Start Of Training Information for Acute Internal Medicine Higher Specialty Trainees:

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Next Review March 2026 (or earlier if there is a curricular change)

Welcome to all new Acute Internal Medicine (AIM) Higher Speciality Trainees (HST) who are about to start their training in AIM and dual accredit in Internal Medicine Training Stage 2 (IMTS2). This document contains some useful tips on how to efficiently navigate this training journey and maximise the most out of your training.

The Curriculum Explained in Short:

As per the AIM Curriculum,*'The purpose of the Acute Internal Medicine (AIM) curriculum is to produce doctors with the generic professional and specialty specific capabilities needed to manage patients presenting with a wide range of medical symptoms and conditions'*. The AIM curriculum is a 4-year whole time equivalent training programme. During this time, HSTs in AIM undertake most of their training in acute medicine departments and have mandatory rotations – usually of 4 months duration - in critical care, respiratory, cardiology and care of the elderly medicine.

Throughout training, HSTs are assessed against several Capabilities in Practice' or 'CiPs' - generic, IMS2 and AIM CiPs. HSTs will be assessed for capabilities in those CiPS based on whether they fulfil certain 'descriptors'. The level of capability in these CiPs will be graded using a scale called 'Entrustment scales'.

The Entrustment Scales:

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

Doctors obtaining CCT in AIM/IM stage 2 will be expected to attain Level 4 entrustment in all the Generic, AIM and IM CiPs.

In addition to the CiPs, HSTs will also need to have achieved the following (*italics indicate IMST2 only*):

Point of care Ultrasound (POCUS) accreditation
Competence in a chosen specialist skill
Passed the Specialty Certificate Exam (SCE) in Acute Medicine
Demonstrated evidence of management skills and knowledge
Exposure to Simulation Training (skills lab procedural sessions and human factors training)
Experience in the running of outpatient clinics
Experience in the management of inpatients
Engaged with Clinical Governance/Quality Improvement Projects - at least 1 QIP per year
Engaged with teaching activities (both attending and delivering)
Have a valid ALS
Competence across a range of medical procedures
Have completed at least one patient survey
Undergo an Annual Review of Competency Progression (ARCP) each year

Trainee progression against the curricular components will be assessed on a yearly basis in the form of Annual Review of Competency Progression (ARCP).

Annual Review of Competency Progression (ARCP):

HST progression will be assessed every year through ARCP.

As detailed in the AIM curriculum and AIM ARCP Decision Aid, during each ARCP, HSTs will be assessed for their progression on the CIPs and mandatory curricular items mentioned above and will be expected to attain a defined degree of

Every year, they will also be expected to have completed the following: (please note that the numbers given, as specified in the ARCP decision aid is indicative and a particular trainee may need more or less than the numbers given below, based on their agreement with their ES)

Workplace-based assessments: at least 4 ACATs (Acute care assessment tools) and 4 SLEs (Supervised learning Events) in the form of CBDs (Case based discussions) and/or mini-CEXs (Clinical evaluation exercises)

Multiple Consultant Report (MCR) – at least 4 MCRs, 3 of which must be from consultants who have personally supervised the trainee in an acute take/post take setting.

Multi Source Feedbacks – at least one MSF per year. Each MSF must comprise of an indicative number of 12 raters, with 3 of them being consultants, and must include feedback from a variety of medical and non-medical staff.

An Educational Supervisor Report for both AIM and IM *(if the Educational supervisor for AIM is also IMST2 accredited, a separate IMST2 supervisor report is not required).*

It is advisable to proactively review the year's ARCP requirements at the beginning of each educational year and when writing a personal development plan.

How to Achieve the Different Curricular Competencies:

CiPs:

As explained above and in the curriculum, HST capability will be judged against several CiPs. HSTs will be expected to attain a certain entrustment level for each CiPs at the end of each ARCP. It is mandatory to attain Level 4 Entrustment in all CiPs in order to be eligible for CCT.

As detailed in the AIM Curriculum, the Generic, AIM and IM CIPs are as follows:

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

Clinical CiPs (Internal Medicine Stage 2)

1. Managing an acute unselected take
2. Managing the acute care of patients within a medical specialty service
3. Providing continuity of care to medical inpatients, including management of comorbidities and cognitive impairment
4. Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions
5. Managing medical problems in patients in other specialties and special cases
6. Managing a multi-disciplinary team including effective discharge planning
7. Delivering effective resuscitation and managing the acutely deteriorating patient
8. Managing end of life and applying palliative care skills

Specialty CiPs

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

The evidence that HSTs can use to demonstrate competence in the CiPs includes, but is not limited to, the following:

a. Work placed based assessments
b. MCRs
c. MSFs
d. ES reports
e. Courses and conferences attended (e.g. leadership and management courses, communication courses, Teaching courses SAM conferences)
f. ALS certificate
g. SCE certificate
h. End of Placement Reports
i. Others: for e.g. Job roles, Teaching certificates, SIM training, etc

HSTs will be asked to self-rate their entrustment level for each CiP. This should be done throughout each year rather than being kept pending till the ARCP date and ideally at each ES meeting held throughout the year. CiP attainment should be confirmed by ES in the ES meeting and documented as such in the curriculum section of the e-Portfolio.

The ES will then give the final rating of that trainee for those CiPs in the ES report after reviewing the evidence gathered by the trainee and uploaded into the portfolio.

POCUS (Point of Care Ultrasound):

This is one of the most exciting additions to the new AIM curriculum and allows AIM trainees to gain the skills and knowledge to become accredited in Point of Care Ultrasound.

HSTs can gain this skill via any formal accreditation process, the most popular and commonly pursued of which is FAMUS.

Whichever the accreditation process, the HST must be competent in the following:

Thoracic: Pulmonary oedema, pneumonia, Pleural effusion, pneumothorax, site marking for drainage of pleural effusions (as per BTS guidance)
Abdominal/renal: hydronephrosis, bladder distensions, abdominal free fluid, site marking for paracentesis/ascitic tap
Lower Limb: Ruling in DVT
Peripheral Vascular access: USG guided peripheral vascular access

HSTs will be supported to get POCUS accreditation through one day per week being reserved for their POCUS training in their work schedule. The national AIM Specialty Advisory Committee (SAC) recommendation is that, accounting for annual and study leaves as well as on call duties, this one day per week will translate to a minimum of 30 days per year which trainees should get as a guaranteed reserve time for their POCUS training alongside the completion of their QIPs and mandatory portfolio work.

It is expected the HST will achieve POCUS accreditation by ST5.

Tips on how to Get POCUS accreditation

With FAMUS being the most popular POCUS accreditation pathway used with AIM training, the following will focus on the FAMUS accreditation pathway:

Consider starting planning early, ideally immediately from the beginning of training

Identify your local FAMUS supervisor (if required, with the aid of your local TPD), who can oversee your FAMUS accreditation pathway.

Make a list of all the FAMUS mentors in your region who can sign your scans off.

Have a meeting with your FAMUS supervisor to discuss your accreditation journey and make sure your FAMUS supervisor agrees to the list of FAMUS Mentors you have made who can sign you off.

Have a discussion with other AIM trainees in your region on whether they have any tips on the FAMUS accreditation process.

If you or your centre has a butterfly probe, you can add your scans for free to a SAM-Butterfly Cloud which can then be remotely viewed by your mentor.

Even though the curriculum mandates POCUS accreditation by the end of ST5, however, if the nature of your rotations does not facilitate you to get that by the end of ST5 (for e.g. you are not getting that protected one day a week for POCUS or you do not have mentors or supervisors in your area), then have a discussion with your TPDs – TPDs usually review and judge your POCUS progression based on the 'POCUS-support' you have received so far.

Specialist Skill:

Doctors training in AIM will have to gain competence in a particular specialist skill.
The full list of specialist skills and details on how to gain the necessary competence in them can be found in the official AIM Specialist Skills document

The Society for Acute Medicine (SAM) Website also has some very useful tips on how to gain the necessary competence in various specialist skills with advice from current and past AIM trainees who have pursued these specialist skills. For more information on this, consider visiting the Specialist Skills segment on the SAM website.

Doctors training in Acute Medicine will be supported with a one day per week (minimum 30 day per year to pursue their specialist skills (along with other mandatory e-portfolio work) once they have gained their POCUS accreditation – please see Appendix 1 for AIM SAC recommendation on this.

SCE (Specialty Certificate Exams) in Acute Internal Medicine:

Passing the SCE in Acute Medicine is a mandatory component of the AIM training process and in order to be eligible for CCT. Doctors training in Acute Medicine must pass their AIM SCE by the end of ST6 otherwise will get a non-standard ARCP outcome. They would also need to have at least attempted the SCE exam by the end of ST5.

Below is a signpost to a number of useful resources with more information on the SCE exams:

SCE segment on SAM website

SCE in AIM segment on the MRCPUK website

SCE in AIM Blueprint

SAM SCE Revision Resources

AIM SCE Sample Questions

Leadership and Management skills:

It is mandatory to demonstrate leadership and management skills to be eligible for CCT in AIM/IMS2. How this may be achieved will have to be agreed with the ES. This can be achieved, for example, by getting engaged in leadership/management roles like leading a QIP, rota management, running local training, effecting an unmeasured but significant change within the team/hospital, or through a formal leadership and management role (for e.g. takeAIM fellowship, roles within SAM, Chief Registrar posts, etc). The trainee should attend leadership/management courses, often run for free by the local deaneries. This must be coupled with a display of leadership/management roles. Simply attending a leadership/management course is not enough to display the necessary curricular leadership and management skills.

Simulation including Human Factors Training:

AIM HSTs are expected to attend regular simulation training including human factors training. As part of the IM stage 2 training, they will be expected to have attended at least 12 hours of human factors simulation training by the end of their CCT.
In addition, it is highly recommended that in order to maintain some of their procedural skills, they attend a number of procedural skills lab training sessions (there is no fixed number for this – what is needed to maintain some of their skills would depend on a mutual agreement with their ESs). Procedures that are not performed on patients must be simulated on a yearly basis – individual regions are responsible and funded for delivering this skills lab training. It is mandatory for the deaneries to ensure that doctors training in AIM and IM are delivered the required sims training as part of their training process.

Outpatient Clinic Experience:

As part of the mandatory IMTS2 requirement, doctors training in AIM/IM must attend at least 20 outpatient clinics sessions outside their parent specialty (i.e. non AIM clinics). This can be achieved, for example, through outpatient respiratory, cardiology and geriatrics clinics during mandatory rotations. Attendance at these clinics needs to be demonstrated through a logbook (for e.g. JRCPTB FIRTH CALCULATOR). Ideally this should be supported by at least 1 OPCAT per block (not a curricular requirement but is a good practice).

Experience of managing acute unselected medical take:

As part of the mandatory IM requirement, doctors training in AIM/IM will need to have managed at least 750 patients presenting to the acute unselected medical take, with at least 100 of them in the final year of their training. This must be formally recorded through a logbook (for e.g. JRCPTB FIRTH CALCULATOR).

Engaging with Clinical Governance and Quality Improvement Projects (QIPs):

Doctors training in AIM/IM must have evidence of engagement with QIPs **AND** clinical governance on an annual basis. Engagement with clinical governance can be demonstrated through responding to complaints, engagement with clinical incident reporting and investigation, engagement with coroners referrals, etc. In addition to yearly engagement with QIPs - ideally demonstrated through 1 Quality Improvement Project Tool (QIPAT) per year - it is also mandatory to **complete** at least one **full** QIP with a completed QI project plan and report.

Engagement with Teaching Activities (Attending and Delivering):

Every year, doctors training in AIM/IMTs2 must attend 50 hours of teaching, of which 20 hours must be based on AIM. These can be through regional teaching days organised by the deanery (TPDs and Deaneries are responsible for arranging regional training days), or other CPD accredited teaching sessions (for e.g. SAM evening webinars , RCP events, SAM conferences, etc).

As part of IMTS2 requirements, it is also mandatory to have completed at least one teaching observation before CCT. Attending a formal teaching course can be further used to demonstrate competence in delivering teaching.

Practical Procedures:

AIM Trainees will need to achieve Level 4 Entrustment for all the procedures mentioned below in order to get their CCT. They must also attain the defined degree of entrustment for each of these procedures by the end of each ARCP, as outlined in the AIM ARCP decision aid.

However during an ARCP, if the trainee is expected to achieve a level 4 entrustment for a procedure they have not had adequate exposure to due to the nature of their rotations so far, then TPDs are usually advised to show discretion in such situations and judge the trainee progression in light of the nature of their rotations.

List of Practical Procedures and associated tips on how to gain them:

Advanced Cardiopulmonary Resuscitation - usually obtained through ALS combined through routinely leading a medical emergency team or arrest team

Central venous cannulation (internal jugular and femoral) – usually obtained through exposure to this procedure during the Critical Care rotation

Intraosseous access – usually obtained through ALS courses; skills lab training suffices

Intercostal drain for effusion – usually obtained through respiratory rotation or even earlier if trainees rotate through a hospital with exposure to chest drains as part of routine practice

Intercostal drain for Pneumothorax – usually obtained through respiratory rotation or even earlier if trainees rotate through a hospital with exposure to chest drains as part of routine practice

Knee aspiration – please contact your friendly Rheumatologists!

Abdominal paracentesis – may be done routinely in the acute medical units with other senior AIM or Gastroenterology resident doctors who can sign you off. If not, consider going to the gastroenterology/hepatology wards.

Setting up NIV or CPAP: plenty of exposure in the AMU or enhanced care units.

Arterial line insertion: usually obtained through the critical care units. In some hospitals, AIM HSTs will be expected to work in medical HDUs as part of their routine work which may give exposure to arterial line insertions as well.

POCUS (discussed in detail earlier)

Yearly Simulation Training - HSTs will be expected to maintain the following procedural competencies which they would have already achieved by the time they started their AIM higher specialty training:

- **Lumbar Puncture**
- **DC cardioversion**
- **Ascitic tap**
- **NG tube**
- **Pleural aspiration for fluid and pneumothorax**
- **Temporary cardiac pacing using an external device (skills lab competence suffices)**

As mentioned earlier, for those procedures which are not routinely performed in patients after initially being signed for them, ongoing competence in them must be demonstrated through attending yearly simulated skills lab training.

How to make best out of rotations:

Doctors training in Acute Medicine will rotate for at least 4 months through each of Respiratory Medicine, Cardiology, Critical Care and Care of the Elderly Medicine. The rest of the training will usually be based in Acute Medicine. The duration of these rotations however may vary depending on the location of training.

During rotation in Acute Medicine, AIM HSTs will have the chance to gain proficiency in managing patients presenting to the acute unselected medical take and gain proficiency on how to effectively manage patients with an acute undifferentiated medical condition. They will also have the invaluable opportunity to manage patients with a wide variety of medical conditions pertaining to a wide variety of different medical specialties. They will have a chance to interact with other specialties, including other allied medical specialties as well as non-medical specialties, primary care, emergency department and critical care department. They will have the chance to lead and manage Acute Medical Units. They will get invaluable experience of working in, leading and managing ambulatory care units/same day emergency care units (SDEC) and will get the chance to learn how SDEC activity can be optimised through sound application of national SDEC guidance (for e.g. SAM SDEC Position Statement, NHS England Ambulatory Emergency Care Guide), applied in context of the local facilities available. They will also get a chance to manage patients at the front door through Emergency Department – In reach/referral services. They will develop vital skills on how to work in effective partnership with other specialties to deliver safe and effective patient care. They will have exposure to most of the procedures mandated in their curriculum. They will also have a chance to learn and become proficient in POCUS.

During the specialty rotations, below is a non-exhaustive of some of the valuable skills and knowledge which can be gained:

An in-depth understanding of how that specialty works
Interface of those specialties with Acute Internal Medicine
Knowledge and skills of the management of medical conditions related to those specialties
Procedural skills (for e.g. DC Cardioversion and pacing and Point of care echocardiogram during cardiology rotation, pleural procedures during respiratory rotation, central venous cannulation and arterial line insertion during critical care rotation)

In addition, rotation through care of the elderly medicine can give opportunities to learn about managing patients through hospital at home pathways and frailty SDECs and managing frail patients at the front door through Frailty Front Door services.

The discussion of the curriculum and the mandatory things associated with it also makes it clear that during each rotation, there will be competing demands on the AIM HSTs– for e.g. excelling as a clinician within the hospital microenvironment, obtaining their specialist skills and POCUS accreditation, attending mandatory teaching, attaining the procedural competencies and obtaining the other mandatory curricular requirements. All this while the services will also naturally expect the doctors to be a useful member of the team and contribute to the wider team's needs.
This also means that HSTs will need to be very efficient in balancing the time they spend for each of these.

An inability to balance these in a skilled manner will result in the HSTs failing to make the best out of each rotation. If needed, the ES will help in this case, and hence this should be discussed as part of the regular ES meetings.

Hence it is very important that AIM HSTs plan each of their rotations carefully, ideally with their ES, and also have an honest and open discussion with the clinical supervisors for each rotation on how they can make themselves an important and useful part of the wider team but also gain the necessary clinical and non-clinical skills and knowledge that this rotation can offer them.

How to make best out of supervision:

It is of paramount importance to have a meeting with the ES at the very start of each training year. Trainees will be allocated an ES for each training year who will help in guiding the training journey for the trainee for that year and are also responsible to rate their progression in that year through their ES report (in contrast, it is the TPD who is responsible to oversee the whole training journey). The ES can help AIM HSTs with their valuable advice on how to attain the needed curricular competencies since they will have good knowledge of both the AIM and IMTS2 training curriculum and also of the local facilities available to help HSTs gain the curricular requirements. When things don't progress as per plan, it is very important to have an open an honest conversation with their ES on why things are not progressing well and what can be done to address this.

In addition to the educational supervision, AIM HSTs should have a clinical supervisor for each of the rotations. The clinical supervisors will guide HSTs through how they can make the best of each rotations and how these rotations might help them in getting the required curricular competencies.

For each rotation, it is good practice to have a start-of, mid- and end-of placement meeting (in addition to ideally once a month ES meetings) with the clinical supervisor and then have the meeting notes documented in the portfolio (please see Appendix 2).

Importance of Engaging well with the e-Portfolio:

Throughout the training process it is very important to engage with the e-portfolio at regular intervals instead of leaving it towards the end of each year before the ARCPs.
This would include staying on top of the required number of workplace based assessments as per ARCP requirements, collecting MCRs and MSFs in a timely manner, regularly uploading all the certificates obtained into the personal library, and regularly updating the logbook of cases managed, POCUS and specialty skills. It is also important to regularly link these to the different CIPs and their descriptors. It is good practice to meticulously ensure that all ES and CS reports are uploaded into the relevant sections of the e-portfolio in a timely manner. It is good practice to regularly engage in reflective practice related to various clinical and non-clinical encounters and upload these reflections in the portfolio.

All the above is important since ultimately it is the portfolio which helps the ES and TPDs judge the progress of the doctor.

How to get involved with the Society for Acute Medicine and make best use of that involvement:

As an HST in AIM, the Society for Acute Medicine has got plenty to offer. Some of these are mentioned below:

takeAIM fellowship: takeAIM is an organisation which is supported by SAM and is a national campaign to promote Acute Medicine as a career choice. This role allows fellows to gain very useful leadership and management experience and has been regarded as a very enjoyable and rewarding experience by fellows who have previously carried out this role.

SAM Trainee Rep: This is a role within the SAM council and trainee reps are elected through a central election process to a 2 year term. This is a very useful leadership and management experience.

Becoming a member of the SAM Subcommittees: Various SAM subcommittees are always looking for interested HSTs in AIM to join them and work for them. Examples include QI, Education and Research Subcommittees. Working in these subcommittees leads to a better understanding of how acute medicine works as a specialty and is also a great networking opportunity with other acute medics working all over the country. These roles also give the chance to members to participate in various national projects.

Useful Contacts

From the beginning of your training process, it would be useful to know who the following are:

Your ES and CS for each rotation

Training Programme Director(s) (TPDs)

Regional Deanery Trainee Reps

SAM Trainee Reps

FAMUS supervisors and mentors locally and in the region

People who have completed or are doing the same specialist skills as you are aiming to do
SAMBassadors: these are members of the healthcare profession, elected for each region around UK, by SAM to help with SAM activities, specially educational activities. They can be a very useful points of contact to help with any SAM or training related queries.

SAC chair and Vice Chair: The Specialty Advisory Committee (SAC) is a national committee which oversees the higher specialty training process in Acute Medicine. The current SAC chair is Dr. Vinay Kolanu-Reddy (who if needed is happy to be contacted directly) and deputy SAC chair is Dr. Nicholas Smallwood. The SAC issues important recommendations on how training in Acute Medicine should be delivered. (The SAC consists of the chair, a Vice-chair, TPDs from all over UK, senior figures from JRCPTB and SAM Trainee Reps among other members.)

SAM Council Members and Subcommittee Leads

Appendix 1:

AIM SAC recommendation on the minimum amount of protected time for AIM HSTs for POCUS/specialist skills/e-portfolio work:

Dear SAC team

As you know, the AIM curriculum demands that higher specialist trainees spend, on average, one day per week of self development time. Using this time to complete their specialist skills and point-of-care ultrasound capabilities, develop leadership and managerial skills and reflect this information into their portfolios.

The SAC have debated the interpretation of “one day” over two separate SAC meetings in 2024 and concluded that one day a week ‘on average’ equates to 30 full days over 52 weeks. For a trainee working less than full time, the total number of days of training will remain the same, but over an appropriately extended period, pro rata approach. Annual holidays, study leave, participation in industrial action, and on call duties do not count against these 30 days and do not alter the total requirement during the 52 weeks. This time must be provided and equally divided between acute internal medicine ***and*** speciality block placements.

A trainee may have not chosen a speciality skill and is not yet ready to learn point of care ultrasound or has completed either one or both capabilities and hence wishes to use this time differently. In that case, they are expected to complete quality improvement projects, develop their portfolio in preparation for supervisor meetings and ARCPs, and gain skills in governance, complaints, leadership, research, education, or other managerial capabilities that they will need to be proficient in as an AIM consultant.

If a trainee does not provide evidence that they are using this allocated time appropriately, I suggest that educational supervisors and training program directors follow the process described in The Gold Guide, section 4, “Progressing as a Doctor.”

If a trainee cannot be scheduled for 30 days of development time in 52 weeks, either because of trainee or site specific issues, I suggest a robust governance approach, including round-table meetings facilitated by your regional educational team.

A consistent commitment to developing all specialist skills is vital to ensuring our trainees qualify to the highest standards possible, which is in the best interests of patients, trainees, colleagues, and the speciality itself.

We are developing work schedules to help you ensure quality assurance within your training programmes. They will be distributed soon.

I appreciate your support. Don’t hesitate to contact me directly if you have any questions. Please share this email with your local STC teams

Kind regards

Vinay

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Appendix 2:

Educational Supervisor Report: