JRCPTB

Joint Royal Colleges of Physicians Training Board

Internal Medicine Training (IMT) Stage 1 ARCP Decision Aid – 2019 curriculum (August 2026 update)

The IMT ARCP decision aid documents 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 https://www.jrcptb.org.uk/training-certification/arcp-decision-aids

Requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
Form R or SOAR (Scotland) **ESSENTIAL**	Form R must be completed and uploaded into personal library for every ARCP – an ARCP review cannot take place without a valid form R within 6 weeks of the ARCP	Valid form R dated within 6 weeks of ARCP	Valid form R dated within 6 weeks of ARCP	Valid form R dated within 6 weeks of ARCP	Form R is completed via the portal and must include all time out of training (TOOT) and record any incidents or complaints
JRCPTB 'CCT' calculator **ESSENTIAL IF WORKING LTFT**	An up-to-date end of IMT stage 1 calculator should be uploaded to the personal library for all resident doctors who are LTFT or out of sync due to sickness, OOP, staggered starts or any other reason	Up to date completed CCT calculator (this does not assess CCT but end of IMT stage 1 timing)	Up to date completed CCT calculator (this does not assess CCT but end of IMT stage 1 timing)	Completed CCT calculator (this does not assess CCT but end of IMT stage 1 timing)	JRCPTB CCT calculator is found at: Calculating completion dates | The Federation
GMC training survey completion **RECOMMENDED**	Evidence of completion of the GMC training survey uploaded to personal library ideally in a folder entitled ARCP IMT1/2/3	Evidence of completion in ARCP IMT1 folder	Evidence of completion in ARCP IMT2 folder	Evidence of completion in ARCP IMT3 folder	Evidence of completion can be found in your GMC online account
Summary of clinical activity and teaching attendance form (SCATA) **ESSENTIAL**	The SCATA (found in assessment > QI/audit, teaching and clinical activities) should be completed each year prior to ARCP supported by logbook of evidence uploaded in the personal library	Completed SCATA form supported with logbook of evidence	Completed SCATA form supported with logbook of evidence	Completed SCATA form supported with logbook of evidence	In this form you input the total numbers in each domain for the last year or since last ARCP which pull through cumulatively each year to summary page

Requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
Logbook of Procedures/clinic patients/teaching **ESSENTIAL**	The logbook should be uploaded to the personal library – ideally in a folder entitled ARCP IMT1/2/3	Up to date logbook in personal library with cumulative numbers	Up to date logbook in personal library with cumulative numbers	Up to date logbook in personal library with cumulative numbers	JRCPTB logbook is found at: IMT acute take calculator and log of clinics and procedures | The Federation

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
Educational supervisor report (ESR) **ESSENTIAL**	One per year to cover the full training year since last ARCP (up to the date of the current ARCP). Note more than one ESR may be needed e.g. if a resident moves Trust and ES between ARCP windows to cover whole period	Confirms meeting or exceeding expectations and no concerns.	Confirms meeting or exceeding expectations and no concerns. Confirms will meet the critical progression point criteria and can progress to IMY3 and act as medical registrar.	Confirms meeting or exceeding expectations and no concerns. Confirms will meet the critical progression point criteria to complete IM stage 1.	The ES report should detail any areas which do not meet ARCP requirements and plans to address these e.g. exams Do not start or complete report until ES has signed off generic and clinical CIP levels
Academic Supervisor Report **ESSENTIAL FOR NIHR ACADEMIC TRAINEES ONLY**	This is for NIHR Academic Clinical Fellows (ACFs) only and is not required by any other resident doctor	Confirms satisfactory progress with academic element of training programme	Confirms satisfactory progress with academic element of training programme	Confirms satisfactory progress with academic element of training programme	
Generic capabilities in practice (CiPs) **ESSENTIAL**	Mapped to Generic Professional Capabilities (GPC) framework and assessed using global ratings. Resident doctors should link evidence and record self-rating for	ES to confirm resident doctor meets expectations for level of training by adding rating in the curriculum for each generic CIP.	ES to confirm resident doctor meets expectations for level of training by adding rating in the curriculum for each generic CIP.	ES to confirm resident doctor meets expectations for level of training by adding rating in the curriculum for each generic CIP.	ES must review linked evidence and rate and confirms 'meets' or 'above' expectations for each individual generic CIP annually

