - Not required if procedures or otherwise have been demonstrated as per the CMT / ACCS-AM / BBT curriculum
- Geriatrics: - Formal placement would not be required
- Outpatients: - CMT quality criteria require attendance at 40 clinics and the IM curriculum mandates 80. A total of 60 clinic attendances would be appropriate but can be determined on an individual basis.
- Critical care: - The minimum requirement for IMT is 10 weeks in ICU/mHDU settings with two periods being acceptable. A single period of five weeks of critical care with no other responsibilities or time out might be acceptable but should be determined on a case by case basis.

Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ACCS-AM	Acute Core Common Stem – Acute Medicine
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
AUT	Acute Unselected Take
BBT	Broad Based Training
CiP	Capabilities in Practice
CbD	Case-based Discussion
CMT	Core Medical Training
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
CBME	Competency Based Medical Education
DME	Director of Medical Education
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
mHDU	Medical High Dependency Unit
MMC	Modernising Medical Careers
MSF	Multi-Source Feedback
NTN	National Training Number
PDP	Professional Development Plan
PS	Patient Survey
SLE	Supervised Learning Event

WBA	Workplace Based Assessment

JRCPTB

Joint Royal Colleges of Physicians Training Board

Revised May 2020

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians