SCHOOL OF EMERGENCY MEDICINE
EAST OF ENGLAND

NHS
Health Education England

ACCS EAST OF ENGLAND
Acute Care Common Stem Training Programme

DRE-EM (Defined Route of Entry into Emergency Medicine) TRAINING PROGRAMME HANDBOOK 2025-26

Trainee Name:	
GMC number:	
College training number:	
Base hospital:	
Overall educational supervisor:	
Emergency Medicine **Dates:** **Clinical supervisor:**	
Paediatric Emergency Medicine **Dates:** **Clinical supervisor:**	
Acute Medicine **Dates:** **Clinical supervisor:**	
Anaesthetics **Dates:** **Clinical supervisor:**	
Intensive Care Medicine **Dates:** **Clinical supervisor:**	

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Contents

Introduction

Welcome to the East of England DRE-EM training programme, this comprises of:

YEAR IN:

To catch up the Competences of ST3/ Intermediate training year

Emergency Medicine (EM) - 6 – 9 months block

Paediatric Emergency Medicine – 3 – 6 months block

YEAR OUT:

To catch up the Competences of Core Training (suggested)

Internal Medicine (IM) - 4 months block

Anaesthetics - 4 months block

Intensive Care Medicine (ICM) - 4 months block

However, the above structure is not rigid. Depending on the local delivery, the above blocks may be rearranged, and blocks lengthened or shortened as long as they are a minimum of 3 months and a maximum of 6 months in duration. The training programme created for each DRE-EM trainee is bespoke according to their previous experience or training.

The DRE-EM training handbook has been designed to outline the requirements of the two years of the ST3 (DRE-EM) training program. It will enable you to keep track of your progress and prepare for your Annual Review of Competence Progression (ARCP), which will take place in June or July every year for a full time trainee. A less than full time (LTFT) trainee may have different timings of ARCP in a year.

Trainees are expected to use Kaizen portfolio to record workplace based assessments and other evidence of competences including courses attended and examinations passed.

The **Structure of Training** is divided into three levels.

- The **Core** Training (Indicative two years for ACCS but one year for DRE-EM trainee),
- **Intermediate** Training (indicative one year) and
- **Higher** Training (three years).

A **DRE-EM trainee** will be entering the training programme at the Intermediate level, spending one year at the ST3 level, followed by Core Training for another year or vice-versa.

YEAR IN (EM and PEM)

EM (6-9 months):

Supervision

Educational supervisor (ES)

Each DRE-EM trainee will be assigned an ES at the beginning of the programme.

The ES is the consultant who supervises the progress of the trainee over the course of their DRE-EM training programme and completes the Educational Supervisor Report (ESR) required for the ARCP.

The ES may also complete workplace-based assessments, Faculty Educational Governance Statement (FEGS), and should contribute to the trainee's 360-degree multi-source feedback.

The first meeting should be within the first 4 weeks of starting the rotation. A supervisor's initial educational meeting form is to be completed on the trainee's Kaizen Portfolio. The Trainee will be required to send a ticket for the initial meeting. During the initial meeting, both the trainee and supervisor should sign the educational agreement in the e-Portfolio, thereby recording their commitment to the training process. In addition, educational objectives will be set, and these will be used to assess the trainee's progress in subsequent meetings.

The second educational meeting should occur about 3 months after starting the rotation to ensure desired progress is made and assessments are done with learning events recorded.

The third meeting should take place 4 weeks before the end of the placement, and an **end of placement report is created.**

Clinical supervisor (CS)

Any consultant who directly supervises the trainee in the clinical setting, completes workplace-based assessments and the End of Placement Report is referred to as a Clinical Supervisor. The ES may also be the CS for adult EM at the ST3/DRE-EM level in this year.

Portfolios

DRE-EM trainees must register with the RCEM Kaizen portfolio.

The e-portfolio should contain a complete record of the trainee's training experience. The trainee is required to capture evidence on a wide range of knowledge, skills, behaviours and attributes, reflecting the broad nature of this speciality in practice. This is reflected in the depth and breadth of the curricular content. Each trainee is required to evidence of on EM specific clinical skills and knowledge through achievement of Specialty Learning Outcomes (SLOs) across 12 domains.

There are 12 **RCEM Specialty Learning Outcomes** that cover the whole of training in the RCEM curriculum. Eight of the **RCEM SLOs** are 'patient facing' and relate directly to patient care or activity in the clinical workplace. 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'.

Assessments

The programme of assessment is broadly composed of two elements:

1. Workplace Based Assessments (WPBAs) and other evidence collected trainees to reflect on their learnings and evidence their progress.
2. Panel-based Judgements are made by a group of senior clinicians who have worked closely with trainees.

Workplace-based assessments (WBPAs)

WPBAs provide a structure for observing the clinical application of knowledge in each part of the curriculum. By providing feedback and encouraging reflection, it also helps trainees develop self-regulated learning skills.

The WPBA programme is used throughout training and offers opportunities for pertinent developmental feedback and the highlighting of concerns at regular intervals when there is a chance to define plans to support training.

The WPBA approach is built around preparing trainees for thresholds in training. To that end, assessments in the workplace are also aligned to entrustment/ independence.

The **RCEM entrustment scale** is shown below:

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 a 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 of each key threshold in training is shown below in the table. The DRE-EM trainees may note that the level of their requirement of the Entrustment Scale at the Intermediate and ACCS levels is separate.

Panel-based Judgements

The training faculty, from time to time, will meet up and discuss the trainee's performance. Faculty Educational Governance (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 workplace 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 a Structured Training Report (STR) 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 which will make a decision regarding progression.

These elements are phased, reflecting the growing knowledge and experience of trainees. At key thresholds in training the workplace 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 three elements:

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 an FEG Statement.

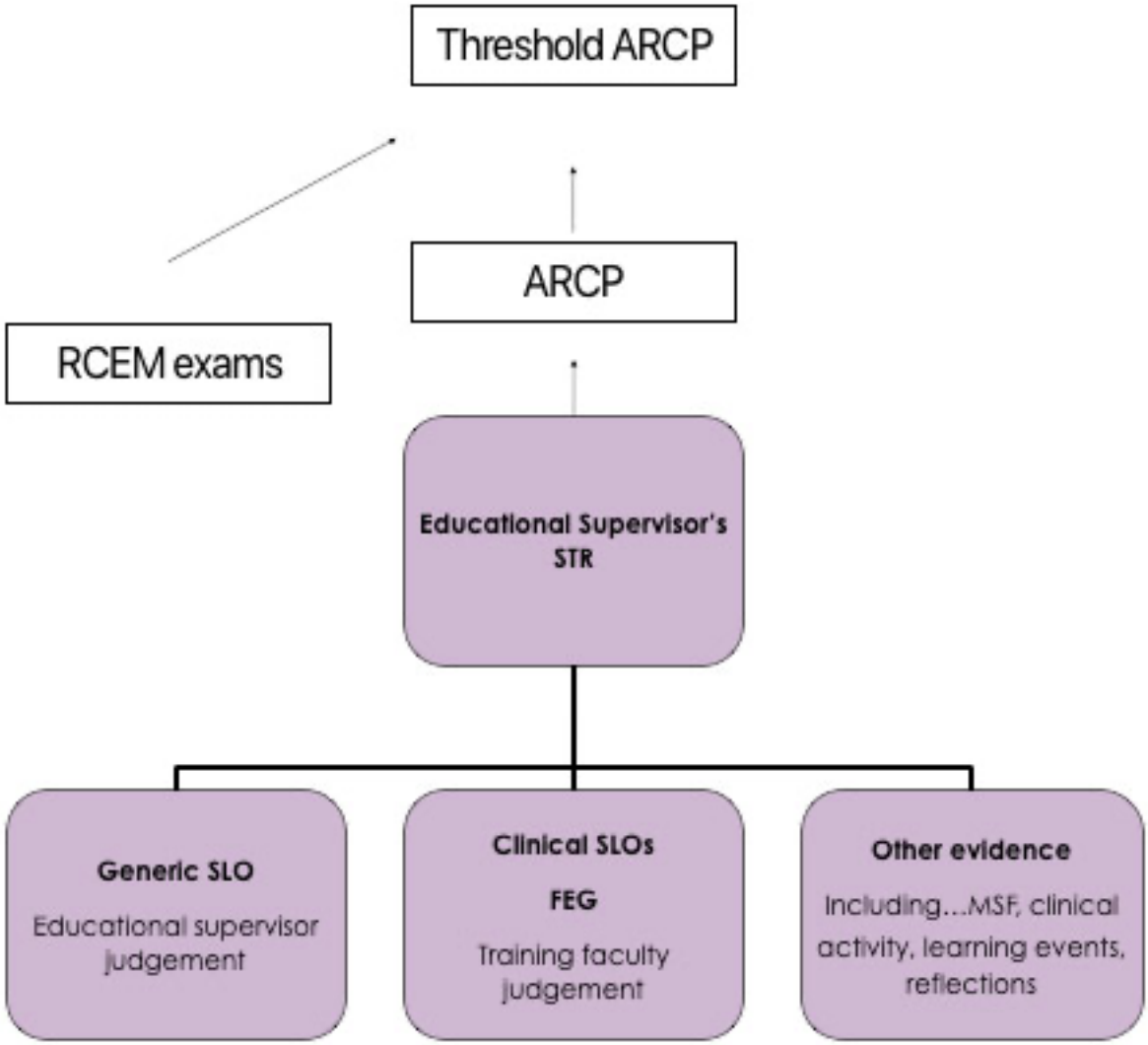
b. The Educational Supervisor reviews the evidence collated for each of the **Generic/ Supporting SLOs** and offers a judgement on progress in these.

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 STR. 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.

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



Specialty Learning Outcomes: ST3 (INTERMEDIATE)

This table sets out the minimum standards to be achieved for each of the clinical and generic SLOs by the end of the ST3 year. The final entrustment rating is made by the educational supervisor at the end of the training year, following a review of all the evidence provided by the trainee against each SLO.

Specialty Learning Outcome *Curriculum progress can be reviewed using the "Goals" e-portfolio dropdown*	**Entrustment requirements**
SLO1: Care for physiologically stable adult patients presenting to acute care across the full range of complexity	3
SLO2: Support the ED team by answering clinical questions and making safe decisions	3
SLO3 Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	3
SLO4 Care for acutely injured patients across the full range of complexity	3
SLO5: Care for children of all ages in the ED, at all stages of development and children with complex needs	3
SLO6: Proficiently deliver key procedural skills in Emergency Medicine	*See SLO6 table*
SLO7: Deal with complex and challenging situations in the workplace	3
SLO8: Lead the ED shift	3
SLO9: Support, supervise and educate	"Satisfactory/ good" or "excellent"
SLO10: Participate in research and managing data appropriately	"Satisfactory/ good" or "excellent"
SLO11: Participate in and promote activity to improve the quality and safety of patient care	"Satisfactory/ good" or "excellent"
SLO 12: Manage, administer and lead	"Satisfactory/ good" or "excellent"

SLO6 Practical Procedures: Entrustment Requirements (ST3)

At the 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.

Assessment of procedural skills is mostly made using the direct observation of procedural skills (DOPS) tool. Some may be assessed by e-learning or course completion – see curriculum/website for details.

The table below sets out the minimum competency level expected for each of the practical procedures by the end of DRE-EM year in and year out training years.

Procedure	ST3
Paediatric sedation	3
Advanced airway management	3
Non-invasive ventilation	3
Open chest drain	3
Direct current cardioversion	3
External pacing	3
Pericardiocentesis	3
ED management of life-threatening haemorrhage	3
Fracture/dislocation manipulation	3
Large joint aspiration	3
Point of care ultrasound	3

Special note: Some of the above procedures related to Anaesthesia and ICM may be completed in the year OUT year (ACCS) rather than in the year IN. So, by the end of two years, the trainee should be able to achieve the required Entrustment score.

Ultrasound (PoCUS) requirement in DRE-EM

The details of US competencies can be found by clicking here.

INTERMEDIATE STAGE:

- Completion of the modular training of PoCUS image interpretation
- Attendance at practical training sessions
- Evidence of PoCUS learning at the bedside
- Development of a logbook
- DOPS assessment in ELS, AAA & e-FAST

SUGGESTED NUMBERS OF SCANS:

Modality	Indicative number	Reflective Notes
AAA	25	5
eFAST / FAFF	25	5
ELS	10	5
Shock Assessment	25	5
Vascular Access	5	5
Fascia Iliaca Block	10	5

Education Development time (EDT):

This time should also enable trainees to meet their personal development plan (PDP) objectives outside of the ED.

EDT will be pro rata for LTFTs. EDT is not accrued during SL and AL. EDT is in addition to time allocated for regional training.

For ST3 it should be 4 hours per week or 160 hours per annum

EDT time should be timetabled in advance on the ED rota for transparency.

An evidence log of achievements must be recorded in the portfolio.

EDT will be made up of patient-facing and non-patient-facing activities and may vary from trainee to trainee and grade depending on individual development needs, the effect of COVID 19 and the scope of practice in each training site. This needs to be worked out in advance to allow for rota planning in discussion with their Educational Supervisor. It should be reviewed at regular ES meetings.

For a detailed information, please visit the following site:

https://res.cloudinary.com/studio-republic/images/v1635624255/Educational_Dev_Time_recommendations_MAY_2021/Educational_Dev_Time_recommendations_MAY_2021.pdf?_i=AA

PEM (3-6 months):

Paediatric Emergency Medicine Curriculum (SLO 5)

Children will be seen throughout the whole of the training programme from ACCS onwards. The focus on children in the third year of training inevitably leads to some arbitrary divisions of what should be known and by when. It is important that all paediatric encounters are used to their maximum educational potential, regardless of when they occur. Some of the emergency presentations are rare and may occur only once or twice throughout the whole training programme. Paediatrics continues throughout the whole of training and although it is indicated that additional areas should be covered in ST4-6, all the areas previously specified will be seen repeatedly and this provides the opportunity for the trainee to become more experienced and expert–dealing with cases of greater complexity and acuity, becoming better at leading and coordinating resuscitation and more skilled at practical procedures (spiral learning). However, we have indicated the most important and often indicated the same condition under different presentations.

The exact format for PEM attachment varies between hospitals but must include at least 3 months paediatrics and the trainees should see a reasonable number of children and keep a record of this for their portfolio. The identifiable details of patients must be removed. Trainees should also attend the regional training programme, including one 2-day PEM course in the autumn. Please contact the School Administrator, Miss Reona Cruz for the detail of the course. By the end of ST3, trainees need to have passed all components of the MRCEM diploma exam to progress to Higher Speciality Training.

The key descriptors and EM capabilities are described in the table below:

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
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

Supervision:

Clinical Supervisor's meeting:

A clinical supervisor could be a paediatrician, or an EM consultant with PEM qualification or an EM consultant with PEM interest.

The first meeting should be scheduled within the first 2-4 weeks of starting the rotation. A supervisor's initial educational meeting form is to be completed on the trainee's Kaizen portfolio. During the initial meeting, educational objectives will be set, and these will be used to assess the trainee's progress in subsequent meetings.

The second meeting for a 3-month or a 4-month placement: this should be the end of the placement meeting to ensure the competences are achieved.

The second meeting for a 6-month placement would be to ensure the trainee is progressing satisfactorily and required assessments on the way of completion.

The third meeting for a 6-month placement should be the end of the placement meeting to ensure the competences are achieved as outlined on the e-portfolio. **An end of placement report should be completed by the Clinical Supervisor.**

At the end of the year of EM & PEM, the Educational Supervisor must complete an Educational Supervisor Report (ESR) covering the achievements the trainees have made throughout the whole year.

