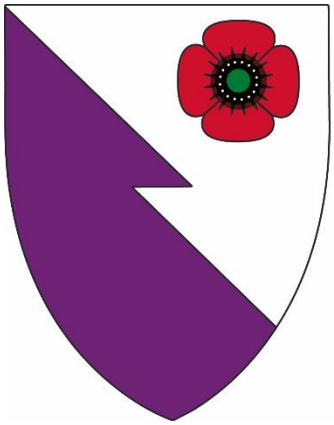
Implementation date 04 August 2021



The Royal College of Emergency Medicine

Curriculum 2021

Implemented 04 August 2021

Change log

This document outlines the curriculum to be used by doctors completing RCEM training in the UK. It is accompanied by the *Assessment strategy*.

This is Version 1.4. As the document is updated, version numbers will be changed, and content changes noted in the table below.

Version number	Date issued	Summary of changes
1.1	01 May 2020	Update to Section 7. Quality management to emphasise role throughout training not just at ACCS level Update to Section 5.5 title
1.2	October 2020	p8 SLO1 descriptor changed to include 'acute physical or mental health' p 23 'guidelines and legislation relevant to the country of practice' inserted bullet 12 p24 bullet 5 Intermediate and Higher: "disposal" change to "disposition" p33 Intermediate and Higher: Delete 'Supra pubic catheter re-insertion' p56 OncP1 Insert "Acute" at beginning. Change "be seen in" to "present to"; and insert "preseptal or peri-orbital" at OptC3. P57 PalP1 insert "and end stage chronic disease" P58 TC6 "Animal bites including human" to replace "human"; insertion XC4. Domestic abuse P66 final paragraph Insert "has been demonstrated by the trainee" P85 remove "ideally cadaveric", Typos corrected p4,5,7,12,21, 23,24,42,45,67, 72,74,79,91
1.3	December 2020	Replacement 'Faculty Entrustment Group Statement' with 'Faculty Educational Governance Statement' p68, 80, 101
1.4	March 2021	Replacement 'QIPAT' with 'QIAT' p41, 46 ACAF, JCF form included for Research SLO p45, 70, Replacement 'STR' with 'ESR' p42, 44, 46, 47, 49, 68, 69, 71, 95, Appendix 2 ARCP guidance updated p96 SLO6 Practical Procedures descriptive narrative text added p79, 82 table 5.5.1 updated, table 5.5.2 updated

Contents

1. Introduction

1.1. Governance and strategic support

This Royal College of Emergency Medicine (RCEM) is written by the Curriculum Sub-Committee. This Sub-Committee was established in 2017 as a standing body to work on the Curriculum and its Programme of Assessment. It meets quarterly and reports to the Education Committee. The committee is constituted of trainees, fellows, lay representatives and RCEM officers (the Dean and Deputy CEO). It has representatives from all devolved nations, an ACCS link, Training Standards Committee representative (Heads of School) and ordinary fellows appointed after open application. It includes fellows with special interest in human factors and clinical reasoning. The members of the Curriculum Sub-Committee are listed in appendix 1.

Excellence by Design

The General Medical Council's (GMC) requirement for curriculum review, described in its 2017 report 'Excellence by Design', was published after the Committee was formed, although the changes were broadly anticipated. The Curriculum Sub-Committee developed an outline of the structure of a new curriculum that met the GMCs requirements and sought feedback on this with a national survey of RCEM members and fellows, a survey of patients and feedback from national and regional meetings.

This initial outline was iterated based on the responses returned and a 'Purpose Statement' sent to the GMC's Curriculum Oversight Group (COG) for review. This step is necessary to evaluate suitability in all devolved nations and compatibility with the findings of the Shape of Training Review and is required before further development can continue. Approval for the Purpose Statement was given by the COG in January 2019.

In parallel, members of the Curriculum-Sub Committee have been working with the Acute Care Common Stem Training Intercollegiate Curriculum Development Board. Core training is ACCS for EM, but the ACCS curriculum also needs to meet the requirements of trainees in each of the four allied ACCS specialities. A Purpose Statement for ACCS training, including Learning Outcomes, has also been submitted to the GMC's COG. It was approved in June 2019.

Stakeholder review

A full working draft of the curriculum was available for stakeholder review. This included RCEM trainees and trainers, others working in EM, Royal Colleges, patient and lay groups, NHS employers among others. Feedback was triangulated and the curriculum iterated prior to full submission to the GMC for approval in February 2020.

The curriculum will be launched in **AUGUST 2021** following a full programme of preparation and training.

1.2. How to use this curriculum

The Curriculum is designed to lay out what is required to be a specialist in EM in the UK. The **Purpose Statement** outlines why EM is vital to the patients of the UK and a key element of the National Health Service.

The curriculum also describes how EM trainees will be trained. It is the result of a significant exercise whereby experienced EM trainers and training and assessment experts have sought to describe an effective approach that can be delivered. The following is a description of how learners and trainers can get the best out of it.

The GMC requires all curricula to include **Generic Professional Capabilities (GPCs)**. These are designed to foster a common set of skills, attitudes and behaviours in the trainee workforce that might be transferrable if needed.

The expertise of an EM consultant working within the NHS involves a wide range of knowledge and technical skills. The breadth of the clinical presentations, or pathophysiological processes, that need to be known by EM specialists are listed as the **Clinical Syllabus**. Up to date knowledge and understanding of the assessment and treatment of patients presenting to the Emergency Department (ED) is a fundamental part of training. The knowledge and understanding will be the subject of private study, departmental and regional teaching and will be assessed in the **Programme of Assessment**, in particular the formal examination schedule.

The clinical knowledge and understanding outlined in the **Clinical Syllabus** is applied in a setting of varying demands, interspersed with rare and challenging situations, delivered by a workforce with a range of experience and the need for overview and leadership from the EM specialist. The requirements of on an EM specialist in this setting are articulated in the **Specialty Learning Outcomes (SLOs)**. The Specialty Learning Outcomes outline what an EM specialist, at the end and at key points within training, will be expected to be able to do independently.

The **GPCs** that relate to each of the **SLOs** are listed.

EM specific **Key Capabilities** are described for each of the SLO's. These are the specific contextualised aspects of the **SLOs** that are fundamental to the practise of EM in the UK. The Key Capabilities form the basis of how the **SLOs** are assessed. Trainees will be required to demonstrate how they are developing in training against each these. The skills of self-regulation will be developed by trainees seeking and considering feedback at work in each of the **Key Capabilities**.

The **Descriptors** section of each **Specialty Learning Outcome (SLO)** gives examples and further guidance for trainees and assessors about what is required. The **SLOs** are designed to support the development of trainees in all dimensions needed to deliver expert EM care effectively. By covering the human factors at play we aim to make the implicit explicit.

The purpose of training for the **SLOs** is the application of clinical knowledge to patient care in the ED, RCEM's vision for the provision of training in the work place is that it acknowledges the challenge that leadership in the ED represents. It also acknowledges that all have varying strengths and areas to improve, and that these be both refined and developed.

The best use of training in the work place for learners is to **find areas of challenge and to seek and reflect on feedback from trainers.** In the curriculum these are grouped within the 12 **SLOs** described. Eight of them relate to work caring for patients directly in the ED and four supporting **SLOs** relate to teaching, research and scholarship, quality improvement and patient safety and leadership and management. It is important to develop in all 12. The requirements at each stage of training are laid out in the **Programme of Assessment**.

A key principle underpinning the Programme of Assessment is that a tick list is not followed, or a specific number of assessments accumulated. It is rather that there is a shared understanding of where trainees need to get to, in terms of the degree of independence, at the next stage of training and that training is geared to readying them. Trainers know which situations and circumstances are demanding and can guide learners to experience these, with support, in the work place. That is the point of work place encounters that are recorded in the RCEM e-portfolio. To that end, assessment in the work place should start at the

beginning of the training year and pitched at outer edges of the trainees' 'comfort zone'.

Expertise in EM is pivotal to the good health of communities in the UK. It is hard won, complex and requires a spread of knowledge, skills and attributes that are often called on all at once. This curriculum sets out what these are and is designed to support their development, integration and assessment. It acknowledges that there are a range of talents within those training in the specialty. The curriculum sets out a minimum requirement, but our aim is also that it is used as the map to guide the pursuit of excellence for individuals. There is scope for developing areas of interest or particular expertise within the specialty. We aim to establish practices that develop clinicians who can thrive as individuals throughout their career in the ED.

2. The Purpose of the RCEM Curriculum

The RCEM curriculum has a clear and stated purpose based on the scope of practice, service, and the patient and population needs.

The purpose of the RCEM Curriculum is to train doctors to be EM Consultants, able to provide urgent and emergency care to all undifferentiated patients attending ED nationwide, 24/7, 365 days every year. This includes leading the multi-professional resuscitation of sick and injured patients of all ages (from birth to advanced age and frailty) in addition to managing, leading and supporting all elements of care delivered by the multi-disciplinary teams throughout the full spectrum of acute illness and injury, physical and mental health needs that present to a modern day ED. They must be able to provide strategic leadership and set the culture within the ED, improve quality, teach and supervise and deliver key administrative tasks. EM trainees using this curriculum will be trained to manage any situation, however complex or challenging, by making those challenges explicit and by supporting their individual development to meet them.

The need for doctors to follow this training programme is clear. There is an on-going increase in demand for UK ED services. In 2016-17 there were 27,329,874 attendances at all types of UK EDs and 18,205,538 in type 1 EDs alone 1. Between 2006-07 and 2016-17 the number of attendances increased by 12.20% or 1.22% per annum. The rise in demand in part reflects the growing number of older patients with complex co-morbidity. This group of patients attend the ED in greater proportion than any other group. EM Consultants are responsible for the care of more than 27.3 million patients per year. This means that in a given year 1 in 2.4 of the UK population will attend an ED. At present these trends show no signs of abating suggesting that future demand will continue to rise.

Whilst current workforce transformation seeks to widen the multi-disciplinary team delivering emergency and unscheduled care the training and supervision of all these other Allied Health Professional roles lies with EM Consultants and so the training as well as service burden continues to rise. There is therefore a continuing need to train individuals and to expand the number of EM Consultants as those with the broadest skill set benefitting the greatest number of patients of any discipline in modern medicine.

The aims of the RCEM curriculum

This curriculum seeks to provide a flexible, attractive training programme for doctors training in EM, ensuring trainees have the opportunity to develop the full range of skills and knowledge they need to meet the standard required of a consultant in EM.

The curriculum provides a framework for training, articulating the standard required to work at consultant level and at key progression points, as well as encouraging the pursuit of excellence in all aspects of clinical and wider practice.

Trainees using this curriculum will be able to develop and apply innovative approaches to teaching and research. They will be required to ensure that they are up to date in their practice, and that they promote and implement research and evidence-based medicine for the benefit of patients. They will be committed to the highest standards of care and of ethical and professional behaviour both within their specialty, and within the medical profession as a whole.

By achieving their CCT, all EM trainees will have demonstrated that they can be trusted to independently deliver each of the SLOs that define the specialty, and also to support and develop others in key areas of EM practise. These SLOs fully incorporate the GPCs, thus also demonstrating that trainees have met the GMC's requirements. In this way we can

demonstrate that on completion of training according to this curriculum a newly qualified consultant in EM can be trusted to lead the line on day one.

The scope of EM practise

EM Consultants are required to display a wide range of knowledge, skills, behaviours and attributes, reflecting the broad nature of this specialty in practice. This is reflected in the depth and breadth of the curricular content. By the point of attaining the CCT, trainees will be skilled in caring for patients, both children and adults, with acute illness, injury, mental health problems, frailty and indeed the many and varied difficulties that may befall humanity leading to an ED attendance. They will have expertise in practical procedures related to the clinical care of such patients, will be expert communicators with strong interpersonal skills, strong emotional awareness and be adept at the management of potentially highly complex situations.

These core areas ensure that doctors in training and beyond CCT can provide safe care whilst working in a range of EDs with a varied case load and staffing skill mix. Our learners' GPCs and EM specific clinical skills and knowledge will be developed and evidenced through achievement of SLOs across twelve domains. These advance in complexity and sophistication as learners progress through the training programme.

Table 1. RCEM Specialty Learning Outcomes

Specialty Outcome	Generic Professional Capabilities	Description
1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	1,2,3,4,6,7	Care for patients presenting with acute physical or mental health concerns and be able to manage the most complex presentations
2. Support the ED team by answering clinical questions and making safe decisions	1,2,3,4,5,6,7	Support the clinical team with a safe and comprehensive approach as an expert diagnostician
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	1,2,3,4,5,6,7	Resuscitate and stabilise critically ill adults, lead resuscitation teams, know when resuscitation is inappropriate or should be stopped and care for ED patients at the end of their life

4. Care for acutely injured patients across the full range of complexity	1,2,3,4,5,6,7	Manage all injured patients presenting to the ED, including major incidents
5. Care for children of all ages in the ED, at all stages of development and children with complex needs	1,2,3,4,5,6,7	Care for and resuscitate children in the ED
6. Deliver key procedural skills	1,2,3,4.5.6.7	Proficiently provide the full range of technical skills needed in Emergency Medicine
7. Deal with complex and challenging situations in the work place	1,2,3,4,5,6,7	Be able to manage the wide variety of challenges, posed personally and to the ED team on the ED shift
8. Lead the ED shift	1,2,3,4,5,6,7	Provide leadership to the whole ED and link with the wider health community on shift
9. Support, supervise and educate	1,2,3,5,6	Support, supervise, mentor and educate the ED team
10. Participate in research and managing data appropriately	1,2,3,9	Understand and be able to utilise and participate in EM research
11. Participate in and promote activity to improve the quality and safety of patient care	1,2,3,5,8	Be able to deliver quality improvement in the ED
12. Manage, Administer and Lead	1,2,3,4,5,6,7	Deliver administrative tasks within the ED and as part of the wider NHS. Provide leadership and help set the culture in the ED

The development of learners in these SLOs is sequenced in the curriculum to reflect a growing level of responsibility. This is reflected in the structure of training. It is divided into three parts with distinct waypoints. Progression is competency based and training duration therefore, indicative.

Structure of Training

Core training (Indicative two years): Following selection into the specialty trainees will enter core training. Trainees will develop the skills and knowledge to care for individual adult patients in core training. This is within ACCS training, shared with anaesthetics, acute medicine and intensive care medicine. At the end of core, trainees will be able to identify sick adult patients and resuscitate and stabilise as part of the wider hospital team. They will be able to deliver key elements of management, including advanced airway skills and circulatory support. There are entrustment decisions at the end of core training to ensure learners can deliver such care before moving to the next stage of training.

Intermediate training (Indicative one year): The aims of intermediate training are twofold. Learners will develop and refine paediatric EM specific skills and knowledge. They will also be supported to start to take a leadership role in the multi-professional resuscitation team and also begin to develop the skills and knowledge to lead and support the wider EM team in general. At the completion of intermediate training the trainee will be entrusted to function safely as the most senior clinician overnight.

Higher training (three years): In Higher Training learners develop further as leaders, refining the skills needed to lead the whole ED shift, as well as dealing with the most challenging cases that may present, not infrequently in parallel. They will also develop mastery of allied administrative, teaching, supervision, and research skills to ensure they can act as leaders in the ED more widely, setting the standards for clinical care and developing strategy.

The framing of a curriculum of SLOs, or activities that a trainee must be entrusted to deliver as a consultant level clinician, encourages holistic judgement as to the trainee's overall capability, and support the move away from a `presentation-based' structure to one that describes a specialty exemplified by the need to attend the broadest range of clinical activity, often simultaneously.

Flexibility and transferability

The curriculum considers interdependencies across related specialties and disciplines. It demonstrates that it has addressed the expectations of the service and healthcare system.

EM interfaces with all aspects of the primary and secondary care. We have sought extensive review from within our college, held a wide ranging consultation with EM trainees and trainers and sought feedback from patients on what is important to them in the doctor that sees them in the ED, in developing our SLOs and we have iterated them based on feedback received.

We have worked with ACCS partners to refine the SLOs that are relevant to this stage of training. The SLOs in core training are designed to meet the needs of all partners and will allow trainees to follow the higher curriculum of each ACCS specialty as efficiently as possible.

The curriculum takes into account the recent development of allied health provider roles, such as Physician Associates and Advanced Care Practitioners. We have made explicit within our programme the need to be able to supervise, answer questions, to lead, support

and to train a multi-disciplinary team in the ED. The implementation of this curriculum represents a step change in developing these key elements of EM consultant work.

The curriculum supports flexibility and the transferability of learning. EM shares direct transferability with the other specialties that make up ACCS training. Trainees in each of these parent disciplines can apply to transfer directly to training schemes of each of the other disciplines on completion of ACCS.

Introducing GPCs will undoubtedly aid transferability. Our SLOs are also largely generic in nature, describing the technical skills and human factors that underpin acute care, supporting learners to develop insight into their leadership and team working skills. These will be directly transferable to other roles within the acute care spectrum.

3. Organisation and content of the curriculum- content of learning

3.1. Generic Professional Capabilities and Good Medical Practice

The GMC has developed the GPCs framework [1]with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of the GMC's Generic Professional Capabilities

Good medical practice (GMP)[2] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

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

The 20 domains and subsections of the GPC framework are directly identifiable in the RCEM curriculum. They are mapped to each of Clinical and Supporting SLOs, which are, in turn,

[1] Generic professional capabilities framework
[2] Good Medical Practice

mapped to the assessment blueprint. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

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

3.2. Specialty Learning Outcomes (SLOs)

There are 11 **ACCS Learning Outcomes** that are followed in core training. Thereafter there are 12 **RCEM SLOs** that cover the whole of training in the RCEM curriculum. The progression in training from ACCS Learning Outcomes to RCEM SLOs is shown in Table 2.

Table 2. Progression from ACCS LOs to RCEM SLOs

ACCS LO	RCEM SLO	Note
1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	Continuous
2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	2. Support the ED team by answering clinical questions and making safe decisions	Increased sophistication and acknowledgement of the need to support others from intermediate training onwards
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	Continuous
4. Care for acutely injured patients across the full range of complexity	4. Care for acutely injured patients across the full range of complexity	Continuous
5. Provide safe basic anaesthetic care including sedation		Content moves to SLO 3 and 6 in Intermediate and Higher Training

	5. Care for children of all ages in the ED, at all stages of development and children with complex needs	Begins in intermediate training as a requirement, although experience and feedback can be accrued in Core Training
6. Deliver key procedural skills	6. Deliver key procedural skills	Continuous
7. Deal with complex and challenging situations in the work place	7. Deal with complex and challenging situations in the work place	Continuous
8. Manage patients with organ dysfunction and failure		Content moves to SLO 3 and 6 in intermediate and Higher Training
	8. Lead the ED shift	Requirement from intermediate training onwards
9. Support, supervise and educate	9. Support, supervise and educate	Continuous
10. Participate in research and managing data appropriately	10. Participate in research and managing data appropriately	Continuous
11. Participate in and promote activity to improve the quality and safety of patient care	11. Participate in and promote activity to improve the quality and safety of patient care	Continuous
	12.Manage, Administer and Lead	Requirement from intermediate training onwards

3.2.1.The ACCS Learning Outcomes

In ACCS training the ACCS Learning Outcomes are common to all four parent specialties. They reflect both the continuity of training for learners following the RCEM curriculum in full, and the need for learners in the other ACCS specialities to be able to transfer seamlessly to parent programmes.

There are 11 **ACCS Learning Outcomes**, eight relating directly to patient care **(Clinical ACCS Learning Outcomes)**, and three to generic activity required in specialty training **(Generic ACCS Learning Outcomes)**, mapped to the GPCs. The Clinical ACCS Learning Outcomes include content relating to basic anaesthetic care and intensive care medicine. Beyond ACCS, this content becomes part of the RCEM SLOs.

3.2.2.RCEM Specialty Learning Outcomes

Eight of the **RCEM SLOs** are 'patient facing' and relate directly to patient care or activity in the clinical work place. These are the 'Clinical SLOs'. The remaining four relate to supporting activities that take place away from the ED clinical areas but are also essential to the development of a specialist in EM. These are the 'Supporting SLOs'. The expectations on trainees in each are clearly described and reflect the growing sophistication of the EM clinician in training.

The **RCEM SLOs** and **ACCS Learning Outcomes** are listed below. Where these are the same, the **Key ACCS capabilities** and **descriptors** are listed within the individual **RCEM Specialty Learning Outcomes**.

In the curriculum requirements we state that by the end of Higher Training an EM clinician ready for independent practice will be 'expert' in the Key Capabilities of Clinical SLOs. For these purposes an expert is a clinician who can:

- Take on the most difficult and complex cases
- Supervise and evaluate the performance of others in such clinical cases
- Do the above whilst maintaining departmental oversight

Clinical SLOs

1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	
Key ACCS Capabilities	At completion of **ACCS** a trainee will be able to: • gather appropriate information, perform a relevant clinical examination and be able to formulate and communicate a management plan that prioritises patient's choices and is in their best interests, knowing when to seek help • assess and formulate a management plan for patients who present with complex medical and social needs ***These capabilities will apply to patients attending with physical and psychological ill health***

ACCS descriptors	• Demonstrate professional behaviour with regard to patients, carers, colleagues and others • Deliver patient centred care including shared decision making • Take a relevant patient history including patient symptoms, concerns, priorities and preferences • Perform accurate clinical examinations • Show appropriate clinical reasoning by analysing physical and psychological findings • Formulate an appropriate differential diagnosis • Formulate an appropriate diagnostic test and management plan, taking into account patient preferences, and the urgency required • Explain clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately select, manage and interpret investigations • Recognise need to liaise with specialty services and refers where appropriate • Demonstrate awareness of the needs of vulnerable adults attending the acute care sector • Demonstrate professional behaviour with regard to patients, carers, colleagues and others
Key EM capabilities	At completion of **Intermediate training** a trainee will be able to: • assess and manage all adult patients attending the ED. These capabilities will apply to patients attending with both physical and psychological ill health • assess and formulate a management plan for patients who present with complex medical and social needs or who manifest as one of the frailty syndromes ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will: • Be expert in assessing and managing all adult patients attending the ED. These capabilities will apply to patients attending with both physical and psychological ill health ***and would be able to manage with no supervisor involvement***

Intermediate & Higher Descriptors	**All ACCS descriptors apply in intermediate and Higher training**

General

- Recognise when care would be more appropriately delivered by other healthcare professionals

Mental Health

- Assess and initially manage patients of all ages presenting with features consistent with mental illness by taking account of their psychiatric and medical history, mental state examination, vital signs and available investigations
- Make a competent assessment of a patient's suicide risk, taking into account circumstances and known risk factors
- Professionally and compassionately assesses a patient in crisis
- Safely manage acutely disturbed behaviour
- Manage the patient threatening to abscond
- Work collaboratively with Psychiatry Liaison staff and other agencies (including the Police) where necessary when caring for patients with mental health problems
- Contribute effectively to multidisciplinary care for frequently attending patients with mental illness
- Identify risk factors for suicide and/or absconsion and mitigates these by appropriate nursing/security observation
- Competently manages the physical/wound care and toxicological consequences of self-harm
- Understand safeguarding responsibilities
- Safely manages aggressive or disturbed behaviour via de-escalation techniques as well as assisting with physical and chemical restraint (rapid tranquilisation) by providing clinical oversight
- Communicate effectively with psychiatry liaison colleagues, nursing staff, security and the police when necessary
- Understand the legal frameworks underpinning the care of the psychiatric patient, as relevant to the ED and ED observation areas
- Respect patient autonomy but understand when a patient lacking capacity should have investigations or treatment made in their best interests

Older patients with complex co-morbidity in the ED

- Able to interact with frail older people especially those with cognitive impairment and their carers and families

- Able to assess for frailty syndromes: falls and fragility fractures, immobility, incontinence, polypharmacy, end of life care, delirium and "non-specific presentations"
- Aware of physiological pitfalls in assessment and management of frail older people including in trauma and resuscitation
- Aware of the evidence base underpinning the utility of investigations and interventions in frail older people
- Aware of safeguarding issues in older people
- Aware of mental health presentations in older people and liaison services
- Aware of pharmacokinetics and pharmacodynamics in frail older people and its interaction with existing polypharmacy
- Aware of medicolegal framework and associations for managing older people with cognitive impairment
- Aware of various models of care delivery for improving quality of care for frail older people including frailty decision units, ambulatory frailty pathways, role of multidisciplinary teams in the ED
- Aware of design principle for EDs to improve person-centred outcomes for older people including structure, resources and processes

Observational medicine

- Able to evaluate patients in a CDU/ observational medicine setting, be able to estimate risk and utilise diagnostic tests appropriately and make safe discharge plans, liaising with other services effectively when needed
- Able to communicate effectively with patients in the CDU/observational medicine setting

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 decisions include...	ACAT CbD ESLE Logbook of cases Mini-CEX MSF RCEM App MCR (AM)

2. Support the ED team by answering clinical questions and making safe decisions

2. ACCS-Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support

Key ACCS capabilities	At completion of **ACCS** a trainee will: • understand how to apply clinical guidelines • understand how to use diagnostic tests in ruling out key pathology, and be able to describe a safe management plan, including discharge where appropriate, knowing when help is required • be aware of the human factors at play in clinical decision making and their impact on patient safety
ACCS descriptors	• Proficient in ECG and plain film interpretation, as relevant to acute care • Aware of the cognitive psychology of decision making • Understand basic diagnostic test methodology • Understand the fundamentals of decision rule design • Aware of the strengths and limitations of using guidelines e.g. NICE • Demonstrate capabilities in dealing with complexity and uncertainty • Share decision making by informing patients, prioritising patient's wishes, and respecting their beliefs, concerns and expectations
Key EM capabilities	At completion of **Intermediate training** a trainee will be**:** • able to support the pre-hospital, medical, nursing and administrative team in answering clinical questions and in making safe decisions for discharge, with appropriate advice for management beyond the ED. • aware of when it is appropriate to review patients remotely or directly ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will be: • able to support the pre-hospital, medical, nursing and administrative team in answering clinical questions and in making safe decisions for discharge, with appropriate advice for management beyond the ED. • aware of when it is appropriate to review patients remotely or directly and able to teach these principles to others. ***and would be able to manage with no supervisor involvement***

Intermediate & Higher Descriptors	**All ACCS descriptors apply in intermediate and Higher training**
	• Aware of the human factors at play in clinical decision making and their impact on patient safety
	• Aware of key steps in diagnostic reasoning including
	  o Cognitive processing and dual process theory – "how we make decisions"
	  o The anchor and adjust heuristic
	  o Factors that affect our decision making
	  o How to use diagnostic tests effectively
	  o How to make therapeutic decisions effectively for the benefit of individual patients
	• Be competent in ECG, clinical image and biochemical assay interpretation
	• Understand diagnostic test methodology
	• Be able to recognise and describe strategies to reduce the incidence of cognitive error
	  o To include metacognition and cognitive debiasing techniques
	• Be able to describe strategies for dealing with uncertainty. To include
	  o The use of pre and post-test probabilities
	  o Bayesian analysis
	  o Risk stratification or decision rule design
	  o Use of guidelines
	• The Emergency Physician should always demonstrate appropriate professional values and behaviours, supporting colleagues, respecting difference of opinion, and working as a collaborative member of a team
	• Able to provide effective feedback on clinical reasoning and decision making

GPCs	Domain 1: Professional values and behaviours Domain 2: Professional 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 teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety
Evidence to inform decisions include...	CbD ESLE FEG RCEM App ACAT MCR (AM) Mini-CEX MSF

3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	
Key ACCS capabilities	At completion of **ACCS** a trainee will: • recognise and manage the initial phases of any acute life threatening presentation including cardiac arrest and peri-arrest situations • be able to provide definitive airway, respiratory and circulatory support to critically ill patients • be able to establish the most appropriate level of care for critically unwell patients - including end-of life decisions - and support their needs as well as those of their loved ones

ACCS descriptors	• Identify an acutely ill patient by taking account of their medical history, clinical examination, vital signs and available investigations • Integrate clinical findings with timely and appropriate investigations to form a differential diagnosis and an initial treatment plan • Institute definitive airway management and initiate and maintain advanced respiratory support • Utilise intravenous fluids and inotropic drugs as clinically indicated, utilising central venous access where required and monitored by invasive monitoring techniques • Manage life-threatening cardiac & respiratory conditions including peri-arrest & arrest situations • Formulate and initiate ongoing treatment plan for a critically ill acute surgical or acute medical patient post resuscitation, including those with sepsis and institute timely antimicrobial therapy with an aim for ongoing stabilisation • Communicate effectively and in a timely manner with fellow members of the multi-disciplinary team including those from other specialties and completing accurate legible and contemporaneous entries in the medical record • Arrange escalation of care when required and provides a succinct structured handover of the relevant patient details including treatment to that point • Recognise a patient is in danger of deterioration or who requires further treatment and provides explicit instructions regarding an ongoing treatment plan and contact details should a further review be required • Decide when it is appropriate to end resuscitation, and is cognisant of the specific care needs of patients and their loved ones when this decision has been made • Respect patient autonomy and understands when and how they should use advance directives & living wills • Recognise the potential for organ donation in certain end of life situations and is aware of associated best practice guidelines and legislation relevant to the country of practice • Demonstrate effective consultation skills in challenging circumstances • Demonstrate compassionate professional behaviour and clinical judgement

Key EM capabilities	At completion of **Intermediate training** a trainee will be able to: • manage all life-threatening conditions including peri-arrest & arrest situations in the ED • care for ED patients and their relatives and loved ones at the end of the patient's life • effectively lead resuscitation teams ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will: • provide airway management & ventilatory support to critically ill patients • be expert in fluid management and circulatory support in critically ill patients • manage all life-threatening conditions including peri-arrest & arrest situations in the ED • be expert in caring for ED patients and their relatives and loved ones at the end of the patient's life • effectively lead and support resuscitation teams ***and would be able to manage with no supervisor involvement***
Intermediate & Higher Descriptors	**All ACCS descriptors apply in intermediate and Higher training** • Respects patient autonomy and understands when and how they should use advance directives & living wills • Can make judgements about junior colleagues' competence in this domain • Can offer constructive, useful feedback in this domain • Whilst assessing and treating a patient the doctor must maintain optimum safety for the patient by recognising the limitations of the environment, the available equipment and personnel and employing best practice guidelines where these exist • Be able to effectively lead the multi-disciplinary team with authority in resuscitation through to disposition regardless of complexity

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 teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decisions include...	CbD ESLE FEG Mini-CEX MCR (AM) MSF RCEM App

4. Care for acutely injured patients across the full range of complexity	
Key ACCS capabilities	At completion of **ACCS**, a trainee will be: • an effective member of the multidisciplinary trauma team • able to assess, investigate and manage low energy injuries in stable patients

ACCS descriptors	• Able to perform primary/secondary trauma survey • Have examination skills required to identify/diagnose injury including vascular and neurological consequences • Appropriately use investigations including XR/CT/US/MRI to confirm presence/consequences of injury • Provide basic management of wounds, soft tissue injuries, fractures and dislocations including local anaesthetic techniques • Provide safe use of basic local anaesthetic techniques e.g. digital nerve block, fascia iliaca block • Use a range of techniques for wound closure (simple dressing, suturing, skin adhesive, steri-strips). • Know the fundamentals of management of fractures and dislocations (slings, splints, basic plastering, manipulation as appropriate) • Able to remove foreign bodies from the eye and ear • Provide opportunistic advice on accident prevention • Understand the pathophysiology and management of injury (including specific populations e.g. elderly, paediatric and pregnancy • Understand the social/economic consequences of injury upon individuals • Estimate a timeline of healing and give general and specific safety net advice on concerning features of potential complications • Understand the importance of considering safeguarding of vulnerable patients • Apply CT guidelines for suspected head and cervical spine injuries • Provide initial care for patients with fractured neck of femur • Understand the impact of injury on patients with markers of frailty
Key EM capabilities	At completion of **Intermediate training** a trainee will be able to: • assess, investigate and manage patients attending with all injuries, regardless of complexity • provide leadership of the Trauma Team ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will: • be expert in assessment, investigation and initial management of patients attending with all injuries, regardless of complexity • provide expert leadership of the Major Trauma Team ***and would be able to manage with no supervisor involvement***

Intermediate & Higher Descriptors	**All ACCS descriptors apply in intermediate and Higher training** • Manage all wounds, soft tissue injuries, fractures and dislocations including local anaesthetic techniques and sedation • Provide calm and effective leadership in major trauma scenarios • Participation in local/national audit and research into trauma care • Supervision of a multi-disciplinary team in trauma care including Nurse Practitioners/ACPs • Aware of Local/regional/national trauma protocols and guidelines • Aware of Human factors/non-technical skills that affect performance of team caring for trauma patient • Ability to predict likely prognosis/recovery time of injuries including potential complications • Able to lead a multi-professional team brief after major trauma 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 teamworking Domain 6: Capabilities in patient safety and quality improvement • Safety Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decisions include...	ACCS App CbD ESLE FEG Mini-CEX MSF

5. Care for children of all ages in the ED, at all stages of development and children with complex needs

Key EM capabilities	At completion of **Intermediate training** a trainee will: • Be able to gather appropriate information, perform a relevant clinical examination and be able to formulate and communicate a management plan that prioritises the child and where relevant the family's choices that is in their best interests. • Be able to identify the sick child and initiate appropriate management steps • Acquire the special skills needed to resuscitate children of all ages, and know that this may differ dependent on developmental age and know how this differs from adult resuscitation • Assess children and young people with concerning presentations and know that some of the presenting symptoms could be manifestations of abuse ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will: • Be expert in assessing and managing all children and young adult patients attending the ED. These capabilities will apply to patients attending with both physical and psychological ill health and include concerning presentations that could be manifestations of abuse • Be able to lead a multidisciplinary paediatric resuscitation including trauma • Be able to assess and formulate a management plan for children and young adults who present with complex medical and social needs ***and would be able to manage with no supervisor involvement***

Descriptors	**Clinical assessment** • Able to interact with children of different stages of development and their families to elicit the history • Able to undertake a careful, sensitive and flexible examination of children of all ages, at different stages of development and with complex needs • Aware of the different developmental stages of children and their assessment and how injury and illness can affect this • Understand the impact of learning disability and chronic complex health needs on acute presentations • Aware of behavioural and developmental issues and learning disabilities in childhood may impact presentations and clinical assessment in the ED, including infection and NAI. • Can engage children appropriately in their own decisions and protects the best interests of the child at all times. **Medical, Surgical and Trauma** • Aware that paediatric life-threatening emergencies are infrequent and therefore prior preparation is essential i.e. successful completion of APLS or equivalent is needed • Able to lead a team debrief following a paediatric resuscitation/trauma • Acquire the special skills needed to manage the paediatric patient– e.g. airway management, vascular access • Know that paediatric trauma is different to adult trauma and be able to apply those differences clinically • Know that the interpretation of vital signs and tests is age dependent e.g. ECG, radiology, bloods • Be able to safely and appropriately arrange tests such as radiology and blood tests, considering factors such as the ALARA principle and the trauma of unnecessary blood tests • Be able to prescribe safely for children • Know when to utilize distraction techniques and play therapists to manage children in the ED • able to identify those patients needing urgent specialist attention and know when and how to refer • Have an understanding of which patients can be safely discharged home and what follow-up they may need • Able to liaise with Paediatric Critical Care Retrieval Services and plan for a time critical transfer • Know the local procedure for sudden unexpected death in infants and children (SUDIC) **General** • Know the immunisation schedules • Have a basic understanding of common problems e.g. toddler tantrums, food refusal **Mental Health** • Have an awareness of the effect of bullying, truancy, and work pressure upon children • Understands consent, capacity to take decisions, and confidentiality in relation to children, respects the ethical and legal framework relating to children in the ED and is aware of the issues of parental responsibility • Know self-harm in children and adolescents as an expression of distress.

- Calculate risk stratification score for those with suicidal ideation and refer appropriately.
- Know how to manage the adolescent refusing treatment for a life – threatening overdose.
- aware of the presentations of mental illness in childhood including depression, anxiety, OCD, bipolar and schizophrenia
- Know how to refer to the Child and Adolescent Mental Health Service team.

Safeguarding

- Knows and understands the ways in which children may present with physical, sexual, emotional abuse and neglect.
- Know which infants are most at risk
- Aware of the stresses to the family and the increased risk of NAI, neglect and DV
- Reliably pick up clues which should give rise to concern
- Able to recognize patterns of injury or illness which might suggest NAI.
- Reliably document concerns, conversations with other professionals, and detailed descriptions of history or examination findings as appropriate.
- Understand the importance of seeking help from experienced colleagues in the assessment of children with possible NAI.
- Understand the ways in which children might reveal sexual abuse.
- Understand and recognise the signs and symptoms of sexual abuse.
- Able to talk with parents and inform them that a social services referral is being made
- Able to initiate safeguarding children procedures including sexual abuse as per local policy.
- Know the relevant national documents which underpin the safeguarding children policy in the emergency setting
- Understand the roles of other systems in protecting children, e.g. Social Services, the Child Protection Plan, Police Child Protection and Domestic Violence Units, SureStart, Childline, Health Visitors, School Nurses, Area safeguarding children Committee, Community Paediatricians

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 teamworking Domain 6: Capabilities in patient safety and quality improvement • Safety Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decisions include...	Assessment of simulated practice CbD ESLE FEG Mini-CEX MSF RCEM App

6. Deliver key procedural skills

Key ACCS capabilities	At completion of **ACCS** a trainee will have: • the clinical knowledge to identify when key ACCS practical emergency skills are indicated • the knowledge and psychomotor skills to perform the ACCS procedural skills safely and in a timely fashion

ACCS descriptors	**Procedural skills-ACCS (Detailed in section 5.5.1)** • Pleural aspiration of air • Chest drain: Seldinger and open technique • Establish invasive monitoring (CVP and Art line) • Vascular access in emergency- IO, femoral vein • Fracture/ dislocation manipulation • External pacing • DC Cardioversion • Point of care ultrasound- Vascular access and Fascia iliaca block • Lumbar puncture
Key EM capabilities	At completion of **Intermediate training** a trainee will have: • the clinical knowledge to identify when key EM procedural skills are indicated • the knowledge and psychomotor skills to perform the ACCS procedural skills safely and in a timely fashion ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will have: • the clinical knowledge to identify when key EM practical emergency skills are indicated • the knowledge and psychomotor skills to perform EM procedural skills safely and in a timely fashion • Will be able to supervise and guide colleagues in delivering procedural skills ***and would be able to manage with no supervisor involvement***

Intermediate & Higher Descriptors	**Procedural skills-Intermediate &Higher Training (Detailed in section 5.5.2)** • Procedural sedation in adults • Paediatric sedation • Advanced airway management • Non-invasive ventilation • Open chest drain • Resuscitative thoracotomy • Lateral Canthotomy • DC cardioversion • External pacing • Pericardiocentesis • ED management of life threatening haemorrhage • Emergency delivery • Resuscitative Hysterotomy • Fracture/ dislocation manipulation • Large joint aspiration • Point of Care Ultrasound
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty
Evidence to inform decision	Assessment of simulated practice ACCS Logbook DOPs EM Logbook ESLE FEG IAC MCR

7. Deal with complex and challenging situations in the work place	
Key ACCS capabilities	At completion of **ACCS** a trainee: • Will know how to reduce the risk of harm to themselves whilst working in acute care • Will understand the personal and professional attributes of an effective acute care clinician • Will be able to effectively manage their own clinical workload • Will be able to deal with common challenging interactions in the work place

ACCS descriptors	• Know how to safely deal with violent or threatening situations
	• Able to handle common but challenging situations:
	  o self-discharge against advice
	  o capacity assessment
	  o adult safeguarding issue
	  o Police/FME enquiries
	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups
	• Behave in accordance with ethical and legal requirements
	• Demonstrate ability to offer apology or explanation when appropriate
	• Demonstrate ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
	• Interact effectively with hospital colleagues when handing over the care of patients, in particular when this appears troublesome.
	• Liaise effectively with healthcare professionals outside the hospital about patient care.

Key EM capabilities	At completion of **Intermediate training** a trainee will: • be able to work effectively with patients who appear angry or distressed • be able to negotiate or manage complicated or troubling interactions • behave professionally in dealings with colleagues and team members within the ED • work professionally and effectively with those outside the ED ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee will: • have expert communication skills to negotiate manage complicated or troubling interactions • behave professionally in dealings with colleagues and team members within the ED • work professionally and effectively with those outside the ED ***and would be able to manage with no supervisor involvement.***
Intermediate & Higher Descriptors	**All ACCS descriptors apply in intermediate and Higher training** • Understanding the effect on the team of stress and fatigue • Support EM team members in challenging or distressing circumstances • Working within a legal framework for shop floor work o Aware of specific legislation: o Data Protection Act, o Information Governance, o Freedom of Information Act o Caldicott Report. o Mental Health Act, o Mental Capacity Act, o Deprivation of Liberty Safeguards o Children's Act. o Advance Directives o DNAR Decisions o DOLS o Organ and Tissue Donation • Able to judge issues of Safeguarding for adults and children. • Behave at all times in a professional manner • Aware of own limitations and ability to ask for help as necessary

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 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decisions include…	Assessment of simulated practice CbD ESLE FEG Mini-CEX MCR RCEM App

8. Lead the ED shift

Key EM capabilities	At completion of **Intermediate training** a trainee will: • have an awareness of other's workload and supports other staff members. • be able to be function as senior clinician in the ED overnight. ***with Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*** At completion of **higher training** a trainee: • Will provide support to ED staff of all levels and disciplines on the ED shift • Will be able to liaise with the rest of the acute / urgent care team and wider hospital as shift leader • Will maintain situational awareness throughout the shift to ensure safety is optimised • Will anticipate challenges, generate options, make decisions and communicate these effectively to the team as lead clinician ***and would be able to manage with no supervisor involvement***

Descriptors	• Know how to safely deal with violent or threatening situations
	• Able to handle common but challenging situations:
	  o self-discharge against advice
	  o capacity assessment
	  o adult safeguarding issue
	  o Police/FME enquiries
	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups
	• Behave in accordance with ethical and legal requirements
	• Demonstrate ability to offer apology or explanation when appropriate
	• Demonstrate ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently
	• Interact effectively with hospital colleagues when handing over the care of patients, in particular when this appears troublesome.
	• Liaise effectively with healthcare professionals outside the hospital about patient care.

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 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decisions include...	ESLE RCEM App MSF FEG

ACCS Learning Outcome: Provide safe basic anaesthetic care including sedation	
Key ACCS capabilities	At completion of **ACCS** a trainee will be able to: • Pre-operatively assess, optimise and prepare patients for anaesthesia • Safely induce, maintain and support recovery from anaesthesia including recognition and management of complications • Provide urgent or emergency anaesthesia to ASA 1E and 2E patients requiring uncomplicated surgery including stabilization and transfer • Provide safe procedural sedation for ASA 1E and 2E patients

Descriptors	• Understand the risks, aetiology, treatment and control processes of infection including the need for and ability to perform an aseptic non-touch technique • Pre-operatively assess patients' suitability for anaesthesia, prescribe suitable pre-medication and recognise when further investigation or optimisation is required prior to commencing surgery and adequately communicate this to the patient or their family • Safely induce anaesthesia in ASA 1 and 2 patients, recognise and deal with complications associated with induction • Maintain anaesthesia for the relevant procedure, utilise appropriate monitoring and effectively interpret the information it provides to ensure the safety of the anaesthetised patient, as a member of the multi-disciplinary theatre team • Safely care for a patient recovering from anaesthesia, recognise and treat the common associated complications and manage appropriate post-operative analgesia, anti-emesis and fluid therapies • Provide urgent or emergency anaesthesia to ASA 1E and 2E patients requiring uncomplicated surgery • Plan and deliver safe sedation using appropriate agents for ASA 1E and 2E patients requiring procedures
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 Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decisions include...	HALO in Sedation IAC MCR DOPS MSF Logbook of cases Simulation training with assessment

ACCS Learning Outcome: Manage patients with organ dysfunction and failure	
Key ACCS capabilities	At completion of **ACCS** a trainee: • Will be able to provide safe and effective care for critically ill patients across the spectrum of single or multiple organ failure • Will be able to plan and communicate effectively with patients, relatives and the wider multi-professional team when attending to the clinical and holistic needs of patients
Descriptors	• Recognise the limitations of intensive care and employ appropriate admission criteria • Recognise, assesses and initiate management for acutely ill adults across the spectrum of single or multiple organ failure • Recognise and manage the patient with sepsis and employ local infection control policies • Perform safely and effectively the clinical invasive procedures to maintain cardiovascular, renal, and respiratory support. • Undertake and evaluate laboratory and clinical imaging investigations to manage patients during their intensive care stay • Manage the ongoing medical/surgical needs and organ support of patients during a critical illness, including the holistic care of patients and relatives • Plan and communicate the appropriate discharge of patients from intensive care to health care professionals, patients and relatives • Support the management of end of life care within the intensive care environment with patients, relatives and the multi-professional team • Understand the role of transplant services when appropriate and the principles of brain-stem death testing • Support clinical staff outside the ICU to enable the early detection of the deteriorating patient

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 • Capabilities in health promotion and illness prevention • Capabilities in leadership and team-working • Capabilities in patient safety and quality improvement • 7. Capabilities in safeguarding vulnerable groups
Evidence to inform decisions include...	MCR CbD Mini-CEX MSF Reflection

This section of the curriculum details the 11 generic and clinical ACCS LO with expected levels of performance, mapping to relevant GPCs and the evidence that may be used to make an entrustment decision.

KEY

ACAT	Acute care assessment tool	ALS	Advanced Life Support
CbD	Case-based discussion	DOPS	Direct observation of procedural skills
GCP	Good Clinical Practice	RCEM App	App based WPBA tool for directly observed episodes
FEG	Faculty Educational Governance statement	ESR	Educational Supervisor report
Mini-CEX	Mini-clinical evaluation exercise	MCR	Multiple consultant report
MSF	Multi source feedback	PS	Patient survey

QIAT	Quality improvement project assessment tool	TO	Teaching observation
IAC	Initial assessment of anaesthetic competence	ESLE	Extended Supervised Learning Event
ACAF	Applied critical appraisal form	JCF	Journal Club Form

Generic ACCS Learning Outcomes

The three generic ACCS LOs cover universal requirements of all specialties as described in the GPC framework that are not exemplified by day to day activity in the work place. Assessment of the generic LOs will be underpinned by the descriptors from the relevant GPC domains and evidenced against the performance and behaviour expected at that stage of training. Satisfactory sign off will indicate that there are no concerns before the trainee can progress to the next part of the assessment of clinical capabilities. In order to ensure consistency and transferability, the generic ACCS LOs have been grouped under GPC-aligned categories.

For each generic ACCS LOs there are a set of descriptors of the observable skills and behaviours which would demonstrate that a trainee has met the minimum level expected. The descriptors are not a comprehensive list and there may be more examples that would provide equally valid evidence of performance.

Supporting Specialty Learning Outcomes

In intermediate training these become the Supporting SLOs, reflecting a greater degree of EM specific content and the addition of a further SLO for leadership, administration and management

9. Support, supervise and educate	
Key ACCS capabilities	At completion of **ACCS** a trainee: • Will be able to set learning objectives for and deliver a teaching session

Key EM capabilities	At completion of **Intermediate training** a trainee will be able to: • set learning objectives for and deliver a teaching session that demonstrates growing expertise from ACCS • deliver effective feedback to a junior colleague or allied health professional At completion of **higher training** a trainee will: • be able to undertake training and supervision of members of the ED team in the clinical environment • be able to prepare and deliver teaching sessions outside of the clinical environment; including simulation, small-group work and didactic teaching • be able to provide effective constructive feedback to colleagues, including debrief • understand the principles necessary to mentor and appraise junior doctors
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act a clinical supervisor to doctors in earlier stages of training
GPCs	Domain 1: Professional values and behaviours Domain 8: Capabilities in education and training
Evidence to inform decision	MCR MSF TO STAT Relevant training courses Educational Supervisor Report (ESR)

10. Participate in research and managing data appropriately	
Key ACCS capabilities	At completion of **ACCS** a trainee will: • be able to search the medical literature effectively and know how to critically appraise studies
Key EM capabilities	At completion of **Intermediate training** a trainee will: • be able to appraise, synthesise and communicate research evidence At completion of **Higher training** a trainee will: • be able to appraise, synthesise, communicate and use research evidence to develop EM care • be able to actively participate in research
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 3: Professional knowledge • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries Domain 9: Capabilities in research and scholarship

Evidence to inform decision	MCR MSF GCP certification Evidence of literature search and critical appraisal of research TO ACAF JCF Evidence of research activity Educational Supervisor Report (ESR)

11. Participate in and promote activity to improve the quality and safety of patient care	
Key ACCS capabilities	At completion of **ACCS** a trainee will: • be able to contribute effectively to a departmental quality improvement project
Key EM capabilities	At completion of **Intermediate training** a trainee will: • be able to describe their involvement and show an understanding of QI methods and reflect on a Quality Improvement Project they have been involved in At completion of **Higher training** a trainee will: • be able to provide clinical leadership on effective Quality Improvement work • be able to support and develop a culture of departmental safety and good clinical governance
Intermediate & Higher Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence

	• Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
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 legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decisions...	MCR MSF QIAT Educational Supervisor Report (ESR)

12. Manage, administer and lead	
Key EM capabilities	At completion of **Intermediate training** a trainee will: • have experience of handling a complaint or preparing a report, and be aware of the relevant medico-legal directives At completion of **higher training** a trainee will: • have experience of handling a complaint, preparing a report, and be aware of the relevant medico-legal directives (elements not completed in intermediate) • Be able to investigate a critical incident, participate and contribute effectively to department clinical governance activities and risk reduction projects • Be able to manage the staff rota, being aware of relevant employment law and recruitment activities including interviews and involvement in induction • Be able to effectively represent the ED at inter specialty meetings
Descriptors	• Respond to complaints in a variety of formats including verbal response, written response and face to face meetings • Construct a report for the coroner/procurator fiscal and/or legal services using information available from clinical notes • Effectively participate, and support others involved, in a serious adverse event investigation and be familiar with some of the tools involved such as RCA/ 5 Whys/Fishbone analysis • Participate and represent the in ED in divisional / inter specialty / CG meetings • Represent the ED on a Hospital Committee (such as resuscitation committee, transfusion committee, trauma committee etc.) and feedback to the ED team • Participate in the rota management ensuring adequate skill mix and cover • Participate in multidisciplinary recruitment for the ED • Aware of the interplay of various agencies in the NHS and how they interrelate in the evolving NHS Landscape • Able to demonstrate a high level of communication skills in all of the above

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 legislative requirements • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision...	MSF Management portfolio Educational Supervisor Report (ESR)

3.3. Clinical Syllabus

The RCEM curriculum, being outcome based, is structured around the things that a trained EM specialist needs to be able to do. Underpinning these actions is the clinical knowledge that informs them.

The breadth of that clinical knowledge is described below in the Clinical Syllabus. It defines the scope of presentations or clinical conditions that an EM clinician may encounter in the work place, and therefore need to know about. These lists are to be used to give a context to the Programme of Learning that supports the delivery of the curriculum. Trainees are expected to develop their knowledge base in each of these presentations or conditions. This might be done in formal teaching, self-directed learning and use of on-line resources.

They will be the context for the formal RCEM examinations and learners will be expected to know about relevant basic sciences as well as relevant epidemiology, differential diagnoses, investigation and management of these conditions.

Key: **Paediatric specific presentations and conditions**

System/ specialty	Clinical presentations	Conditions/ issues
Resus	RP1. Acute airway obstruction RP2. Anaphylaxis/Anaphylactoid reaction RP3. Cardiorespiratory arrest RP4. Major Trauma RP5. Respiratory failure RP6. Sepsis RP7. Shock RP8. Unconsciousness	RC1. Choking RC2. Stridor RC3. Organ donation **RC4. BRUE** **RC5. SUDIC Protocol**
Allergy	AP1. Acute allergy AP2. Anaphylactoid reactions AP3. Angioedema AP4. Urticaria	AC1. Drug allergy
Cardiology	CP1. Chest pain CP2. Breathlessness CP3. Palpitations CP4. Transient Loss of Consciousness	CC1. Acute Coronary Syndromes CC2. Myocardial infarction CC3. Arrhythmias CC4. Cardiac failure CC5. Cardiac tamponade CC6. Congenital heart disease CC7. Diseases of the arteries, including aortic dissection CC8. Diseases of myocardium CC9. Hypertensive emergencies CC10. Pacemaker function & failure CC11. Pericardial disease CC12. Sudden Cardiac Death CC13. Valvular heart disease
Dermatology	DP1. Dermatological manifestations of systemic illness DP2. Rashes	**DC1. Common childhood exanthems** DC2. Cutaneous drug reactions DC3. Eczema DC4. Erythroderma DC5. Infections of skin and soft tissues DC6. Necrotising Fasciitis DC7. Pressure ulcers DC8. Purpuric rash including **Henoch Scholein Purpura** DC9. Stevens-Johnson syndrome DC10. Toxic-epidermal necrolysis DC11. Urticaria

Ear, nose and throat	EP1. ENT foreign bodies EP2. ENT injuries EP3. Epistaxis EP4. Hearing loss EP5. Painful ear EP6. Sore throat EP7. Vertigo	**EC1. Croup** EC2. Epiglottitis EC3. Glandular Fever EC4. LMN facial nerve palsy EC5. Meniere's disease EC6. Nasal fractures EC7. Otitis externa EC8. Otitis media EC9. Pharyngitis **EC10. Post-tonsillectomy bleed** EC11. Tonsillitis EC12. Tracheostomy emergencies EC13. Quinsy EC14. Salivary gland disease EC15. Vestibular neuritis
Elderly care	EIP1. Delirium EIP2. Deterioration in mobility EIP3. Falls EIP4. Fragility fractures EIP5. Frailty EIP6. Hypothermia EIP7. Incontinence EIP8. Increasing care needs EIP9. Memory loss EIP10. Unsteadiness / balance disturbance	EIC1. Comprehensive geriatric assessment EIC2. Acute confusion EIC3. Ceiling of care & End of life care EIC4. Dementia – cognitive impairment EIC5. Fragility fractures EIC6. Mobility EIC7. Osteoporosis EIC8. Pharmacology considerations in the older patient
Endocrinology	EnP1. Addisonian Crisis EnP2. Hyperglycaemia EnP3. Hypoglycaemia	EnC1. Adrenal disorders EnC2. Diabetic ketoacidosis EnC3. Diabetes mellitus & complications including diabetic foot EnC4. Hyperosmolar hyperglycaemic state EnC5. Pituitary disorders EnC6. Thyroid emergencies

Environmental emergencies:		EnvC1. Heat stroke and heat exhaustion EnvC2. Drug-related hyperthermias EnvC3. Hypothermia and frost bite EnvC4. Decompression sickness EnvC5. Near-drowning EnvC6. Radiation exposure and safety EnvC7. Industrial chemical incidents EnvC8. Bites and envenomations typical for the UK EnvC9. High altitude emergencies - cerebral and pulmonary oedema EnvC10. Acid attacks
Gastroenterology and hepatology	GP1. Abdominal and loin pain GP2. Abdominal swelling or mass GP3. Ascites GP4. Constipation GP5. Diarrhoea GP6. Haematemesis and melaena GP7. Jaundice GP8. Anal pain and rectal bleeding GP9. Nausea and vomiting GP10. Dysphagia	GC1. Alcohol related liver disease including withdrawal GC2. Decompensated cirrhosis **GC3. Dehydration in children** GC4. Functional bowel disorders GC5. Gastrointestinal infections GC6. Hepatitis GC7. Inflammatory bowel disease GC8. Peptic ulcer disease **GC9. Pyloric stenosis**
Haematology	HP1. Anaemia HP2. Bruising and spontaneous bleeding HP3. Massive haemorrhage	HC1. Anti-coagulant reversal HC2. DIC HC3. Haemophilia HC4. ITP HC5. Leukaemia HC6. Lymphoma HC7. Marrow failure HC8. Sickle cell disease/crisis HC9. Transfusion reactions
Infectious diseases	IP1. Fever IP2. Pyrexia in travellers IP3. Sepsis IP4. Needlestick injury/exposure to blood borne viruses	IC1. Influenza IC2. Infection in immunocompromised patients IC3. Infestations **IC4. Kawasaki Disease** IC5. Notifiable diseases IC6. Pyrexia of Unknown origin – different age groups IC7. Malaria IC8. HIV infection

Maxillofacial/dental	MaP1. Dental pain MaP2. Facial swelling MaP3. Avulsed or fractured teeth MaP4. Facial bone injury	MaC1. Dental abscess MaC2. Facial wounds MaC3. Post extraction complications MaC4. TMJ dislocation
Mental Health	MHP1. Aggressive or disturbed behaviour MHP2. Anxiety/Panic MHP3. Physical symptoms unexplained by organic disease MHP4. Self-harm MHP5. Refusal of treatment	MHC1. Alcohol and substance misuse MHC2. Depression MHC3. Eating disorders MHC4. Personality disorders MHC5. Acute Psychosis including bipolar, schizophrenia MHC6. Somatic symptom disorders MHC7. Stress disorders MHC8. Suicide
Musculoskeletal (non-traumatic)	MuP1. Acute back pain MuP2. Limb pain and swelling MuP3. Neck pain MuP4. Joint swelling MuP5. Acute hot swollen joint	MuC1. Cauda equina syndrome MuC2. Crystal related arthropathies MuC3. Septic arthritis MuC4. Limb pain and swelling: bursitis & tendonitis in the upper and lower limb including ruptured biceps, Achilles tendonitis, plantar fasciitis, metatarsalgia, carpal tunnel and other entrapment neuropathies plus sinister causes bone tumour, stress fracture MuC5. Spinal pain and radiculopathy MuC6. Risks of rheumatological disease modifying drugs MuC7. Spinal infections **MuC8. Torticollis** **MuC9. Limping child** **MuC10. Osteochondritis**
Neonatal Emergencies		**NeoC1. Delivery and resuscitation of the newborn** **NeoC2. Neonatal sepsis** **NeoC3. Cyanotic/ non-cyanotic congenital heart disease** **NeoC4. Jaundice** **NeoC5. Feeding patterns**

Nephrology	NepP1. Electrolyte disorders NepP2. Oliguria	NepC1. Acute kidney injury NepC2. Drugs and the kidney NepC3. Electrolyte disorders NepC4. Fluid balance disorders NepC5. Renal replacement therapy
Neurology	NeuP1. Acute Confusion NeuP2. Headache NeuP3. Seizures/status epilepticus NeuP4. Speech disturbance NeuP5. Hemiparesis/hemiplegia NeuP6. Gait abnormality NeuP7. Visual disturbance NeuP8. Weakness/paralysis NeuP9. Dizziness and vertigo	NeuC1. Botulism NeuC2. Cerebral venous sinus thrombosis **NeuC3. Febrile Convulsion** NeuC4. Functional illness NeuC5. Guillian-Barre NeuC6. Meningitis and encephalitis NeuC7. Multiple sclerosis NeuC8. Myasthenia gravis NeuC9. Parkinson's disease and other movement disorders, epileptic and non-epileptic NeuC10. Peripheral neuropathy (acute) NeuC11. Subarachnoid haemorrhage NeuC12. Stroke & TIA NeuC13. Tetanus NeuC14. Tumours involving the brain and spinal cord NeuC15. VP Shunts NeuC16. Wernicke's Encephalopathy

Obstetrics & Gynaecology	ObP1. Pelvic pain ObP2. Vaginal bleeding ObP3. Pregnancy ObP4. Genital injury/Assault ObP5. Vaginal discharge ObP6. Foreign bodies ObP7. Patient in labour	ObC1. Ante-partum haemorrhage ObC2. Bleeding in early pregnancy ObC3. Exposure to infections during pregnancy eg chickenpox ObC4. Ectopic pregnancy ObC5. Genital injury /Female Genital Mutilation ObC6. HELLP ObC7. Heavy menstrual bleeding ObC8. Hyperemesis Gravidaram ObC9. Maternal Collapse ObC10. Post-partum haemorrhage ObC11. Pre-eclampsia/ eclampsia ObC12. Pelvic infection ObC13. Post menopausal bleeding ObC14. Prescribing in pregnancy ObC15. Rhesus D prophylaxis ObC16. Sepsis in and following pregnancy ObC17. Thrombosis during and following pregnancy ObC18. Trauma in pregnancy ObC19. OHSS
Oncological Emergencies	OncP1. Acute presentations of undiagnosed cancer that may present to the ED (including weight loss, dysphagia, pain etc)	OncC1. Complications related to local tumour progression e.g. acute cord compression, upper airway obstruction, pericardial and pleural effusions, SVC compression syndrome, raised intracranial pressure OncC2. Complications relating to cancer treatment including - neutropenic sepsis, anaemia and thrombocytopenia and immunotherapy OncC3. Biochemical complications of malignancy- hypercalcaemia, SIADH, adrenocortical insufficiency

Ophthalmology	OptP1. Diplopia OptP2. Eye trauma including foreign bodies OptP3. Painful eye OptP4. Red eye OptP5. Sudden visual loss	OptC1. Acute glaucoma OptC2. Cranial nerve palsy OptC3. Orbital & per-orbital preseptal or peri-orbital cellulitis **OptC4. Ophthalmia neonatorum** OptC5. Inflammatory eye disease OptC6. Temporal arteritis
Pain & sedation		PC1. Analgesics PC2. Non-pharmacological methods of pain management PC3. Pain assessment PC4. Sedation
Palliative and end of life care	PalP1. Advanced malignancy and end stage chronic disease	PalC1. Advanced care planning PalC2. Anticipatory medications PalC3. End stage organ failure PalC4. Pain management PalC5. Physical symptoms other than pain PalC6. Psychosocial concerns including spiritual care and care of the family PalC7. The dying patient
Pharmacology and poisoning	PhP1. Medication side effects/interactions PhP2. Overdose PhP3. Accidental Poisoning	PhC1. Overdose of prescription and non-prescription medications including legal and non-legal drugs PhC2. Poisoning – carbon monoxide, cyanide, organo-phosphate PhC3. Toxidromes PhC4. Use of antidotes PhC5. Batteries, household chemicals, poisonous plants
Respiratory	ResP1. Chest pain ResP2. Breathlessness ResP3. Haemoptysis ResP4. Cough	ResC1. Asthma **ResC2. Bronchiolitis** ResC3. COPD ResC4. Foreign body inhalation ResC5. Pertussis ResC6. Pleural effusion ResC7. Pneumonia ResC8. Pneumothorax ResC9. Pulmonary Aspiration ResC10. Pulmonary embolus **ResC11. Viral induced wheeze in children**

Sexual health	SeP1. Genital discharge SeP2. Genital lesions SeP3. Emergency contraception SeP4. Post-exposure prophylaxis	SeC2. Sexual assault SeC3. Sexually transmitted infections
Surgical emergencies	SuP1. Abdominal pain SuP2. Abdominal swelling/mass SuP3. Constipation SuP4. Diarrhoea SuP5. GI bleeding SuP6. Anal/rectal pain SuP7. Nausea/vomiting	SuC1. Ano-rectal abscesses SuC2. Appendicitis SuC3. Bilary colic SuC4. Bowel obstruction SuC5. Breast abscess SuC6. Cholangitis SuC7. Cholecystitis SuC8. Diverticular disease SuC9. Haemorrhoid disease SuC10. Hernias **SuC11. Intussusception** SuC12. Ischaemic Bowel SuC13. Lower gastrointestinal and rectal bleeding SuC14. Pancreatitis SuC15. Viscus perforation SuC16. Volvulus
Trauma	TP1. Head injury TP2. Spinal injury TP3. Chest and lung injury TP4. Major vascular injury TP5. Abdominal injury TP6. Pelvic injury TP7. Limb and joint injury TP8. Burns TP9. Inhalational injury TP10. Wounds	TC1. Compartment syndrome TC2. Limb and joint injury including bony, musculo-tendinous and complications TC3. Electrical burns TC4. Salter- Harris classification TC5. Infection - paronychia, pulp space, flexor sheath nail bed, amputations etc. TC6. Animal bites including human TC7. Injury to bladder, urethra, testes or penis
Urology	UP1. Dysuria UP2. Injury to bladder, urethra, testes or penis UP3. Urinary retention UP4. Testicular pain/swelling UP5. Loin pain UP6. Haematuria	UC1. Epididymo-orchitis UC2. Renal stone disease UC3. Phimosis/Paraphimosis UC4. Priapism UC5. Testicular torsion UC6. Prosatatis UC7. UTI/Pyelonephritis
Vascular		VC1. Acute limb ischaemia VC2. Aortic aneurysmal disease VC3. DVT
Other clinical presentations		XC1. Major Incident Management XC2. PHEM XC3. Safeguarding in adults XC4. Domestic abuse

Safeguarding & Psycho-social emergencies in children	SaP1. Self-harm in children and adolescents SaP2. Concerning presentation	SaC1. Conditions presenting as a symptom of NAI or psychological distress, e.g. deliberate self-harm, aggression or risk-taking behaviour, recurrent abdominal pain, headaches or faints, recurrent attendances in young children. SaC2. Roles of other systems in protecting children, e.g. Social Services, the Child Protection Plan, Police Child Protection and Domestic Violence Units, SureStart, Childline, Health Visitors, School Nurses SaC3. Mental illness in childhood including depression, anxiety, OCD, bipolar and schizophrenia SaC4. Sexual abuse

4. Programme of learning

4.1. Learning and Teaching

The organisation and delivery of postgraduate training is the responsibility of Health Education England (HEE) and its Local Education and Training Boards (LETBs), NHS Education for Scotland (NES), the HEIW and the Northern Ireland Medical and Dental Training Agency (NIMDTA). A Training Programme Director will be responsible for coordinating the ACCS and EM training programmes.

Progression through the RCEM curriculum will be determined by the ARCP process and the training requirements for each indicative year of training are summarised in the ARCP decision aid (available on the RCEM Website) Appendix 2. The successful completion of EM training will be dependent on achieving the expected standard in all SLOs. The Programme of Assessment will be used to monitor and determine progress.

The sequence of training in ACCS is flexible and will be determined locally on an individual basis: the trainees can do the indicative six-month attachments in any order.

Each trainee will be assigned a GMC approved clinical supervisor for each six-month ACCS specialty placement: this will be a consultant in an acute specialty. Where possible, trainees have an overall educational supervisor for the duration of the ACCS generic training programme, who will provide pastoral and educational support across the two years.

In EM training there will be a GMC approved Educational Supervisor and a GMC approved Clinical Supervisor in each placement if the Educational Supervisor is based elsewhere.

4.2. The training environment

This curriculum should be used to help design training programmes locally that ensure all EM trainees can develop their skills in a variety of settings and situations. It is designed to ensure that it can be applied in a flexible manner, meeting service needs as well as supporting each individual doctor- in-training's learning and development plan. The requirements for the provision of training have not changed as a result of this new curriculum. All training must comply with the GMC requirements presented in Promoting excellence: standards for medical education and training (2017). This stipulates that all training must comply with the following ten standards:

Theme 1: Learning environment and culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.

S1.2 The learning environment and organisational culture value and support education and training, so that learners are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.

Theme 2: Educational governance and leadership

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability and responding when standards are not being met.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training.

S2.3 The educational governance system makes sure that education and training is fair and is based on the principles of equality and diversity.

Theme 3: Supporting learners

S3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in Good Medical Practice, and to achieve the learning outcomes required by their curriculum.

Theme 4: Supporting educators

S4.1 Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities.

Theme 5: Developing and implementing curricula and assessments

S5.1 Medical school curricula and assessments are developed and implemented so that medical students are able to achieve the learning outcomes required for graduates.

S5.2 Postgraduate curricula and assessments are developed and implemented so that doctors in training are able to demonstrate what is expected in Good Medical Practice, and to achieve the learning outcomes required by their curriculum.

It is the responsibility of HEE and its local offices, NES, HEIW, and NIMDTA to ensure compliance with these standards for specialty training, and to notify RCEM if further support is required in achieving this. Training delivery must also comply with the requirements of the latest edition of the COPMeD's 'Gold Guide'.

4.3. Teaching and learning methods

ACCS

The ACCS related specialties are practical, craft specialties and much of the education and training is acquired through experiential learning and reflective practice with trainers. A variety of learning experiences enable the achievement of the learning outcomes. There will be a balance of different learning methods from formal teaching programmes to experiential learning 'on the job'. The proportion of time allocated to each method may vary depending on the nature of the attachment within a rotation, which should be constructed to enable the doctors-in-training to experience the full range of educational and training opportunities.

Intermediate & Higher Training

In intermediate training there is a requirement that trainees have experience of all aspects of the ED, including paediatric EM, minor illness and injury, major trauma and resuscitation, as well as experience of taking leadership role in individual cases, areas of the ED and eventually the whole ED. Training rotations need to ensure this breadth of experience is available during training

4.3.1. Practice-based experiential learning

ACCS

ACCS specialty training is largely experiential in nature with any interaction in the work place having the potential to become a learning episode. The work place provides learning opportunities on a daily basis for ACCS doctors-in-training and the programme of placements is decided by the local faculty for education within a location. The nature of

ACCS training in four closely related specialties provides opportunities to work in a variety of settings: the ED 'shop floor', on the acute medical admissions unit, the critical care unit and in theatres. It is essential that trainees spend an appropriate amount of time in each of these areas to meet their training needs and those of the programme.

Clinical experience should be used as an opportunity to undertake WPBAs and reflection. Every patient seen, in ED, in theatre, on ICU or in assessment unit/ acute medical ward provides a learning opportunity which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems. Every time a trainee observes another doctor seeing a patient or their relatives there is an opportunity for learning. Ward rounds (including post-take) should be led by a more senior doctor and include feedback on clinical and decision-making skills.

To ensure patient safety, ACCS doctors in training new to each specialty must, at all times, be appropriately supervised for their level of competence and entrustment. Trainees will need direct supervision for considerable periods in the ACCS programme: during the anaesthesia placement trainees require direct supervision until they have passed the IAC. These concentrated periods of supervision are essential to ensure that these trainees complete all the required learning outcomes in a very full programme.

It is important to ensure that supervised sessions have relevance to the ACCS curriculum and training that individual doctors are undertaking at the time; the concept of a balanced programme of training is essential.

Intermediate training

Intermediate training is geared to preparation for the responsibilities of higher training. Trainees must therefore be supported to take responsibility in the resuscitation room, including the leadership of resuscitation teams under supervision. Feedback and reflection on grey cases or where there is significant challenge are particularly helpful as the Intermediate Trainee is readied for Higher Training. Intermediate trainees should also be trained to provide support to the team, with direct feedback, such as at departmental board rounds as they begin to develop the skills of oversight and the human factors that are key to shift leadership.

Higher Training

In Higher Training experiential learning must continue to include development in all areas of the ED. It is important that trainees continue to receive feedback on resuscitation cases, including a growing responsibility for challenging cases and development as team leaders, in paediatric and adult emergency care. Experiential learning also includes the Supporting SLOs, and experience of presenting, active participation in quality improvement meetings and preparation for representing the specialty to others will be required.

4.3.2.Independent self-directed learning

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

- RCEMLearning- there is content mapped to all of the Clinical Syllabus and SLOs and maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects

- achieving personal learning goals beyond the essential, core curriculum.

4.3.3. Learning with peers

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

4.3.4. Formal postgraduate teaching

The content of formal postgraduate education sessions and access to other more formal learning opportunities are determined by the local faculty responsible for EM education and will be based on the RCEM curriculum. There are many opportunities throughout the year for formal teaching locally and at regional, national and international meetings.

Where appropriate formal teaching and meetings should include the multi-professional team. Access should also be provided to key meetings within the service. Suggested activities include:

- a programme of formal 'bleep-free' regular teaching sessions
- attendance and presentation at mortality and morbidity meetings
- case presentations
- research, audit and quality improvement projects
- attendance and presentation at governance and risk meetings
- lectures and small group teaching
- clinical skills demonstrations and teaching
- critical appraisal and evidence-based medicine and journal clubs
- joint specialty and multi-professional meetings
- attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.

4.3.5. Simulation training

Procedural competency training, using simulation aimed at achieving technical competence for certain procedures should be provided as early as possible in in ACCS training and continue through all 3 stages of training. Scenario-based immersive simulation training is expected to be undertaken in in all relevant Specialty Learning Outcomes, with human factors incorporated into the scenarios where appropriate.

Examples of simulation courses that should be used to deliver aspects of the curriculum include, but are not limited to:

ACCS

- Novice Anaesthesia Skills and Drills
- Assessment of failed intubation drill
- Vascular access
- Human factors
- Critical thinking

***Intermediate and Higher* Training**

- Paediatric sedation
- Procedural skills- including emergency thoracotomy; emergency caesarean section, surgical airway
- Resuscitation team leadership
- Dealing with challenging situations in the work place
- Human factors
- Critical thinking

4.3.6. Formal study courses

Time to be made available for formal courses is encouraged, subject to local conditions of service, in line with local study leave policy.

4.3.7. Protected time for Trainee Development

ACCS

To facilitate the acquisition of the essential generic capabilities required for safe, effective and high quality medical care as prescribed by the GMC GPC framework, and to recognise the contribution doctors in training make outside of the clinical setting, the ICACCST recommends that local Schools of ACCS consider mechanisms to enable and encourage trainee involvement in research, audit and quality improvement, as well as allowing time for them to work on publications and presentations and participate in teaching and aspects of hospital management. One way to do so is to allow 'Supporting Professional Activities' (SPA) time to help the development of these important skills and recommended that all ACCS doctors in training receive this, although the amount of time required may vary throughout the training programme.

Intermediate and Higher Training

The curriculum for intermediate and higher training includes the requirement to develop in the four supporting SLOs. The expectation on trainees, as outlined in the ARCP guidance, is that they are proficient in the key skills in these areas. To gain this experience it is recommended that full time trainees receive the equivalent of half a day a week, to be put towards curricular activities within their own departments. For less than full time trainees this would be pro-rata.

In higher training there is a requirement for trainees to take more responsibility and contribute to the ED in the Supporting SLOs as senior members of the team. There is a greater requirement for experiential learning of these aspects of EM work compared to intermediate training. It is therefore recommended that full time trainees in Higher Training receive the equivalent of a day a week.

This time, in both intermediate and higher training would also be used to cover the broader aspects of the new curriculum including but not limited to:

- attendance at handovers
- local departmental/ shop-floor " bedside" teaching/ in situ simulation - (as educator role or as learner)
- critical appraisal activity i.e. journal clubs (either as educator or learner)

- quality improvement projects
- maintenance of critical care and procedural skills - anaesthesia/ ICM/ respiratory
- development as educator or learner of Ultrasound skills
- development of management portfolio- e.g. complaints, serious incident investigation, training or governance meetings etc
- to ensure coverage of broader skills within EM e.g. normal delivery, ophthalmology/ ENT/ fracture clinics

There should be a timetabled log of activity and skills recorded and uploaded to the ePortfolio to be reviewed by educational/ clinical supervisor at every quarterly meeting. Areas for development should be detailed in the trainee's personal development plan and progress monitored. It is expected that this time will be spent in the Emergency Department unless there is prior agreement with the ES/CS.

4.3.8. Academic Training

Trainees may train in ACCS specialties as an academic clinical fellow (ACF) or equivalent. Academic trainees may be recruited during ACCS training - i.e. at CT1 or CT2.

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

5. The Programme of Assessment

5.1. The purpose of assessment

The purposes of the RCEM Programme of Assessment fall into three broad categories:

Assurance:

- demonstrate trainees have acquired the Generic Professional Capabilities and meet the requirements of Good Medical Practice
- ensure that trainees possess the essential underlying knowledge required for their specialty
- provide robust, summative evidence that trainees are meeting the curriculum standards during the training programme

Regulating progression & targeting remediation:

- assess trainees' actual performance in the work place
- inform the ARCP, identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme
- identify performance concerns and ultimately trainees who should be advised to consider changes of career direction

Fostering self-regulated learners:

- enhance learning by providing formative assessment, enabling trainees to receive immediate feedback, understand their own performance and identify areas for development
- drive learning and enhance the training process by making it clear what is required of trainees and motivating them to ensure they receive suitable training and experience
- To identify and encourage excellence

The purposes above have driven the design of the RCEM assessment strategy from start to finish. We have sought to define a fully integrated and complementary programme of assessment that recognises the strengths and limitations of its constituent parts to deliver a programme as a whole. The programme of assessment is made up of three major elements.

1. A suite of formal RCEM examinations
2. A programme of work place based assessments (WPBAs)
3. A programme of regular, panel-based, information-rich, individualised judgements that regulate each trainee's progression and remediation (where necessary).

Formal examinations

The formal RCEM examinations prioritise **assurance** for all stakeholders including trainees. Consequently, the design focus is on reliability and a nationally consistent hurdle with transparent standards. The suite of examinations provides assurance that a standard of knowledge and basic technique has been demonstrated by the trainee. The MRCEM, in particular, aims to assess not only the attainment of learning, but also the potential to develop and thrive as an independent leader and practitioner following training.

Work Place Based Assessments (WPBAs)

The WPBA is designed to foster **self-regulated learners** and to provide the all-important information that will **regulate trainees' progression** through the programme.

WPBA provides a structure for observing the individualised and contextualised application of learning. By providing feedback and encouraging reflection it also helps trainees develop self-regulated learning skills. The transparent links between the WPBA judgements, the entrustability judgements made by Faculty Educational Governance panels, and the levels of independence expected at each of the thresholds are critical for orienting learners to what is expected of them; this gives them both the stimulus and the data that they need to regulate their own learning.

Despite compromises in reliability, WPBA offers a better prediction of day-to-day performance than formal examinations with all the complexity that EM work includes. In particular, the RCEM instruments have been designed to make it easy for supervisors and others to flag up concerns about any given trainee. Conventional WPBA questions allow clear concerns to remain unshared, and this would create problems both for patients, trainees and services.

The WPBA programme is designed to be used throughout training, and so offers the opportunity for pertinent developmental feedback and the highlighting of concerns at regular intervals through training when there is a chance to define plans to support learning.

Panel-based judgements

FEG statements work with the ARCP process to provide regular, panel-based, information-rich, individualised judgements that regulate each trainee's progression and remediation (where necessary). Like the WPBA programme, they are designed to foster **self-regulated learners** and to **regulate trainees' progression** through the programme. The faculty will consider the trainee's work place performance and provide a summative recommendation about whether a trainee has met the standard in the SLOs relevant to their stage of training. This information is combined with other evidence in an Educational Supervisor Report (ESR) that is completed by the trainee's Educational Supervisor at the end of a block of training. This, in turn, is reviewed by the ARCP panel who will make a decision regarding progression.

These elements are phased, reflecting the growing knowledge and experience of trainees. At key thresholds in training the work place based assessment and RCEM examinations are co-ordinated to enable ARCP panels to adjudge readiness to cross a threshold in training. This approach acknowledges the complementary nature of the component parts of the assessment programme.

The flow of information in the new programme of assessment is shown in Figure 1.

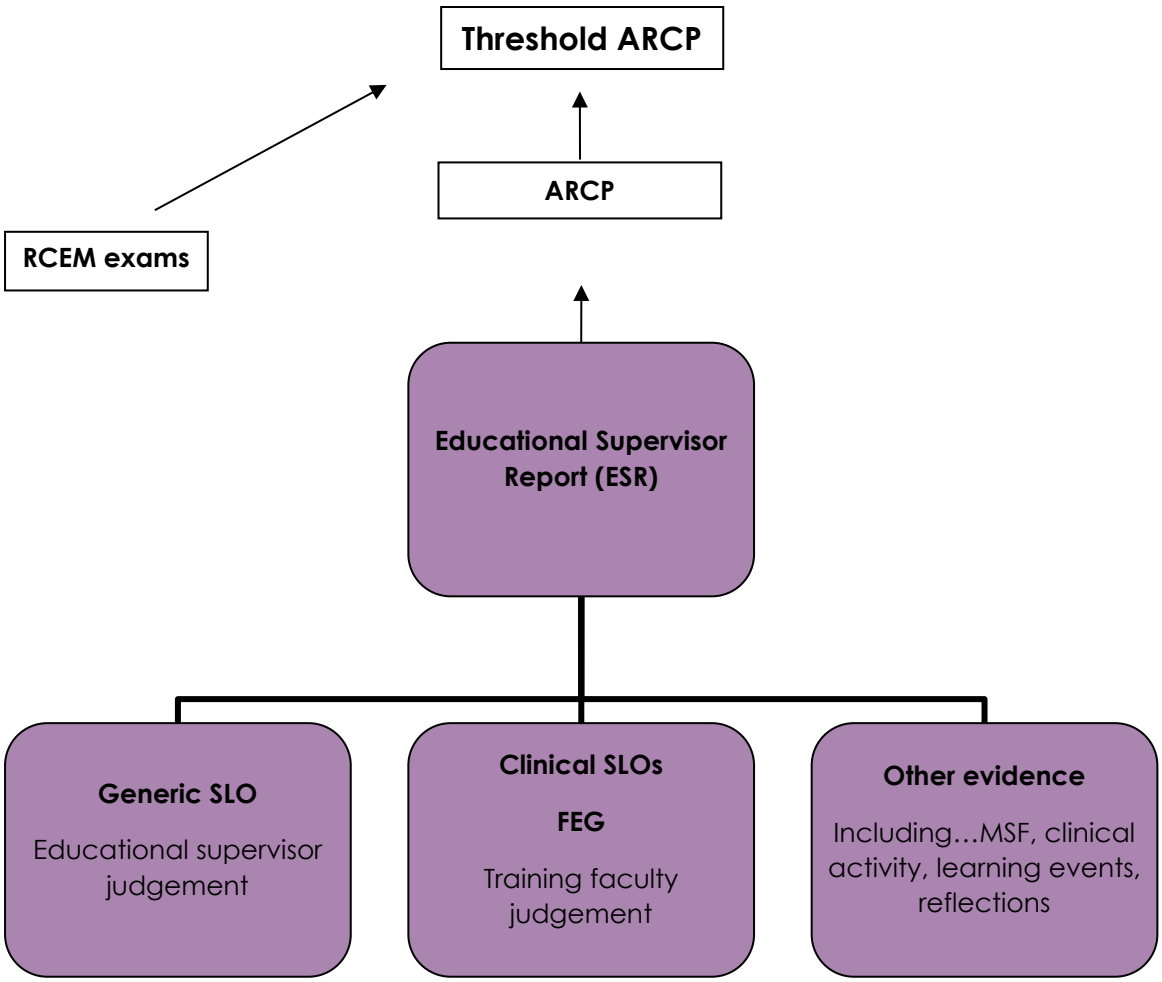
a. The Training Faculty will deliver a summative recommendation on each of the **Clinical SLOs** that are relevant to the trainee's stage of training, i.e. have they met the standard for entrustment. This is summarised within a FEG Statement.

b. The Educational Supervisor reviews the evidence collated for each of the **Generic/ Supporting SLOs** and offers a judgement on progress in these. A matrix providing guidance for Educational Supervisors in these SLOs is available. (Appendix 2 below)

c. The Educational Supervisor also reviews WPBAs, Multi-Source Feedback and other relevant data, such as case load, critical incidents, reflections, log books and considers and offers insight on flags of concern. This allows for an integrated and individualised collation of diverse evidence.

These three elements form the basis of the Educational Supervisor's ESR. This, in turn, is reviewed by the ARCP panel. The panel will have access to all the relevant source material and will be able to provide oversight and ensure a nationally consistent approach and standard. The ARCP panel will make the final summative decision about progression. When an ARCP occurs at a threshold in training (Threshold ARCP), the data held within the Educational Supervisor's report will be combined with RCEM examination data to arbitrate on whether a trainee can cross the threshold, either into Higher Training, or to complete.

Figure 1. Information flow in RCEM Programme of Assessment



5.2. The RCEM assessment blueprint

The blueprint maps the Programme of Assessment to the curriculum (table 3). It shows that each of the SLOs is assessed in a number of ways.

The SLOs provide the structure for the formal RCEM examinations. The RCEM examinations are also tagged to the RCEM Clinical Syllabus. In essence, anything that is in the Clinical Syllabus can appear in the formal examinations, and each of the relevant SLOs will be tested.

For the WPBA programme, it is not necessary to use each of the tools shown in the blueprint table for each of the SLOs. These are examples of tools that might be used to provide evidence of learning in each of these. The 'summative' element of the WPBA programme is the entrustment decision for the Clinical SLOs and the Educational Supervisor's review of the Generic/Supporting SLOs.

Although we have moved away from a tick list, it is important for the trainee to show their development as a self-regulating learner by recording and reflecting on evidence in each of the **Key Capabilities** in the relevant SLOs relevant to their stage of training throughout each training attachment, from start to finish. Engagement in training is very important and a marker of a trainee who is seeking to develop beyond their current capabilities and is a key principle that underpins the ethos of assessment in the work place.

Table 3. RCEM assessment blueprint

	Specialty Learning outcome	MRCEM Primary	MRCEM Intermediate	MRCEM OSCE	FRCEM Final SBA	FRCEM Final OSCE	Faculty Educational Governance (FEG) statement	Educational Supervisor Report ESR	MSF	ELSE	CBD	Mini CEX	DOPS	Portfolio (incl. logbook, RCEMLearning, ACCS/RCEM App, reflection, management portfolio, research, QI)	QIAT	ACAF	Teaching assessment tool
1	Complex stable patient	*	*	*	*	*	*		*	*	*	*		*			
2	Answering questions			*	*	*	*		*	*	*	*		*			
3	Resus	*	*	*	*	*	*		*	*	*	*		*			
4	Injured patient	*	*	*	*	*	*		*	*	*	*		*			
5	PEM	*	*	*	*	*	*		*	*	*	*		*			
6	Procedural skills		*	*	*	(*)	*			*			*	*			

7	Complex & challenging situations				*	*	*			*	*	*		*			
8	EPIC				*	*	*		*	*				*			
9	Educate and Supervise			*		*		*	*	*				*			*
10	Research	*			*	(*)		*	*					*		*	
11	Patient safety & QI				*	(*)		*	*					*	*		
12	Lead, manage & administer				*	*		*	*					*			
	Basic sciences syllabus	*															

Key	Exams	Summative	All formative

5.3. RCEM Examinations

The RCEM examinations are an integral part of RCEM's programme of assessment. They provide trainees with the opportunity to demonstrate, at critical progression points, the required outcomes of their training programme. The RCEM exams comprise a programme of summative assessments in two parts: Membership of the Royal College of Emergency Medicine (MRCEM) and Fellowship of the Royal College of Emergency Medicine (FRCEM) examinations. Each part uses validated assessment methods to test a broad-spectrum of knowledge, understanding, skills, behaviours and attitudes, as defined by the RCEM curriculum.