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
	all generic CIPS to facilitate discussion with ES.				If signed correctly, CIPS will appear with a green dot on Summary of Progress table
Clinical capabilities in practice (CiPs) **ESSENTIAL**	See grid below (page 11) of levels expected for each year of training. Resident doctor must complete self-rating to facilitate discussion with ES. Annual ES ratings (prior to ARCP) and ESR will confirm entrustment level for each individual CiP and overall global rating.	ES to confirm resident doctor is performing at or above the level expected for all CiPs by rating in the curriculum for each clinical CIP.	ES to confirm resident doctor is performing at or above the level expected for all CiPs by rating in the curriculum for each clinical CIP.	ES to confirm resident doctor is performing at or above the level expected for all CiPs by rating in the curriculum for each clinical CIP.	The ES should not rate all clinical CIPS as level 4 – this equates to CCT level (exception of CIP 7 which required sign of at level 4 by end of IM3) If rated expected standard or above CIPS will appear with a green dot on Summary of Progress tab
Multiple consultant report (MCR) **ESSENTIAL**	Each MCR is completed by a consultant who has supervised the resident doctor's clinical work. The ES should not complete an MCR for their own resident doctor. The number listed is the minimum required number for each year.	4	4 In IMY2 at least 3 of the 4 MCRs must comment on acute take ability	4 In IMY3 at least 3 of the 4 MCRs must comment on acute take ability	The breadth of MCRs should comment on and cover a range of activity from acute take, inpatient and outpatient work. Ideally the CS for each placement should complete an MCR (except when also the ES)
Multi-source feedback (MSF) **ESSENTIAL**	A valid MSF includes a minimum 12 raters (with 3 consultants) and a mixture of other staff (medical and non-medical) with all 12+ replies received within a 3-month window and with no concerns.	1 valid MSF	1 valid MSF	1 valid MSF	MSF report must be released by the ES and feedback discussed with the resident doctor before ARCP. If concerns are raised, arrangements should be made for reflection and a repeat MSF.

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
Supervised learning events (SLEs): Acute care assessment tool (ACAT) **ESSENTIAL**	Minimum number to be carried out by consultants. Resident doctors are encouraged to undertake more, and supervisors may require additional SLEs if concerns or learning needs are identified.	4 At least 2 of the 4 ACAT must relate to the acute take	4 At least 2 of the 4 ACAT must relate to the acute take	4 At least 2 of the 4 ACAT must relate to the acute take	ACAT is designed for acute unselected medical take but may also be on a ward round or covering a day's management of admissions and ward work. ACAT assesses overall global assessment managing a cohort of patients rather than detailed individual case management.
Supervised Learning Events (SLEs): Case-based discussion (CbD) and/or mini-clinical evaluation exercise (mini-CEX) and **ESSENTIAL**	Minimum number to be carried out by consultants. Resident doctors are encouraged to undertake more, and supervisors may require additional SLEs if concerns or learning needs are identified.	2 mini-CEX or CBD	2 mini-CEX or CBD	2 mini-CEX or CBD	CBD is a discussion about a specific case Mini-CEX is a directly observed encounter e.g. leading a ward round, seeing a patient in clinic
Supervised Learning Events (SLEs): Outpatient care assessment tool	Minimum number to be carried out by consultants. resident doctors are encouraged to undertake more, and supervisors may require additional SLEs if concerns or learning needs are identified.	2	2	2	

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
(OPCAT) **ESSENTIAL**					
MRCP (UK) **ESSENTIAL**	Failure to pass Part 1 at end of IMY1 or full MRCP by the end of IMY2 will affect ARCP outcome.	Part 1 passed. **If Part 1 not passed, recommended ARCP outcome**: An IMY1 without Part 1 can progress to IMY2 on an outcome 2 U5 if there are no other training/capability concerns.	Full MRCP(UK) diploma achieved. **If full MRCP UK not passed, recommended ARCP outcome:** An IMY2 with only some or no parts of MRCPUK but no other training/capability concerns can progress to IMY3 on an outcome 2 U5. If full MRCP not achieved plus training/capability concerns an ARCP outcome 3 should be considered.	Full MRCP(UK) diploma achieved. **Recommended ARCP outcome**: if full MRCP not complete at end IMY3 an ARCP outcome 3 U5 should be awarded. If it is an exam only outcome 3 U5 (all other capabilities complete and no training concerns), a resident doctor may wish to take additional training time or achieve MRCPUK outside of training.	An outcome 4 should not be issued at the end of IMT3 where exams are the only outstanding requirement in the absence of other training concerns (an outcome 3 U5 should instead be used), **however** If at any point in their training, a resident doctor has exhausted all attempts at a part of MRCPUK, (including extenuating circumstances/appeals), an outcome 4 should be considered.
Advanced life support (ALS) **ESSENTIAL**	An expired ALS certification alone should not affect resident doctor progression or ARCP outcome however there should be a clear plan	Valid	Valid	Valid	The ES rating for clinical CiP 7 (delivering effective resuscitation) and capability for advanced CPR in the procedures

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
	in place to recertify (course booking or outline of plan in ES report to achieve recertification).				section of the curriculum should be considered.
Quality improvement (QI) project **ESSENTIAL**	One QI project plan and report to be completed and assessed with quality improvement project tool (QIPAT) by end of IMY2.		1 project completed with QIPAT		For NIHR ACFs evidence of significant involvement in a research project may be equivalent although involvement in QI is encouraged
Outpatients **ESSENTIAL**	Summary of clinical activity should be recorded on ePortfolio and in personal logbook with evidence of outpatient activity in SLEs including OPCAT and MCRs.	Indicative minimum 20 outpatient clinics by end of IMY1.	Indicative minimum 20 outpatient clinics in IMY2 *or* cumulative 40 clinics by end of IMY2.	Indicative minimum 20 outpatient clinics in IMY3 and cumulative 80 outpatient clinics in total (IMY1-3).	Resident doctors should achieve these minimum numbers, but numbers (max 15% below) requirements should not affect resident doctor progression or ARCP outcome however there should be a clear plan in place to achieve these before the training period is complete with details of this in the ESR
Acute unselected take **ESSENTIAL**	Active involvement in the care of patients presenting with acute medical problems is defined as having sufficient input for the resident doctor's involvement to be recorded in the patient's clinical notes – this can be a clerking, initial review, senior review, acute admission assessment or acutely	Evidence that resident doctor actively involved in the care of a minimum of 100 patients presenting with acute medical problems in IMY1.	Evidence that resident doctor actively involved in the care of a minimum of 200 patients presenting with acute medical problems by the end of IMY2.	Evidence that resident doctor actively involved in the care of at least 100 patients presenting with acute medical problems in IMY3 and an indicative minimum 500 patients in total (IMY1-3).	Resident doctors should achieve these minimum numbers, but numbers (max 15% below) requirements should not affect resident doctor progression or ARCP outcome however there should be a clear plan in place to achieve these before the training period is complete with details of this in the ESR e.g.

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
	unwell patient review for a patient new to the resident doctor	ES to confirm level 3 for clinical CiP1.	ES to confirm level 3 for clinical CiP1.	ES to confirm level 3 for clinical CiP1.	where an acute take block occurs after the ARCP
Continuing ward care of patients admitted with acute medical problems **ESSENTIAL**	Resident doctors 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 **ESSENTIAL**	At least one MCR should be completed by a critical care consultant by the end of IMY2		Critical care placement completed Minimum of 10 weeks of critical care in one single block or equivalent (ICU or HDU) by end of IMY2.		If full critical care block has not been achieved by the end of IMY2 then an OC2 with a clear plan to achieve this in IMY3 should be documented'
Geriatric medicine **ESSENTIAL**	At least one MCR should be completed by a geriatric medicine consultant by the end of IMY2		Geriatric medicine placement completed	Minimum of four months in a team led by a consultant geriatrician by the end of IMY3	A resident doctor who completes a four-month geriatric medicine placement at **less than** 0.8WTE will require additional geriatric medicine time prior to the end of IMT3
Simulation **ESSENTIAL**	All practical procedures should be taught by simulation as early as possible in IMY1.	Evidence of simulation training to include all IMT stage 1 procedural skills.	Evidence of simulation training to include human factors and scenario training.		Refresher training in procedural skills should be completed if required but is not mandatory.

Evidence / requirement	Notes	IM year 1 (IMY1)	IM year 2 (IMY2)	IM year 3 (IMY3)	
Teaching attendance **ESSENTIAL**	Minimum hours per training year. Summary of teaching attendance to be recorded in ePortfolio and in personal logbook.	50 hours teaching attendance to include minimum of 20 hours IM teaching recognised for CPD points or organised/ approved by HEE local office or deanery.	50 hours teaching attendance to include minimum of 20 hours IM teaching recognised for CPD points or organised/ approved by HEE local office/deanery.	50 hours teaching attendance to include minimum of 20 hours IM teaching recognised for CPD points or organised/ approved by HEE local office/deanery.	Internal hours are those delivered within your hospital e.g. local/Trust IMT teaching or internal CPD meetings. External hours are those delivered outside e.g. regional teaching days, conferences, royal college teaching or external e-learning

Beginning and end of placement clinical and educational supervisor meetings, personal development plans for each rotation and evidence of engagement in reflective practice are all strongly recommended

Practical procedural skills

Resident doctors must be able to outline the indications for the procedures listed in the table below and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthesia, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the resident doctor must be able to appreciate and recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary. Please see table below for minimum levels of competence expected in each training year.

For satisfactory sign off for skills lab level there must be either skills lab DOPS or skills lab certificate with relevant procedure listed. For sign off as competent to perform unsupervised a summative DOPS must be completed confirming **both '**competent to perform unsupervised and manage complications' **and** that the resident has 'pass' for the summative DOPS. A summative DOPS with 'pass' but signed of as needing 'limited supervision' is not sufficient for sign off as unsupervised practice.

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
Advanced cardiopulmonary resuscitation (CPR)	Skills lab or satisfactory supervised practice	Participation in CPR team evidenced by DOPS or mini-CEX	Leadership of CPR team evidenced by DOPS or mini-CEX

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
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] competence
Lumbar puncture	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a] competence
Nasogastric (NG) tube	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a] competence
Pleural aspiration for fluid (diagnostic) It can be assumed that a resident doctor 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] competence
Access to circulation for resuscitation (femoral vein or intraosseous) The requirement is for a minimum of skills lab training or satisfactory supervised practice in one of these two mechanisms for obtaining access to the circulation to allow infusion of fluid in the patient where peripheral venous access cannot be established	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice
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 or 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

Practical procedures – minimum requirements	IMY1	IMY2	IMY3
Direct current (DC) cardioversion	Skills lab or satisfactory supervised practice	Competent to perform unsupervised as evidenced by summative DOPS	Maintain[a] competence
Abdominal paracentesis	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice	Skills lab or satisfactory supervised practice

[a] When a resident doctor has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure unless they or their educational supervisor think that this is required (in line with standard professional conduct). Demonstration of maintaining competence includes keeping a logbook of procedures completed and/or supervised, teaching the skill or if required, further skills lab training/updates.

[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. A summative DOPS for pleural aspiration should be signed of as 'competent to perform the procedure unsupervised and recognise the complications and respond appropriately'. A pleural DOPS signed off as 'able to perform the procedure with limited supervision/assistance' and 'pass' is acceptable for independent sign off if accompanied by a clear statement from the assessor that the supervision/assistance relates to the use of ultrasound only.

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 may be made on the basis of performance in other related CiPs if the resident doctor is not in a post that provides acute specialty-related take.**
****Clinical CIPS (except for CIP 7 at IMT3 level) should *not* be signed off as level 4 as this related to completion of higher specialist training (CCT) level.**