Portfolios/Assessment

In this part of the training, a DRE-EM trainee will be required to use the PEM part of the Intermediate Curriculum. The focus should be **SLO 5**.

The evidence to be included are following:

Evidence to inform decisions include…	**Assessment of simulated practice** **CbD** **ESLE** **FEG** **Mini-CEX** **MSF**

The Assessment, both WPBAs and Panel based will continue in the same format as mentioned on page 5 and 6.

YEAR OUT (Anaesthesia, ICM & AIM)

For the year out (Anaesthesia, ICU, IM 4 months each):

Supervision:

In the year out, trainees will be assigned a specific Clinical Supervisor in the relevant specialty to complete their progress reports in that specialty. The educational supervisor would remain the same from the Emergency Medicine.

Each trainee is expected to meet two to three times with their assigned Clinical Supervisor. Sometimes a trainee may be placed on 6-month rotation in Anaesthesia and/or ICM, during which the trainee is expected to meet the CS at least 3 times.

The Trainee will be required to insert the name of the supervisor on the portfolio and inform the College's Kaizen Portfolio team to allow access to the clinical supervisors.

The following should be completed at the supervision meetings:

Initial meeting with Clinical Supervisor

To be scheduled within 4 weeks of starting the rotation. A supervisor's initial educational meeting form is to be completed on the trainee's electronic training record. During the initial meeting, educational objectives will be set, and these will be used to assess the trainee's progress in subsequent meetings.

Mid-term meeting with Clinical Supervisor (in cases of 6-month placements)

To be scheduled at the end of the third month of the rotation. A supervisor's mid-term educational meeting form is to be completed on the trainee's electronic training record.

Final meeting with Clinical Supervisor

To be scheduled during the fourth or sixth month of the rotation and prior to the final educational supervisor's meeting if the trainee is in a post outside their parent specialty. The Clinical Supervisor should complete the end of placement report and should state whether the trainee has completed all the required competencies achieving appropriate Entrustment Scale in each Learning Outcome.

Final meeting with Educational Supervisor (applicable to all trainees irrespective of 4 or 6 months of placement)

To be scheduled at the end of the third or fourth month of training and at least four weeks prior to the trainee's scheduled ARCP. The **Educational Supervisors Report** is to be completed at least four weeks in advance of the ARCP date so that any problems or missing evidence is identified, and the trainee has adequate time to complete any outstanding competencies. Evidence of achievement of the learning objectives, together with the Entrustment Scales of the WPBAs and all mandatory competency requirements will be reviewed and will form the content of the report including the assigning of the Entrustment Scales. When the trainee has been in a specialty outside their parent specialty, the educational reports of the clinical supervisor, including the clinical supervisor's end of placement review will provide the evidence for completion of the report. Included in the final report will be attendance at regional training (expected to be 75%) and documentation of the *number of days of absence* (other than annual & study leave). Additional training time in the relevant speciality may have to be considered in the event of absence of more than 14 days per year.

The trainee should be made fully aware of the content of the report before it is submitted. The whole portfolio and all reports must be ready two weeks before the date of the ARCP.

The ARCP panel will review the Educational Supervisors Report, and the trainee's 'Kaizen Portfolio of Evidence' to confirm all required competencies and the Entrustment Scales have been achieved before the trainee is allowed to proceed to the next level of training.

ASSESSMENT:

There are 11 **ACCS Learning Outcomes** that are followed in core training (year OUT of DRE-EM training programme). Out of these 11 ACCS LOs, 8 are related directly to patient care (**Clinical ACCS Learning Outcome**) and 3 to generic activity required in specialty training (**Generic ACCS Learning Outcome**). 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.

Each trainee must maintain an up-to-date portfolio throughout their training program. The portfolio is designed to record the required educational supervision meetings, workplace-based assessments, multi-source feedback, reflective notes and ARCP outcomes and has a facility to allow trainees to upload additional evidence.

Ultrasound (PoCUS) requirement in DRE-EM

The requirements are broken down in the ACCS and ST3 years. Please follow the individual curriculum to obtain the competencies.

The details of US competencies can be found by clicking here.

CORE STAGE:

- Completion of my modular training
- Attendance at practical session
- Evidence of PoCUS learning at bedside
- Start to compile the logbook
- DOPS assessment in central and peripheral venous access (PVA), Fascia iliaca block

SUGGESTED NUMBER OF SCANS:

Modality	Indicative number	Reflective Notes
AAA	25	5
eFAST / FAFF	25	5
ELS	10	5
Shock Assessment	25	5
Vascular Access	5	5
Fascia Iliaca Block	10	5

ACCS Learning Outcomes: Requirements by Placement

By the end of the YEAR OUT year, all 11 Learning Outcomes should be complete. Therefore, you should continue to map to all your learning outcomes which have not yet been signed off.

This table sets out the minimum standards to be achieved in each ACCS placement for each of the clinical and generic ACCS Learning Outcomes.

Learning Outcome	Entrustment requirements			
	EM	IM	An	ICM
1. Care for physiologically stable adult patients presenting to acute care	2b	2b		
2. Make safe clinical decisions, appropriate to level of experience,	2a	2a		
3. Identify sick adult patients, be able to resuscitate and stabilise and know	2a	2a	2a	2a
4. Care for acutely injured patients	2b			
5. Deliver key ACCS procedural skills	See LO5	See LO5	See LO5	See LO5
6. Deal with complex and challenging	2a	2a	2a	2a
7. Deliver safe anaesthesia and sedation			2b (HALO	
8. Manage patients with organ				2a
9. Support, supervise and educate	Satisfactory	Satisfactory	Satisfactory	Satisfactory
10. Participate in research and manage data appropriately	Satisfactory	Satisfactory	Satisfactory	Satisfactory
11. Participate in and promote activity to improve the quality and safety of	Satisfactory	Satisfactory	Satisfactory	Satisfactory
Other evidence	Requirements			
	EM	IM	An	ICM
Faculty Educational Governance (FEG)	1			
Multi-Consultant Report (MCR)		1		1
Multi-Trainer Report (MTR)			1	
HALO			1	1

IAC (EPA 1 and 2)			1	
Clinical Supervisor End of Placement	1	1	1	1

ACCS LO5 Practical Procedures: Entrustment Requirements

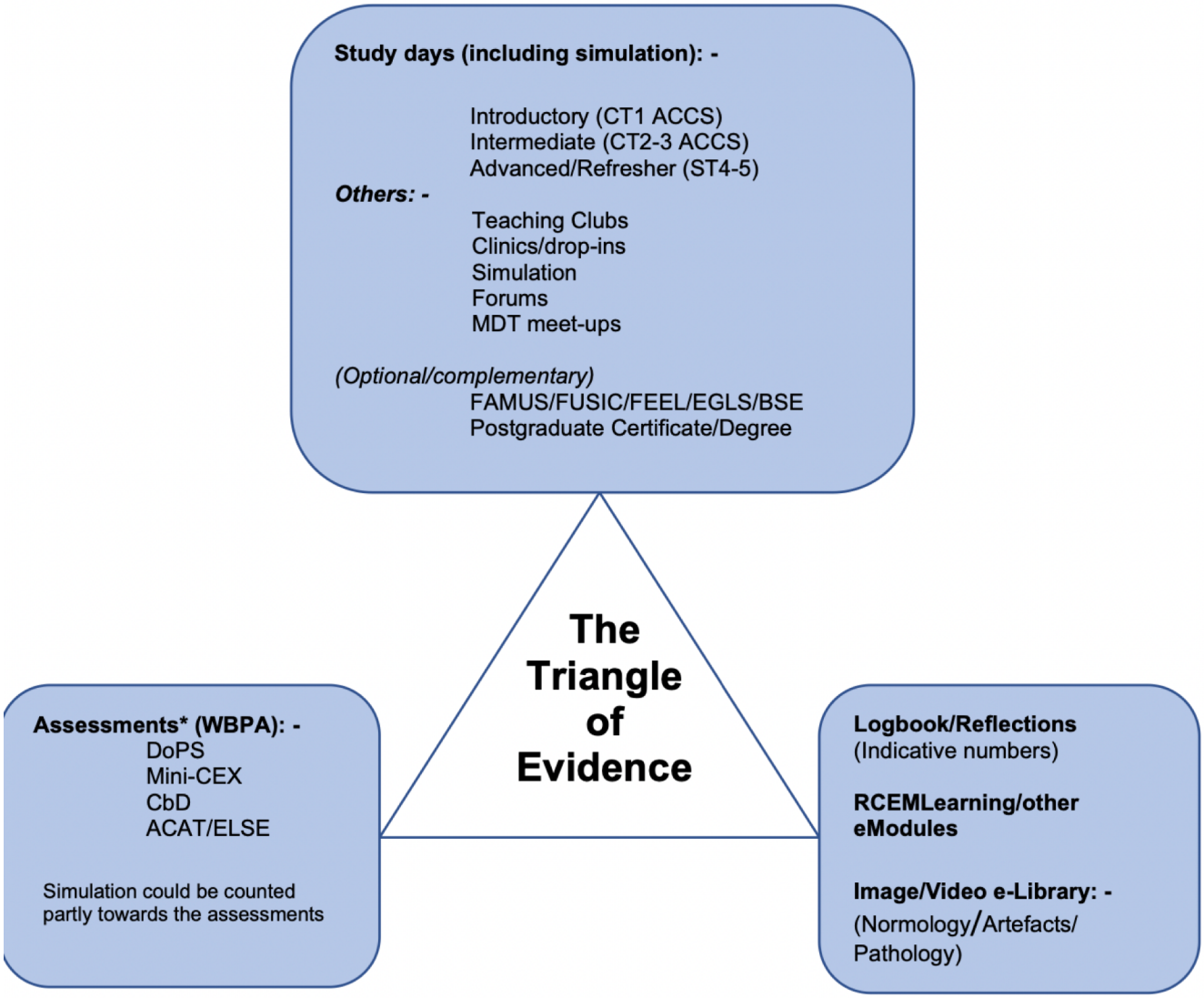
ACCS trainees must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures, the trainee must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialities 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 is made using the direct observation of procedural skills (DOPS) tool.

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

Procedure	Entrustment level at completion of the first two generic years of ACCS
Pleural aspiration of air	2a
Chest drain: Seldinger technique	2a
Chest drain: open technique	1
Establish invasive monitoring (central venous pressure and arterial line)	2a for both
Vascular access in emergency (intraosseous infusion and femoral vein)	1 for either
Fracture/dislocation manipulation	1
External pacing	2a
Direct current cardioversion	2a
Point of care ultrasound-guided vascular access and fascia	2a for both
Lumbar puncture	2a

- The Triangle of Evidence is an example of how evidence could be continuously gathered from different sources to support assessment:-



https://rcemcurriculum.co.uk

For further reading the full ACCS curriculum may be found at

https://www.accs.ac.uk

Anaesthesia:

You will be invited to attend an Introductory day at the start of your rotation. This day is organised by the Anaesthesia Education TPD, and the Anaesthesia core Training Programme Directors. When you start your year in rotation, you will be required to contact the Anaesthetic College Tutors in your Trust at least 6 months in advance to make them aware of your forthcoming rotations in Anaesthesia and ICM. They will also invite you to novice anaesthesia training days.

Further aim of making the above contact is to be aware of your novice regional training programme for anaesthesia during your anaesthesia placement via email. These are **COMPULSORY**. These are the priority over your specialty training days.

Requirements for LO7:

- Learning outcome 7 signed off
- HALO in sedation
- Anaesthetic logbook
- MTR (at least 3 responses)
- MSF one per year minimum (recommended one per placement)
- IAC (EPA1 and 2). Every descriptor/key capability should be mapped to. There should be a selection of WBPAs which demonstrate the required entrustment level. If not all are at the required level, the HALO or EPA1/2 (IAC) can still be completed if the assessment faculty agree that the trainee is performing safely at the required level. This should be supported by the Multiple Trainer Report feedback.
- Continue to contribute to other learning outcomes including non-clinical LOs.
- **End of placement report**. The form must be created in Kaizen by your clinical supervisor.

Logbook

All trainees should maintain a logbook of their anaesthetic cases, from the ***start*** of anaesthesia which **needs to be available to your ARCP panel as a summary report by age, speciality, ASA grade and level of supervision.** Theatres in individual trusts may collate this electronically. Trainees should ensure that their name is in the theatre "book" and that their involvement with cases is kept on record. We do not recommend other logbook apps as there are data protection issues and the apps are not maintained by the developers.

Keep this record from the start of your anaesthetic placement. If the necessary evidence is not available at a trainee's ARCP, it is difficult to obtain the information in retrospect.

There is a logbook available on the following website:

https://heeoe.hee.nhs.uk/emergency_medicine/handbooks-guidelines

IAC

The Initial Assessment of Competence (IAC) is available on the following link:

https://www.rcoa.ac.uk/sites/default/files/documents/2021-06/EPA-1and2-workbook.pdf

https://www.rcoa.ac.uk/documents/2021-anaesthetics-curriculum-guidance-accs-anaesthetists-training-educational-0

Trainees are expected to successfully complete the HALO for procedural sedation as per the RCoA Stage 1 curriculum. Click here for details of the procedural sedation domain of learning https://www.rcoa.ac.uk/documents/2021-curriculum-learning-syllabus-stage-1/procedural-sedation

This involves:

· Conducting appropriate pre-assessment of patients with respect to sedation, understanding patient related risk factors, and planning accordingly

· Choosing safe, appropriate sedative drugs to deliver conscious sedation

· Describing the particular dangers associated with the use of single or combinations of sedative drugs, particularly in the frail, elderly or critically ill patient and those requiring transfer

· Monitoring a sedated patient's physiology appropriately

· Ensuring the provision of safe post-procedural care

· Explaining the different levels of sedation and being able to appreciate the risks associated with these

· Being able to recognise and manage the complications of sedation

Entrustment Decisions:

- IAC: Level 2b
- Sedation: Level 2a

Please refer to the ACCS website, learning outcome 7, which should be signed off in its entirety:

https://www.accs.ac.uk/2021-curriculum/accs-los

Evidence may be linked to different key capabilities/descriptors. Therefore, trainers & trainees need to know the breadth of curriculum (across domains) in order to have an understanding of which key capabilities/descriptors can be linked.

Intensive Care Medicine

This unit is delivered in a single 3- 6-month block. During Basic training in ICM, the trainee will be working under direct supervision for the majority of the time, being introduced to the knowledge and skills required for ICM. A broad-based outline knowledge of the wide range of problems which are seen in ICM is necessary at Basic level.

Comprehensive ICM e learning modules are available on bridge/ PGVLE. All trainees should access the e learning modules available on bridge, prior to their ICM regional teaching half day. This will allow you to make the most of your regional teaching day. The ICM regional teaching half day is **COMPULSORY**.

Resources:

1) ICM learning on Bridge/ PGVLE or equivalent in the region.

2) FICM e-learning modules via e-LFH

3) For Neurocritical care, NACCS have recently launched their e-learning, all endorsed by FICM on https://naccs.org.uk/resource/contents/

4) The Basic Assessment and Support in Intensive Care course is a relevant course for novices

The new ICM Curriculum is available at

http://www.ficm.ac.uk

Trainees are expected to successfully complete the HALO for ICM as per the RCOA stage 1 curriculum:

https://www.rcoa.ac.uk/documents/2021-curriculum-learning-syllabus-stage-1/intensive-care

All trainees should keep a logbook – a procedural logbook (required for learning outcome 5) including ultrasound. In addition, they should keep a clinical case mix portfolio – with date; diagnosis; system support; learning point; personal involvement; level of supervision, for cases they have been heavily involved in. This can be on an anonymised excel spreadsheet. There is no minimum number of cases or procedures that need to be logged.

You should provide evidence for every descriptor of **learning outcome 8**.

For 'Recognises the acutely ill child and initiates management of paediatric emergencies', evidence that can be used includes: APLS, e-learning, simulation, and cases managed during the EM placement.

Requirements for learning outcome 8 (LO8):

- HALO for learning outcome 8 signed off
- Logbook – a procedural logbook including ultrasound; an ICU case mix logbook
- MCR (at least 3 responses)
- MSF one per year minimum (recommended one per placement)
- Entrustment decision
- Continue to contribute to other learning outcomes including non-clinical LOs
- **End of placement report**. The educational supervisors end of year report should be created by the supervisor on Kaizen.

http://www.rcoa.ac.uk/system/files/TRG-CCT-ANNEXF.pdf

Internal Medicine

The trainee should take part in shifts of acute medical take monthly to acquire evidence equivalent of a number of patients seen with Internal medicine problems by the end of the placement. The trainee should also gain experience in managing patients with ambulatory medical conditions in an area such as a Same Day Emergency Care (SDEC) unit.

Learning Outcomes 1, 2, 3, 6, and 9 – 12 are covered during the Internal Medicine placement.

WPBA tools used during this placement may be as follows:

- Reflection
- Acute Care Assessment Tool (ACAT)
- Case-based Discussion (CbD)
- Mini-Clinical Evaluation Exercise (mini-CEX)
- Direct Observation of Procedure Skills (DOPS)
- Multi-Source Feedback (MSF)
- Quality Improvement Project Assessment Tool (QIPAT)
- Teaching Observation (TO)
- Multiple Consultant Report (MCR)
- The Structured Teaching Assessment Tool (STAT)

For further detailed information, please follow the links below:

https://www.accs.ac.uk/assessments

https://rcemcurriculum.co.uk/wpba-tools/

https://rcemcurriculum.co.uk/the-syllabus/

ACCS Regional Teaching Programme

DRE-EM trainees in their Year out year should attend the ACCS regional teaching programme. The sessions are held on the first Friday of every month and are a mixture of face to face events

and virtual. Where possible we try to offer a hybrid model. Details of which can be found here. Please get in touch with your individual departments to arrange study leave on these days.

We run several exam preparation courses throughout the year. Please click here for further details.

Simulation training

ACCS Simulation Course

The ACCS Simulation course is delivered at various sites across the region. There are several courses throughout the year and we encourage all ACCS trainees to attend. HEEOE funds these courses for all ACCS CT1 trainees. Please organise this directly with the School of Emergency Medicine Administrator. All course dates are advertised on the website.

Educational Development Time (EDT):

The EDT is variable during the year out year in An, ICM and IM. Please discuss with your Clinical Supervisor on your initial meeting to incorporate into your rota.

Less than Full Time

As a part of HEE's work to Enhance Junior Doctors Working Lives several initiatives have been developed with partners to increase flexibility within Post Graduate Medical Education. Please contact us as early as possible if you would like to work less than full time.

Trainees may apply for LTFT under the following categories:

Category 1 (Responsibility for caring for children / Health related reasons / Direct carer for ill/disabled partner, relative or dependent)

Category 2 (Unique opportunity for Professional development / Short term extraordinary responsibility Religious commitment / Other)

Category 3 (Trainees who choose to train LTFT as a personal choice)

There is a 12-week notice. Therefore, the application must be approved 12 weeks before the start date. Please note it can take up to 28 working days to process your application, so please do not delay submitting your LTFT application form.

https://heeoe.hee.nhs.uk/faculty-educators/less-full-time-training

Gathering evidence in Kaizen

During your DRE-EM period, rotating through ACCS and ST3 specialities, you will gather evidence of competency across a broad curriculum.

The evidence must take the form of workplace-based assessments (WPBAs) where specified and additional competencies may be demonstrated with a combination of e-learning, reflective entries, teaching, and audit.

It is recognised that some rare presentations may only be encountered in a simulation session or life support course. Workplace-based assessments can be requested on courses in the same way that they are requested in real practice but should make up only a small number of your overall competency assessments and should only be required for the presentations that you are less likely to encounter in everyday practice.

The ARCP decision tool for each stage of training (ST3 & ACCS) is shown below. The table is for your reference, and it is advised that you must demonstrate the appropriate evidence in each SLOs to achieve an outcome 1 at the ARCP. The table is valuable as a reference for you as you populate your e-portfolio and for your Educational Supervisor when completing your Educational Supervisor Report (ESR).

It is recommended that you start early to gather evidence in the form of WPBAs and other documentation. It is very difficult to adequately evidence your progress if you wait until too late in the year and remember that the final Educational Supervisor's meeting should take place 4 weeks in advance of your scheduled ARCP. The DRE-EM ARCPs are generally scheduled in July

For further information please visit the RCEM Curriculum website mentioned above.

During your time in each specialty, you should attend all locally arranged educational sessions and the required ST3 Regional Training Days.

Annual Review of Competence Progression

The Annual Review of Competency Progression (ARCP) process is the means by which doctors in training are reviewed each year to ensure that they are offering safe, quality patient care, and to assess their progression against standards set down in the curriculum for their training programme.

It is also the process through which their full scope of work review is undertaken to satisfy revalidation requirements.

Requirement:

ARCP at the end of each year of training.