The **MRCEM examination** consists of three components: Two Single Best Answer (SBA) multiple-choice papers and an Objective Structured Clinical Examination (OSCE). All MRCEM components are blueprinted to the RCEM curriculum - focussing on SLOs 1-7 and 9. Questions used in each component are tagged to the RCEM basic science and clinical syllabi. The SLOs and the capabilities relevant to each SLO are set out in the assessment blueprint. Successful completion of all three Primary exam components is required to complete intermediate training as part of a programme of assessment designed to ensure readiness for Higher Training.

The **FRCEM examination** consists of two components: A Single Best Answer (SBA) test of knowledge, and a Multi Station Oral (MSO) exam. The examinations used in the FRCEM are blueprinted to SLOs 1-12. The questions used in the FRCEM examinations are also tagged to the RCEM Clinical Syllabus. The SLO and the relevant capabilities are set out in the assessment blueprint. Successful completion of the FRCEM examination is the part of the Programme of Assessment that signifies readiness for independent practice at completion of training.

5.3.1. The MRCEM examinations:

MRCEM Primary - Single Best Answer paper. This examination samples the basic science syllabus, ensuring a sound background knowledge in the basic science underpinning EM care. It can be undertaken at any point post registration as a medical practitioner. It comprises 180 questions to be answered in three hours.

MRCEM Intermediate - Single Best Answer paper. This examination samples the clinical syllabus and ensures a sound understanding of the full range of conditions and presentations that may present to the ED. The exam samples how the trainee synthesises and interprets data and clinical findings to make decisions and inform management plans. It It comprises 180 questions, four hours testing time sat in two papers on the same day.

MRCEM OSCE - OSCE. This examination objectively samples the clinical skills of trainees and ensures they are those of someone ready for Higher Training. It includes history taking, examination, communication, decision making, dealing with challenging situations and resuscitation scenarios, using medium fidelity simulation. There are 16 stations blueprinted to SLOs 1-7 and 9 and to the RCEM Clinical Syllabus.

The purpose of the MRCEM examinations

The MRCEM Primary ensures a high standard of knowledge of basic sciences relevant to EM at the outset of training. It functions at the base of Bloom's revised taxonomy, remembering and understanding. It is an examination that can be sat during foundation training and doesn't require clinical experience to complete.

The MRCEM Intermediate examination tests whether the trainee can integrate and synthesise information. It functions at the levels of understanding and applying in Blooms revised taxonomy. This examination does require a measure of clinical experience, and is designed and timed to build on the Primary.

Together these examinations ensure a thorough grounding in clinical knowledge and the ability to interpret and utilise clinical information and diagnostic results to develop safe and effective management decisions – a fundamental requirement for higher specialist training.

The MRCEM OSCE is a summative assessment of a candidate's clinical and communication skills, applied technical knowledge of equipment, time management, and decision making under time pressure. It uses a simulated clinical environment, including communication with simulated patients. The MRCEM OSCE functions at the applying and analysing levels of Bloom's revised taxonomy. A successful candidate will have demonstrated the clinical skills and applied technical knowledge across multiple clinical scenarios required of a clinician entering HST.

Candidates must pass all parts to be awarded MRCEM. They are designed to complement one another. The primary purpose of the OSCE is to ensure that trainees are ready to be safe practitioners during HST. The additional purpose of the Primary and the Intermediate is to ensure that they have foundations in place that will give them the potential to develop, in time, into independent and able leaders with the ability to work beyond protocols to solve unforeseen problems at the end of HST.

5.3.2.The FRCEM Examinations

FRCEM SBA

This is a Single Best Answer (SBA) paper. This examination is blueprinted to the advanced clinical elements within the SLOs and the RCEM Clinical Syllabus. In addition to specific knowledge-based competences, examination material may be developed from guidance or recommendations published by healthcare organisations such as the RCEM, NCEPOD, NICE, SIGN, NPSA, etc. The public expects doctors to keep up to date with important developments and such material may be examined under the collective umbrella of 'professionalism'. This paper can be sat from the start of ST5. It comprises 180 questions, four hours testing time sat in two papers on the same day.

The purpose of the FRCEM SBA

The FRCEM SBA examination is a summative assessment, blueprinted to all 12 RCEM SLOs. The exam assesses the knowledge required of a trainee readying for independent practice. It tests factual knowledge and understanding and the ability to prioritise information.

FRCEM OSCE exam

Face-to-face, multi station examination. This examination is blueprinted to the complex or challenging situations an EM clinician will face, including the requirements of leadership and support within the ED. These are found in SLOs 3, 7-12. It will consist of 16 stations. It will involve simulation using simulated patients and medium fidelity simulation equipment. A key feature of this assessment is structured viva exploring decision-making and data analysis. It is geared towards 'evaluating and analysing' in Bloom's Revised Taxonomy . Here we are more concerned with the trainee's reasoning than with whether they simply reach a reasonable conclusion or undertake an appropriate action. Reflection-in-action may be a more reliable predictor of future performance than an appropriate response to a single

challenge[3]. The examination consists of 16 stations with one examiner per station. This examination can be sat from the start of ST5.

The purpose of the FRCEM OSCE

The FRCEM OSCE is a summative assessment of a candidate's knowledge, understanding and decision-making abilities in EM and the applied clinical science underpinning it. It is also blueprinted to key elements of consultant practice within the curriculum, such as supporting other team members on the floor in the role as Emergency Physician in Charge, dealing with uncertainty and challenging emergent situations and understanding data and medical literature as it is relevant to decision-making in the ED, as well as the ability to communicate complex or sensitive issues expertly with patient and colleagues. It is the last component of the FRCEM examination suite to be taken, and successful candidates are awarded the Fellowship. The OSCE complements formative assessments undertaken in the work place, such as ESLE. Together this programme of assessment in HST provides assurance that candidates have reached the accepted national standard required of an independent practitioner in EM.

5.3.3.Standard setting

The MRCEM and FRCEM examinations are high-stakes summative assessments that have the potential to impact on trainee careers and patient safety. The processes that underpin pass/fail decisions must be robust, consistent and fair. This is laid out in detail in the RCEM assessment strategy.

5.3.4.Fairness

The fairness of an exam refers to its freedom from bias. To this end and in the exercising of its duties under the Equality Act 2010, the RCEM must give due regard to:

- eliminating discrimination, harassment, victimisation and any other unacceptable conduct;
- advancing equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- fostering good relations between persons who share a relevant protected characteristic and persons who do not share it.

The RCEM aims to ensure that everyone has equal opportunity to demonstrate their ability in the examinations and that no candidate is treated less favourably than another on grounds of race, disability, sex, transgender, sexual orientation, age, religion, or pregnancy and maternity.

To ensure RCEM exams do not disadvantage any candidate, or group of candidates, on any basis other than the candidate's lack of the knowledge and skills, all RCEM exam item developers take particular care in the wording of questions to avoid ambiguity or offence across cultures. Additionally, examiners seek advice from specific experts/organisations/ associations or the experience of individuals in the work place on topics which may potentially affect certain ethnicities or cultures.

[3] Crossley, J. 'Work place Based Assessment' in Delaney, C. and Molloy, E (eds.) Learning and Teaching in Clinical Contexts: a Practical Guide (Chatsworth NSW: Elsevier, 2018) p.255-267

RCEM encourages feedback from candidates on the examination process and its content, and this provides access to a viewpoint on some protected characteristics not reflected in our examiner groups.

5.3.5. Reasonable adjustments

RCEM considers reasonable adjustments for exam candidates with disability, as set out in the examination regulations. Special arrangements for pregnancy and temporary medical conditions are also provided where necessary. Full details are available within the RCEM examinations regulations.

5.3.6. Equality analysis

Equality analysis is an integral part of examination policy, content and practice. RCEM carries out objective, evidence-based equality analysis when making decisions relating to exam changes, policies, question writing and practices. This ensures that full consideration is given to the effect such decisions may have on the fairness of the exam, and aims to prevent discrimination, promote diversity and inclusivity for all groups of people.

5.3.7. Quality assurance

A full Person Specification and Job Description is provided for examiners. The Examiner Regulations give full details of all parts of the selection and appointment process used by the RCEM.

Examiner training is mandatory for new examiners, which includes the principles of assessment, standard setting, examiner practice and calibration, and known and unknown bias. After attendance at an Examiner Workshop, examiners are required to observe an OSCE day prior to examining. This gives them the opportunity to assess candidates in a real examination. Examiners are required to attend the Examiners' Workshop every five years.

RCEM exams do not currently use lay examiners, although lay input is encouraged through attendance at committees and working groups.

5.3.8. Feedback

RCEM believes it is important to provide feedback to candidates beyond a standard pass-fail result, to assist them in understanding and interpreting their overall result. RCEM does not attempt to justify the result given or the marks awarded, whether overall or for specific sections or skill domains. Marks are awarded using strict guidelines. The decision on marks awarded is final and therefore papers cannot be remarked.

The following feedback is provided in all exam results letters/feedback enclosures:

- Confirmation of the candidate's pass-fail result
- Confirmation of the number of attempts used/maximum number of attempts
- The examination pass mark as a raw score in relation to the maximum achievable test score (e.g. 315/420) and/or the percentage value (e.g. 75%)
- The candidate's overall score as a raw score and/or as a percentage

5.4. Entrustment Decisions

Transitions and the crossing of thresholds are about taking on new responsibilities with a higher degree of independence. Knowing whether a trainee is ready to do so is complex. It requires a clear working knowledge of what the responsibilities involve, and the ability to predict how a trainee will respond when given responsibility. An example is the care of patients in the resuscitation room (SLO3) when the consultant is at home when on call.

This kind of assessment is an example of 'judgement-based' assessment. Scholarship in this field has seen a major transition from reductionism (breaking the assessment down to multiple 'objective' elements and assessing these) to entrustment (making the most of the sophisticated, contextual, individualised global judgements of which clinician trainers are capable)[4][5]. Key features of good judgement-based assessment are *asking the right people and asking the right questions*[3]. The FEG panels are composed of staff who know the trainee well and know the responsibilities of the job well. This provides us with the best chance of meaningful FEG judgements. Critically, the judgements are framed in terms of entrustment and independence[6]. This aligns with the natural decision-making heuristics of clinician supervisors, and there is good empirical evidence that that such 'construct aligned' judgements are significantly more dependable that judgements framed in terms of training stage or merit (e.g. poor, satisfactory, or good).[4]

The WPBA approach is built around preparing trainees for thresholds in training. To that end, assessments in the work place are also aligned to entrustment/ independence. The RCEM entrustment scale is shown in table 4.

Table 4. RCEM entrustment scale

1	Direct supervisor observation/involvement, able to provide immediate direction/ assistance
2a	Supervisor on the 'shop-floor' (e.g. ED, theatres, AMU, ICU), monitoring at regular intervals
2b	Supervisor within hospital for queries, able to provide prompt direction or assistance and trainee knows reliably when to ask for help
3	Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision
4	Would be able to manage with no supervisor involvement (all trainees practice with a consultant taking overall clinical responsibility)

The expectation of EM trainees at each of the key thresholds in training are shown in figure 3. This ensures that the requirements are transparent and explicit for all – trainers, trainees and the public. Making these expectations transparent for trainees is one of the ways our assessment scheme is designed to foster self-regulating learners. By providing a common and transparent map of what is expected from start to finish over the training journey, we give trainees the best chance of orienting themselves in terms of the progress so far and their

[4] Crossley J, Jolly B Making sense of work-based assessment: ask the right questions, in the right way, about the right things, of the right people. Medical Education 2012 46(1):28-37

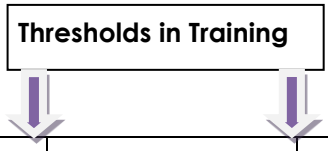
[5] Learning and Teaching in Clinical Contexts: A Practical Guide Delaney and Molloy 2018 ISBN 9780729542722

[6] Ten Cate O. Nuts and bolts of entrustable professional activities. J Grad Med Educ. 2013;5(1):157–158

next steps. We also unify consistency of feedback across the whole learning journey making it more credible to learners[7].

FEG decisions are extremely important for trainees and should not come as a surprise at the end of a period of training. The design of WPBAs, with entrustment score offered in feedback, means that should not be the case if trainees engage with training opportunities available.

Figure 3. RCEM Entrustment requirements



	Core: **ACCS: 6 months covering each of anaesthetics, acute medicine, intensive care medicine and emergency medicine. Can be worked in any order. SLOs reviewed in each post. Entrustment level required by end of ACCS**				**Intermediate:** **paediatric emergency medicine, leadership roles, support wider EM team**	**Higher Specialty Training:** **leading, EPIC, delivering challenging cases, management and administration toolkit, research, supervision and teaching**		
Clinical SLOs	**EM**	**IM**	**An**	**ICM**	**Intermediate**	**ST4**	**ST5**	**ST6**
Care for physiologically stable patients attending the ED across the full range complexity	2b	2b			**3**	*	*	**4**
Answer clinical questions	2a	2a			**3**	*	*	**4**
Resuscitate and stabilise	2b	2b	2b	2b	**3**	*	*	**4**
Care for an injured patient	2b				**3**	*	*	**4**
Care for children in the ED					**3**	*	*	**4**

[7] James G. M. Crossley (2014) Addressing learner disorientation: Give them a roadmap, Medical Teacher, 36:8, 685-691

Deliver key procedural skills	Refer to Clinical ACCS LO 5 table				**3**	*	*	**4**
Deal with complex situations in the workplace	2a	2a	2a	2a	**3**	*	*	**4**
Lead the ED shift					**3**	*	*	**4**
Provide basic anaesthetic care (ACCS)			2b					
Manage patients with organ dysfunction and failure (ACCS)				2a				
Supporting SLOs								
Teach and supervise	*ES report*				*ES report*	*ES Report*		
Participate in research								
Patient safety & quality improvement								
Lead, manage, administer								

*Progress in each of the clinical SLOs towards independence will be assessed in each year in HST

** Entrustment level for procedural skills varies in ACCS. Please see Section 5.5.1 for details

5.4.1.Faculty Educational Governance (FEG) Statement

What is it?

This is a statement that summarises the collated views of the training faculty about the progress of a trainee, specifically, their suitability to move to the next stage of training. This judgement is based on the observation of the trainee in the work place , on feedback from staff and patients and what faculty members have learned about the trainee's performance from WPBAs. (Individual WPBAs and reflections need not be reviewed by the training faculty at each FEG meeting, but they are available for review if the faculty judges that they need more data to make their judgement.). Within this statement, the strengths of the trainee are also summarised as well as areas to develop thus giving the opportunity to reflect and encourage excellence. The FEG panel can also offer a suggestion for how the trainee might address any on-going training needs, potentially making the FEG an 'adaptive' or individualised assessment.

The FEG Statement was introduced in RCEM training in 2015, with a decision relating to the whole training year in general. The evolution in this current programme of assessment is that the decision is now linked explicitly to progress in the relevant Specialty Learning Outcomes. Anchoring this decision to independence with a clear description of what is required will be a significant benefit to trainees and trainers in making these decisions fairer and more transparent.

The FEG Statement serves a summative purpose within our assessment programme. It is then triangulated with other information in the Educational Supervisor's report, to inform ARCP decision making. The FEG Statement is held on the e-portfolio and is accessed by the trainee and the Educational /Clinical supervisor and Training Programme Director only. The FEG process provides the opportunity for deeper, more timely, and more information-rich scrutiny of progress towards the key work place SLOs than the old Supervisor Report was able to deliver.

How is it done?

The FEG Statement can be made in different ways according to local arrangements. However, the key feature of the FEG is that it includes the views of the right people – those who know the trainee and know the responsibilities of the job. It must represent the collated views of the training faculty as to whether they believe a trainee has met the requirement for practise in each of the relevant SLOs at the level of independence specified for their stage of training. The decision will relate to the **Key Capabilities** for each SLO that are relevant to the trainee's stage of training.

The faculty is bound by the requirements on them of the GMC's Good Medical Practice guidance, by the requirements for fairness and transparency, the requirement that equality and diversity is respected and by the personal ethics and probity of individual members.

Good practice from a number of centres has been that 'educational governance' is a standing agenda item at consultant meetings and discussions of all trainees occur at regular (e.g. two- monthly) intervals. This approach ensures that concerns are documented and shared early and trainees can be better supported. It facilitates encouragement of trainees and the feedback of excellence. It is also fair to trainees who will receive a summative decision from the same panel that they are fully aware of how that group are minded towards their progress in each of the relevant SLOs.

The final meeting is for the purposes of FEG Statement completion. A quorate meeting would include at least three consultants, who must be trained Educational Supervisors.

Other centres have a designated training faculty from among their consultant body that perform this function at a formal Educational Governance meeting comprised of the College Tutor (or equivalent), Educational /Clinical supervisor and at least two other consultant trainers. At this meeting the progress of each trainee against each SLO is discussed and the output of this meeting is the Faculty Educational Governance Statement.

Example:

SLO1: Care for a complex stable patient across the full range of complexity. Core (ACCS) trainee:

'We believe this trainee can be trusted take a history, examine the patient and elicit key clinical signs, construct a differential diagnosis that considers a realistic worst case scenario and describes an appropriate management plan with senior help available, but not directly overlooking their work. The trainee can be relied upon to seek help when required'

This is the Key Capability for SLO 1 and describes entrustment level 2b.

The panel's view is sought. Panellists will be asked to reflect on their experience of trainees across the full spectrum of cases. This decision is a statement about the confidence of the team that a learner can be relied upon to make a safe assessment and seek help as needed. A yes/ no answer is required.

This process is repeated for the other SLOs that are relevant to the current phase of training.

The FEG Statement is recorded in the trainee's e-portfolio by their Educational or Clinical Supervisor. The FEG Statement also includes general feedback on trainee strengths and areas to develop.

When is it done?

Final FEG statements are made towards the end of a given block of training in an Emergency Medicine placement. This is typically six months (whole time equivalent) during ACCS and Intermediate Training, and yearly in Higher Training. However, with most approaches to FEG, it should be possible for the faculty to indicate to the trainee their general progress towards the final FEG statement at regular intervals ahead of time. WPBA performance should also give a strong indication of progress.

What if a trainee is deemed not ready to progress?

For the large majority of trainees these decisions will be positive. However, if problems or concerns are raised about a trainee in departmental education governance meetings, or by other means, these can be fed back with learning needs identified and a plan to remediate put in place. If these persist throughout an entire block of training this will be reflected in the FEG Statement and the subsequent ARCP panel will outline an appropriate training plan.

An opinion that a trainee is not ready to progress should not come as a surprise at the end of a placement, and should not be seen as punitive by the trainee or trainers. It is a formal recording of the opinion of the faculty on progress at the end of that training block and reflects support and deliberation throughout the block.

Indeed, the fact that not all trainees will reach the threshold after the same duration of training is a realistic reflection of the variation that exists between learners, their experience and the complex and highly responsible role a higher trainee and consultant in EM clinician embodies.

5.5. Assessment of Specialty Learning Outcome 6 Procedural skills

5.5.1. Procedural skills in ACCS (ACCS Learning Outcome 5)

There are a number of procedural skills in which a trainee must become proficient to the level expected by the end of ACCS.

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

ACCS trainees should ideally receive training in procedural skills in a clinical skills lab before performing these procedures clinically, but this is not mandatory. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool on simulated or actual patients.

The table below sets out the minimum competency level expected for each of the practical procedures at the end of ACCS.

When an ACCS trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with standard professional conduct). This also applies to procedures that have been signed off during other training programmes. They would be expected to continue to record activity in their logbook.

Minimum standards for progression from ACCS training

Procedure	End of ACCS
Pleural aspiration of air ***Entrustment requirement: 2b***	Programme of learning e-learning module Simulated practice or supervised practice on patient Programme of assessment DOPS assessment

Procedure	End of ACCS
Chest drain: Seldinger technique ***Entrustment requirement: 2b***	Programme of learning e-learning module Simulated practice and/or supervised practice on patient Programme of assessment DOPS assessment
Chest drain: open technique ***Entrustment requirement: 1***	Programme of learning e-learning module Simulated practice and/or supervised practice on patient National Safety Standards for Invasive Procedures (NatSSIPs) checklist ATLS or equivalent trauma course Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded Simulated practice with reflection recorded OR ATLS certificate
Establish invasive monitoring (CVP and arterial line) ***Entrustment requirement: 2b***	Programme of learning Simulated practice and/or supervised practice Programme of assessment DOPS assessment for CVP line AND DOPS assessment for arterial line
Vascular access in emergency (IO and femoral vein) ***Entrustment requirement: 1***	Programme of learning Simulated practice and/or supervised practice ATLS or similar trauma course Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded OR Simulated practice with reflection recorded

Procedure	End of ACCS
Fracture/dislocation manipulation ***Entrustment requirement: 1***	Programme of learning Supervised practice on patient Programme of assessment DOPS assessment OR Supervised practice with reflection recorded
External pacing ***Entrustment requirement: 2b***	Programme of learning e-learning module on bradyarrhythmias Simulated practice and/or supervised practice on patient ALS course Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded OR Simulated practice with reflection recorded
DC cardioversion ***Entrustment requirement: 2b***	Programme of learning e-learning module on broad and narrow complex tachycardias Simulated practice and/or supervised practice ALS course Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded OR Simulated practice with reflection recorded
Point of care ultrasound-guided vascular access and fascia iliaca nerve block ***Entrustment requirement: 2b***	Programme of learning Simulated practice and/or supervised practice on patient Modular level 1 theory training Programme of assessment DOPS assessment for peripheral and central vascular access AND

Procedure	End of ACCS
	DOPS assessment for fascia iliaca nerve block
Lumbar puncture ***Entrustment requirement: 2b***	Programme of learning e-learning module Simulated practice and/or supervised practice on patient Programme of assessment DOPS assessment

Continued performance of ACCS procedural skills in intermediate and higher training will be recorded in the RCEM log book. This record includes any complications and the level of support received if relevant. Episodes where the trainee was supervising others in these skills will also be recorded.

5.5.2. Procedural Skills in Intermediate and Higher Training

During Intermediate and Higher training learners will be expected to become more expert in all the practical procedures previously undertaken.

Continued performance of ACCS procedural skills in intermediate and higher training will be recorded in the RCEM log book. This record should include any complications and the level of support received if relevant. Episodes where the trainee was supervising others in these skills should also be recorded as learning events. The primary tool for the assessment of procedural skills is the direct observation of procedural skills (DOPS) tool which can be used on simulated or actual patients unless specified in the table below.

The purpose of this document is not to provide an exhaustive list of medical procedures which an Emergency Medicine Consultant may need or choose to perform over the course of their career and accordingly there are common medical procedures that are not included in the following list. It is intended to ensure that Emergency Medicine trainees are trained in emergency procedures typically required to preserve life, limb or treat painful emergency conditions in a timely and effective manner when there is no other more expert or appropriately trained practitioner immediately available.

It should be noted that there are a number of life-saving skills covered in this curriculum, such as resuscitative thoracotomy and resuscitative hysterotomy that are used rarely. These skills are included because it is conceivable that they may be required by a "day one" consultant in Emergency Medicine. Because these interventions are rare it is not expected

that every trainee must have observed practice in these areas however it is required that higher trainees are able to outline the indications for these procedures, know where to request help and have had observed practice of the skill in a simulated environment, including decision making and human factors. Whilst it is not essential or mandatory it is recommended that this includes cadaveric experience, where appropriate, prior to completion of training.

We have indicated that by the end of intermediate training trainees should have progressed to the level 3 entrustment grade for all emergency procedures and level 4 but the end of higher training (see table 4 for the RCEM entrustment scale). This does not imply that the trainee would be entrusted to perform any or all procedures independently without assistance or supervision at the start of higher training. It is intended for this to be interpreted as that the trainee is entrusted to reliably recognise when a particularly procedure is indicated and begin preparation to proceed while waiting for appropriate assistance to attend in order for things to proceed safely. This is likely to include the Emergency Medicine consultant on duty and other members of the multidisciplinary team i.e. anaesthetist or relevant surgeon. After intermediate training the trainee would be expected to have reached a standard where they can play a valuable role in this team. This role would develop through higher training upon completion of which they would have reached a point where they could be entrusted to lead this multidisciplinary team or perform any role in it.

Minimum standards for progression from intermediate and higher training

Procedure	End of intermediate training	End of higher training
Paediatric sedation	Programme of learning Completion of RCEM e-learning module on paediatric sedation Attendance at paediatric sedation simulation session Performance of observed procedural sedation patients under the direct supervision of an ED Consultant Programme of assessment Certificate of completion of RCEM e-learning module Certificate of attendance at paediatric sedation simulation day DOPS assessment for paediatric sedation (simulation)	Programme of learning Performance of observed procedural sedation patients under the direct supervision of an ED Consultant Programme of assessment Logbook record DOPS assessment of observed practice on patient if intermediate DOPS was a simulation
Advanced airway management	Emergency surgical airway RSI Programme of learning IAC training during ACCS Ongoing observed or simulated practice Simulated skills practice including surgical airway training ATLS or similar trauma course Programme of assessment IAC certificate DOPS assessment Log book record	Emergency Surgical airway RSI Programme of learning 10 Intubations a year on patients- may include RSI activity in ED/ theatres (including as part of a multi-disciplinary team) Simulated skills practice session including surgical airway training Programme of assessment Logbook record

Non-invasive ventilation	Programme of learning e-learning module on NIV Observed or simulated practice of NIV initiation Programme of assessment Certificate of completion of e-learning module DOPS assessment	Log book record of skill maintenance
Open Chest drain	Programme of learning Understanding of National Safety Standards for Invasive Procedures (NatSSIPs) checklist Observed or simulated practice Programme of assessment DOPS assessment Log book record	Programme of learning Observed practice Observed instruction of technique Programme of Assessment DOPS assessment of observed practice on patient if intermediate DOPS was a simulation Logbook record of skills maintenance
Resuscitative thoracotomy	Programme of learning e-learning module Simulated practice Programme of assessment Certificate of completion of e-learning module	Programme of learning Simulated practice Programme of assessment DOPS assessment
Lateral Canthotomy	Programme of learning e-learning module Simulated practice Programme of assessment Certificate of completion of e-learning module	Programme of learning Simulated practice Programme of assessment DOPS assessment

DC cardioversion	Programme of learning e-learning module on broad and narrow complex tachycardias OR ALS course Observed or simulated practice Programme of assessment DOPS assessment Logbook record	Programme of learning Maintenance of skills throughout HST Observed instruction of management of tachydysrythmias Programme of assessment Logbook record
External pacing	Programme of learning e-learning module on bradyarrhythmias OR ALS course Observed or simulated practice Programme of assessment Certificate of completion of eLearning module OR ALS certificate DOPS assessment Logbook record	Programme of learning Maintenance of skills throughout HST Observed instruction of management of bradydysrythmias Programme of assessment Logbook record
Pericardiocentesis	Programme of learning e-learning module Simulated practice Programme of assessment Certificate of completion of e-learning module	Programme of learning Simulated practice Programme of assessment DOPS assessment

ED management of life-threatening haemorrhage	Programme of learning e-learning modules ATLS or similar trauma course Observed or simulated practice of direct and indirect haemorrhage control techniques including but not exclusive to; • Wound management • Bleeding varicose veins • Nasal packing • Splints (e.g. pelvic sling, traction splint) • Tourniquet • Use of haemostatic agents Programme of assessment Certificates of completion of e-learning modules DOPS assessments of relevant techniques Logbook record	Programme of learning Observed practice Observed instruction of technique Programme of Assessment DOPs assessments for observed practice on patients of relevant techniques and teaching Logbook record of skill maintenance
Emergency delivery	Programme of learning E-learning module Simulated practice Programme of assessment DOPS assessment Logbook record	Programme of learning Observed or simulated practice Programme of assessment DOPS assessment Logbook record
Resuscitative hysterotomy	Programme of learning e-learning module Simulated practice Programme of assessment Certificate of completion of e-learning module	Programme of learning Simulated practice Programme of assessment DOPS assessment

Fracture / Dislocation manipulation	Programme of learning Supervised practice of fracture and dislocation manipulation and splinting techniques including but not exclusive to; • Shoulder • Elbow • Wrist • Finger • Hip • Femur • Lower leg • Ankle • Toes • Mandible Programme of assessment DOPS assessments for various fracture reduction and joint manipulation techniques Logbook record	Programme of learning Observed practice Observed instruction of technique Programme of assessment DOPS assessments for relevant observed practice of various techniques and teaching Logbook record of skill development and maintenance
Large joint aspiration	Programme of learning e-learning module Observed or simulated practice Programme of assessment DOPS assessment Logbook record	Programme of learning Maintenance of skills throughout HST Programme of assessment Logbook record

Point of care Ultrasound (Diagnostic)	Programme of Learning e-learning USS resources on data interpretation Ongoing observed and simulated practice of ACCS skills Observed and simulated practice of; • Echo in Life Support (ELS) Is the heart contracting? Is there pericardial effusion causing cardiac tamponade? Is there evidence of right ventricular strain? • AAA • eFAST / Focussed Assessment for Free Fluid (FAFF) Programme of Assessment Log Book record DOPS assessments Educational supervisor review of logbook regarding progress towards sign off when competent?	Programme of Learning e-learning USS resources on data interpretation Ongoing observed and simulated practice of ACCS and intermediate skills Observed and simulated practice of; • Shock assessment - including IVC measurement, global contractility and assessment of fluid status (including overload and hypovolaemia). Programme of Assessment Log Book record DOPS assessments **Educational supervisor review of logbook and sign off by the end of HST for :** • ELS • Shock assessment • AAA • eFAST/ FAFF Entrustment based- for guidance approximate number of scans expected: ELS 10; AAA 25; Shock Assessment 25; eFAST/FAFF 25. Scans recorded in the log book throughout training. Maintain log book for each modality when scanning independently

6. Supervision and feedback

This section of the curriculum describes how RCEM trainees will be supervised, and how they will receive feedback on performance. Detailed guidance can be found by referring to the AoMRC guidance[8] on improving feedback and reflection to improve learning.

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

Trainers should be supported to deliver valuable and high quality feedback. This can be by providing face to face training to trainers

6.1. Supervision

All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Organisations must make sure that each doctor in training has access to a named clinical supervisor and a named educational supervisor. The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training.

Educational supervisor

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

Clinical supervisor

The clinical supervisor oversees the doctor's clinical work throughout a placement and should be a member of the trainee's clinical specialty team. The clinical supervisor leads on reviewing the doctor's clinical or medical practice throughout a placement, and contributes to the educational supervisor's report on whether the doctor should progress to the next stage of their training.

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

[8] AoMRC Improving feedback and reflection to improve learning. A practical guide for trainees and trainers

It is essential that training in assessment is provided for trainers and trainees in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of the WPBAs and the application of standards. Opportunities for feedback to trainees about their performance will arise through the use of the work place based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from ARCP.

Trainees

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

It is the responsibility of trainees to seek feedback following learning opportunities and WPBAs. Trainees should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.2. Appraisal

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

Induction appraisal

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

Mid-point review

At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Work place -based assessments and progress through the curriculum can be reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed.

End of attachment appraisal

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

the programme director should be informed. Information gathered from this meeting should be incorporated into the Educational Supervisor Report (ESR).

7. Quality management

7.1. Quality management in RCEM training

The organisation of training programs for EM Training is the responsibility of HEE Offices/local teams and the devolved nations' deaneries. The HEE Offices/deaneries will oversee programmes for postgraduate medical training in their regions.

The HEE Offices/deaneries together with the School of EM will undertake the following roles:

- oversee recruitment and induction of trainees from foundation training into ACCS
- allocate trainees into ACCS rotations appropriate to their curriculum training needs
- allocate trainees into EM training posts in Intermediate and higher Training
- oversee the quality of training posts provided locally
- interface with other specialty training faculties
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across the training programme
- oversee the Work Place-Based Assessment process within the programme
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide less than full time training
- recognise the potential of specific trainees to progress into an academic career

Educational programmes to train educational supervisors and assessors in WPBA may be delivered by HEE Offices/deaneries or by the colleges or both.

Development, implementation, monitoring and review of the curriculum for ACCS are the combined responsibility of the RCEM, RCoA, RCP and the FICM via their Training Committees and the Intercollegiate Committee for ACCS Training (ICACCST). This Committee is formally constituted with representatives from each ACCS specialty and with trainee and lay representation. It will be the responsibility of the Colleges to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

In intermediate and Higher Training RCEM has this responsibility. RCEM is actively involved in assisting and supporting LETBs/deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing application for new post and programme, provision of external advisors to deaneries and recommending trainees eligible for CCT or Certificate of Eligibility for Specialist Registration (CESR).

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience. These are monitored and reviewed by ICACCST and RCEM to improve the provision of training and ensure enhanced educational experiences.

8. Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from RCEM via the website. (Appendix 2)

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

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

Recording progress in the e-Portfolio

On enrolling with RCEM trainees will be given access to the e-Portfolio. The e-Portfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support trainees' education and development.

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

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

Deaneries, TPDs, college tutors and ARCP panels may use the e-Portfolio to monitor the progress of EM trainees for whom they are responsible.

RCEM will use summarised, anonymous e-Portfolio data to support its work in quality assurance.

All appraisal meetings, PDPs and WPBAs (including MSF) should be recorded in the e-Portfolio. Trainees are encouraged to reflect on their learning experiences and to record these in the e-Portfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other e-Portfolio content should be used to provide evidence towards acquisition of curriculum capabilities.

9. Equality and diversity

RCEM comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

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

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

Compliance with anti-discriminatory practice will be assured through:

- monitoring of recruitment processes
- ensuring all College representatives and Programme Directors have attended appropriate training sessions prior to appointment or within 12 months of taking up post
- LETBs/deaneries ensuring that educational supervisors have had equality and diversity training (for example, an e-learning module) every 3 years
- LETBs/deaneries ensuring that any specialist participating in trainee interview/appointments committees or processes has had equality and diversity training every 3 years
- ensuring trainees have an appropriate, confidential and supportive route to report examples of inappropriate behaviour of a discriminatory nature. LETBs/deaneries and Programme Directors must ensure that on appointment trainees are made aware of the route in which inappropriate or discriminatory behaviour can be reported and supplied with contact names and numbers. LETBs/deaneries must also ensure contingency mechanisms are in place if trainees feel unhappy with the response or uncomfortable with the contact individual
- providing resources to trainees needing support (for example, through the provision of a professional support unit or equivalent)
- ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.

Appendix 1

Curriculum Sub-Committee

The curriculum has been developed by the following

Will Townend (Chair) RCEM Fellow

Jason Long (RCEM Dean) RCEM Fellow

Emily Beet (Deputy CEO, RCEM)

Dan Becker (ACCS (EM) representative)

Scott Carrington (Trainee representative)

Russell Duncan (Head of school representative)

Amanda Farrow (Training Standards Committee/Head of School representative)

Lynsey Flowerdew (RCEM ordinary fellow)

James Folan (RCEM learning)

Susannah Grant (Head of Examinations, RCEM Team)

David Greening (RCEM Team)

Mal Jones (ACCS and HOS representative)

Jane Knox (RCEM team)

Nick Mani (Trainee representative)

Amar Mashru (Trainee representative/ Chair of EMTA)

Maya Naravi (Chair of Training Standards Committee)

Richard Parris (RCEM ordinary fellow)

Derek Prentice (RCEM lay chair)

George Sebbage (RCEM team)

Vikas Sodiwala (RCEM ordinary fellow)

Jill Stafford (RCEM exams representative)

Chris Walsh (RCEM learning)

Tom Wiles (RCEM ordinary Fellow)

Appendix 2

ARCP decision aids

RCEM Curriculum

Preparing for ARCP

Judging achievement of Specialty Learning Outcomes to support progression decisions

A practical guide for Trainees,

Supervisors and ARCP panel

This document describes what an ARCP panel will be looking for at the end points of each level of training to satisfy themselves that trainees are fulfilling the requirements of the RCEM curriculum. It is designed to guide trainees and their Educational Supervisor as to what evidence should be recorded in their ePortfolio through the intervening years, so they can meet the curriculum requirements at the ARCP at the end of each training level.

Trainees and supervisors should also refer to the RCEM curriculum and Clinical Syllabus.

Evidencing the curriculum

In the revised RCEM curriculum there are 12 Specialty Learning Outcomes which map to the GMC's Generic Professional Capabilities (GPCs). The curriculum is outcome-based, which means that it describes the behaviours and performance required at the completion of the three stages of training (Core training, Intermediate and Higher training, on achieving CCT). Trainees will need to ensure they have provided evidence demonstrating how they have met the Specialty Learning Outcomes.

Supervisors and ARCP panels will make a professional judgement as to the sufficiency of this evidence.

The RCEM Specialty Learning Outcomes contain Key Capabilities (the mandatory aspects that must be explicitly evidenced to satisfy the requirements of the Learning Outcome), and a range of examples ('descriptors') of skills, behaviours and attitudes that relate to them.

Trainees will **not** be expected to provide evidence addressing each of the descriptors; the evidence should be aimed at demonstrating each **Key Capability** and, therefore, each Specialty Learning Outcome.

Trainees need to demonstrate evidence in their ePortfolio for each Specialty Learning Outcome at their level of training. This will consist of a mixture of documentation of learning from formal training courses, skills log of activities carried out in training, work place based assessments including Multi-Source Feedback, the other RCEM exams and assessments, as well as reflective notes and educational supervisor reports. The ePortfolio has been configured to enable easy display of the data tagged to each domain. This will support the Educational Supervisor and ARCP panel in the way they can evaluate the evidence submitted against the SLOs.

How to use this document

This document aims to describe the standard of evidence and level of performance required for a trainee to show they have satisfactorily demonstrated achievement of the Specialty Learning Outcomes, which is a requirement before they may progress to the next level of training (or CCT). This will ensure that trainees are assessed consistently throughout the UK. This guidance should be used by ARCP panels to support their decision making process, and by Educational Supervisors and trainees to help them consider the type, depth and breadth of evidence required.

This is generic guidance and does not replace any specific targeted learning objectives that may have been agreed between the trainee, Supervisor and Deanery/LETB following a previous unsatisfactory ARCP outcome. Supervisors and ARCP panels should also ensure trainees have met the RCEM examination requirements.

Clinical SLOs

The Clinical SLOs have entrustment statements that cover the Key Capabilities. This means that the training faculty will give their opinion about whether the trainee has met the standard in each of these. It is important that trainees also record evidence that demonstrates their progress in each of the Clinical SLOs, and do so from the start of each training attachment. Examples of the evidence that would be suitable in each of the Clinical SLOs is provided in Table 1.

Generic SLOs

Assessment of the Generic Specialty Learning Outcomes is by the professional judgement of the Educational Supervisor/ ARCP panel. To ensure consistency of judgements at each of the three levels of training, a grid has been provided, offering guidance (explicit where possible/appropriate) as to the standard of evidence and level of performance required. Each of the Generic SLOs outline the standard required at key waypoints at the end of training:

• By the end of ST2 (core/ACCS)

• By the end of ST3 (intermediate)

• By the end of ST6, prior to CCT (higher)

Trainees who are not at the end of each level, where the guidance criteria are set, need to show satisfactory progress towards meeting the requirements by the end of their current level.

In addition to describing minimum standards, guidance and pointers as to what might be deemed excellent are also included. The guidance is set out in table form as below:

- Not yet achieved: Details for expected outcomes for this grade
- Good /Acceptable: Details for expected outcomes for this grade
- Excellent: Details for expected outcomes for this grade

Guidance is provided below for the Generic SLOs learning outcomes at each level

- Education and training
- Quality improvement
- Research
- Lead, manage, administrate (Intermediate and Higher)

The RCEM curriculum and all syllabus documents, as well as other supporting guidance, are available at www.rcemcurriculum.co.uk.

Table 1. Recommended WPBA to provide evidence for Clinical SLOs

Clinical SLOs	**ACCS** **EM/AM**	**Intermediate**	**ST4**	**ST5**	**ST6**
Care for physiologically stable patients attending the ED across the full range complexity	Mini-CEX; ACAT; RCEM App; RCEMlearning activity; reflective entries	ESLE; CBD; RCEM App	ESLE; RCEM App; CBD	ESLE RCEM App; CBD	RCEM App; CBD
Answer clinical questions	CBD, RCEM App; RCEMlearning activity relating to clinical reasoning; reflective activity	ESLE; CBD, RCEM App;	ESLE RCEM App; CBD	ESLE RCEM App; CBD	ESLE RCEM App; CBD
Resuscitate and stabilise		ELSE; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity	ELSE; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity	ESLE; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity	ESLE RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity
Care for an injured patient	RCEM App; Mini-CEX; CBD; reflective activity	ELSE; RCEM App; Mini-CEX; CBD; reflective activity	ELSE; RCEM App; RCEM Mini-CEX; CBD; reflective activity	ELSE; RCEM App; Mini-CEX; CBD; reflective activity	ESLE; RCEM App; Mini-CEX; CBD; reflective activity
Care for children in the ED		ESLE; Mini-CEX; CBD; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity	ESLE; Mini-CEX; CBD; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity	ESLE; Mini-CEX; CBD; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity	ESLE; Mini-CEX; CBD; RCEM App; RCEM Resuscitation Mini-CEX; RCEM Resuscitation CBD; reflective activity

Deliver key procedural skills	DOPS; Record of skills lab activity; RCEM logbook		DOPS; Record of skills lab activity; RCEM logbook		DOPS; Record of skills lab activity; RCEM logbook	DOPS; Record of skills lab activity; RCEM logbook	DOPS; Record of skills lab activity; RCEM logbook	
Deal with complex situations on the shop floor	RCEM App; CBD		RCEM App; CBD		ELSE; RCEM App; CBD	ELSE; RCEM App; CBD	ELSE; RCEM App; CBD	
Lead the ED shift			ESLE; reflective activity		ESLE; reflective activity	ESLE; reflective activity	ESLE; reflective activity	
Provide basic anaesthetic care (ACCS)	Mini-CEX, CBD, DOPS, RCEM logbook, RCEMLearning							
Manage patients with organ dysfunction and failure (ACCS)	Mini-CEX, CBD, DOPS, logbook, RCEMLearning							

The Faculty Educational Governance (FEG) statement is summative evidence that the trainee has met the required standard for each of the relevant SLOs for their stage of training. The Educational Supervisor can therefore explore in more depth the strengths and areas to work on for their trainee.

The entrustment statement frees the trainee from producing an exhaustive list of episodes to 'tick off'. The purpose of the ePortfolio is to provide evidence that can be triangulated with the Faculty Educational Governance statement, but also to ensure the trainee is developing as a self-regulating learner and taking the opportunities to develop in the clinical sphere.

That being said, what follows is some guidance for trainees and trainers about how the supporting evidence in the ePortfolio might be collated.

WPBA Requirements for Clinical SLOs for ARCP

- At least three ESLEs are required in each training year in intermediate and higher training.
- One MSF in each year of training. The MSF must be completed in the first 6 months of the training year so any training needs can be addressed in year, if necessary.

- Evidence of interaction with the training faculty in each of the Clinical SLOs relevant to the stage of training from the outset of training. This will be reviewed at the first 3 month review with the Clinical/Educational Supervisor

- There are no absolute numbers of WPBAs thereafter- the quality of the learning or reflection is of greater importance. There needs to be evidence collated of observed practice in each of the **Key Capabilities** of each of the Clinical SLOs, and assessments in each SLO need to include a number of assessors.

    - Aiming for around one observed episode every week across each of the Clinical SLOs would be a reasonable aim. These episodes need not necessarily be lengthy. It is more important that the relevant learning point is explored. This may be quite focussed, eg for an intermediate trainee evidencing SLO2- answering questions, this may be an observation of the clinician answering a question posed by a junior staff member. The feedback may be focussed and offer one or two things to reflect upon. It may take a matter of minutes. The trainee would provide a focussed reflection that might take longer, depending upon the learning encounter, but the episode in the work place might be brief.

SLO: Teach, Supervise, educate

Key capabilities:

1. ...able to set learning objectives for and deliver a teaching session

Not yet achieved	• Minimal evidence of participation in teaching and reflection on performance. • Evidence of teaching skills needing further development or unwillingness to teach (MSF, mini-CEX, trainers report).
Acceptable/Good	• Evidence of participation in local departmental teaching, for example through development log entries. • Evidence of feedback on teaching and learning events delivered by the trainee with reflection and goal setting for development of teaching skills.
Excellence	• Evidence of participation in regional or national education or training delivery. • Participation in formal teacher training programme. • Quality improvement activity in the area of education.

SLO: Patient Safety & Quality Improvement

Key capability

1. …able to contribute effectively to a departmental quality improvement project

Not yet achieved	• Minimal evidence of activity in quality improvement activity.
Acceptable/Good	• Evidence of engagement in quality improvement processes within the NHS Trust. • For each year of training, evidence of involvement in an audit or other process related to quality improvement (service evaluation, audit, re-audit, quality improvement, guideline development, etc.). • Presentation at local QI meeting.
Excellence	• Presentation of the findings and actions from more than one project or in more than one setting. • Demonstrates translation of findings and learning from one audit into another area of practice or another hospital.

SLO: Research

Key capability

1. …able to search the medical literature effectively and know how to critically appraise studies

Not yet achieved	• Minimal evidence of regular involvement in research-related activity (e.g. literature review, audit, critical appraisal). • Poor use of clinical questions in ePortfolio with no critical review of the relevant literature.
Acceptable/Good	• Evidence of regular involvement in research related activities, e.g. literature review, audit, critical appraisal; evidence may include, for example, reflection on audit projects or journal club presentations. • Good use of clinical questions in ePortfolio, incorporating critical review of the relevant literature.
Excellence	• Evidence of skills in interpretation and communication of research findings to patients, plus to the multidisciplinary team; evidence may include, for example, mini-CEX and MSF feedback.

SLO9: Support, supervise and educate

Key capabilities

1. …able to set learning objectives for and deliver a teaching session
2. ...able to deliver effective feedback to a junior colleague or allied health professional

Not yet achieved	• Minimal evidence of participation in teaching and reflection on performance. • Evidence of teaching skills needing further development or unwillingness to teach (MSF, mini-CEX, trainers report).
Acceptable/Good	• Evidence of participation in local departmental teaching, for example through development log entries. • Evidence of feedback on teaching and learning events delivered by the trainee with reflection and goal setting for development of teaching skills.
Excellence	• Evidence of participation in regional or national education or training delivery. • Participation in formal teacher training programme. • Quality improvement activity in the area of education. • Evidence of reflection providing pastoral support to a junior colleague or allied health professional

SLO10: Participate in research and managing data appropriately

Key capabilities

1. …able to appraise, synthesise, communicate and use research evidence

Not yet achieved	• Little or no evidence of participation in research or evidence appraisal/ synthesis
Acceptable/Good	• Presentation at journal club with feedback • Evidence of critical appraisal and evidence synthesis in ePortfolio
Excellence	• ePortfolio populated with high quality evidence of development as a critical appraiser, including communication of findings to patients/ colleagues. • Presentation of research findings at regional/ national/ international meetings. Peer reviewed papers. Higher degree.

SLO11: Participate in and promote activity to improve the quality and safety of patient care

Key capability

1. ...able to describe their involvement and show an understanding of QI methods and reflect on a Quality Improvement Project they have been involved in

Not yet achieved	• Minimal evidence of quality improvement work. • Little perseverance or insight into challenges to change management
Acceptable/Good	• Evidence of a QI project that the trainee has participated in. • Evidence that the team has been multi-disciplinary and there is satisfactory account of the QI methods and reflection on the conduct of the project.
Excellence	• High quality QI project leading to significant improvement in clinical care • Presentation of QI project at regional or national meeting • Evidence of innovation/ QI team leadership/ perseverance in making change

SLO12: Manage, administer and lead

Key capability

1. ...have experience of handling a complaint or preparing a report, and be aware of the relevant medico-legal directives

Not yet achieved	• Inadequate or unsatisfactory interaction with the management portfolio • No or little evidence of constructive use of EDT time
Acceptable/Good	• Satisfactory interaction with the management portfolio. At least one element in each year of training completed to standard and four complete by the end of training.
Excellence	• Handling of complex episodes, e.g. serious incidents, complaints with maturity. • Evidence of effective proactivity in self-development as a leader.

SLO9: Support, supervise and educate

Key capabilities

1. …able to undertake training and supervision of members of the ED team in the clinical environment
2. ...able to prepare and deliver teaching sessions outside of the clinical environment; including simulation, small-group work and didactic teaching
3. …able to provide effective constructive feedback to colleagues, including debrief
4. …understand the principles necessary to mentor and appraise junior doctors

Not yet achieved	• Minimal evidence of participation in the modalities of teaching required. • Evidence of teaching skills needing further development or unwillingness to teach (MSF, mini-CEX, trainers report). • Minimal evidence of preparation for role as a mentor/ supervisor
Acceptable/Good	• Evidence of participation in local departmental teaching, for example through development log entries. • Evidence of feedback on teaching and learning events delivered by the trainee with reflection and goal setting for development of teaching skills.
Excellence	• Evidence of participation in regional or national education or training delivery. • Participation in formal teacher training programme. • Quality improvement activity in the area of education. • Evidence of reflection of providing pastoral support to junior colleague or allied health professional

SLO10: Participate in research and managing data appropriately

Key capabilities

1. ...able to appraise, synthesise, communicate and use research evidence to develop EM care
2. ...able to participate in research

Not yet achieved	• Little or no evidence of participation in research or evidence appraisal/ synthesis
Acceptable/Good	Evidence of reasonable engagement with CLA eg • Presentation at journal club with feedback in each year of training • Evidence of critical appraisal and evidence synthesis in ePortfolio in each year of training • Good Clinical Practice Training up to date by end of training • Evidence of training or learning on consent/ recruiting patients/ conduct of research within the ED by end of training
Excellence	• ePortfolio populated with high quality evidence of development as a critical appraiser, including communication of findings to patients/ colleagues. • Presentation of research findings at regional/ national/ international meetings. Peer reviewed papers. Higher degree.

SLO11: Participate in and promote activity to improve the quality and safety of patient care

Key capabilities

1. ...able to provide clinical leadership on effective Quality Improvement work
2. ...able to support and develop a culture of departmental safety and good clinical governance

Not yet achieved	• Minimal evidence of quality improvement work. • Little perseverance or insight into challenges to change management
Acceptable/Good	• Evidence of a QI project that the trainee has led on. • Evidence that the team has been multi-disciplinary and there is satisfactory account of the QI methods and reflection on the conduct of the project. • Evidence of sharing of the results in a meeting with feedback on the effectiveness of communication
Excellence	• High quality QI project leading to significant improvement in clinical care • Presentation of QI project at regional or national meeting • Evidence of innovation/ QI team leadership/ perseverance in making change

SLO12: Manage, administer and lead

Key capabilities

1. ...able to manage a complaint, preparing a report, and be aware of the relevant medico-legal directives (elements not completed in intermediate)

2. ...able to investigate a critical incident, participate and contribute effectively to department clinical governance activities and risk reduction projects

3. ...able to manage the staff rota, being aware of relevant employment law and recruitment activities including interviews and involvement in induction

4. ...able to effectively represent the ED at inter specialty meetings

Not yet achieved	• Inadequate or unsatisfactory interaction with the management portfolio • No or little evidence of constructive use of EDT time
Acceptable/Good	• Satisfactory interaction with the management portfolio. At least one element in each year of training completed to standard and four complete by the end of training. • Evidence of effective personal contribution to departmental meetings with feedback reflected upon.
Excellence	• Handling of complex episodes, e.g. serious incidents, complaints with maturity. • Evidence of effective proactivity in self-development as a leader.