At the end of **Year IN** training: ARCP to sign off ST3 competencies (EM and PEM). In this year of training, you need to populate all the assessments under **Intermediate Curriculum**. All the meetings with supervisors are recorded in this curriculum in this year.

At the end of **Year OUT** training: ARCP to sign off ACCS competencies (An, ICM & AIM). In this year of training, you will need to upload all the evidence of ACCS competencies under **ACCS Curriculum.** All the meetings with supervisors are recorded in this curriculum in this year.

Work-place-based assessments (WPBA) or specific training modules must be completed, signed, uploaded and linked to the SLO's on your e-portfolio as evidence that you have achieved the adequate entrustment level.

Keeping up with your **e-portfolio** as you go along will prevent any last-minute rushes and avoidable stress. Remember your **MSF** should be completed in good time before your ARCP. Please ensure that your **Educational Supervisor report (ESR)** has been reviewed and approved by your Educational Supervisor and College tutor so that it is uploaded and ready **TWO WEEKS** prior to your ARCP date. If this is not done in a timely manner may result in an outcome 5 (Incomplete evidence presented – additional training time may be required) at your ARCP.

The following table summarises the evidence that trainees must provide for ARCP and the standards expected in order to achieve satisfactory ARCP outcome at the end of DRE-EM training programme.

REQUIREMENT	EVIDENCE REQUIRED	STANDARD REQUIRED Year IN (ST3)	STANDARD REQUIRED Year OUT SPECIALTIES
Educational Supervisor Report (ESR)	One per year to cover the training year since the last ARCP	Confirms meeting minimum requirements to progress into next stage of training (see checklist also)	Confirms meeting minimum requirements to progress into next stage of training (see checklist)
Multisource Feedback (MSF)	Minimum one MSF per year, with satisfactory number/range of Respondents (minimum 3 consultants)	Overall suggests meeting minimum requirements to progress into the next stage of training	Confirms meeting minimum requirements to progress into next stage of training.
End of Placement (Clinical Supervisor) Reports	One for each placement in each year	Confirms meeting minimum requirements to progress (Adult and Paediatric EM)	Confirm meeting or exceeding minimum requirements to progress (Anaesthesia, ICM and AIM)
Extended Supervised Learning Episodes (ESLEs)	Minimum three for the ST3 year only	Confirm meeting expectations for stage of training and no concerns in all **three** ESLEs including PEM-focused ESLE	Not Applicable
Clinical Specialty Learning Outcomes (SLOs)(ST3) & ACCS Clinical Learning Outcomes (ACCS)	Faculty Educational Governance (FEG) statement; overall ESR based on adequate SLO evidence	Minimum levels achieved for each Clinical SLO	Minimum levels achieved/ exceeded for all eight Clinical ACCS LOs
Practical Procedures (SLO 6 for ST3 & LO 5 for ACCS)	Faculty Educational Governance (FEG) statement/Multisource feedback (&/OR MCR for ACCS); overall ESR - *refer to SLO6 & LO5 practical procedure checklist*	Confirms meeting minimum requirements.	Minimum levels achieved/ exceeded for each procedure
Generic Specialty Learning Outcomes (SLOs)for both ST3 & ACCS	Educational Supervisor Report (ESR)	"Satisfactory/good" or "excellent" for all four Generic SLOs	"Satisfactory/good" or "excellent" for all three Generic ACCS LOs
Revalidation	Form R/SOAR declaration	Fully completed and submitted	Fully completed and submitted

Multisource feedback (MSF)

The trainee is expected to undertake a multisource feedback with a minimum of **12 responses**, including a minimum of **3 from consultants**, at least **once a year**.

A DRE-EM trainee must complete an MSF in both the year in and in the year out.

In addition, each parent specialty has a unique form of multi-consultant review that must be completed prior to the end of the rotation. The specific requirements are outlined within the sections dedicated to each specialty, below.

What Happens Next?

Towards the end of your two-DRE-EM years, after achieving all the ACCS & ST3 competences, you are contacted by the TPD of HST for your ST4 – ST6 placements.

DRE-EM Specific Teaching

The DRE-EM trainees who are in their EM and PEM year, are expected to attend the specific regional monthly teaching programme. Please get in touch with your individual departments to arrange study leave on these days. The ST3/DRE-EM regional training programme occurs on the 2nd Friday of the month except the month of August which is the induction month.

For the DRE-EM trainees who are in their year out period, are expected to attend the departmental and regional teaching programmes in the specific specialties.

Contacts (under development)

- Dr Pawan Gupta, Head of School of Emergency Medicine & National Lead for DRE-EM. pgupta@nhs.net
- Dr Athar Yasin, EM **TPD for CT3/ST3 and DRE-EM** atharyasin@nhs.net
- Dr Rajesh Vasiraju, **ACCS TPD** r.vasiraju@nhs.net
- Dr Muniswamy Hemavathi, HST Emergency Medicine Training Programme Director muniswamy.hemavathi@ldh.nhs.uk
- Dr Rajeev Madan, US TPD rajeev.madan@nhs.net
- Dr Diego Olmo-Ferrer, Simulation TPD for EM, DIEGO.OLMO-FERRER@nnuh.nhs.uk
- Dr Eoin Macdonald-Nethercott, TPD for digital support and blended learning. eoin.macdonald-nethercott@nhs.net
- Miss Reona Cruz, Admin Manager, East of England School of Emergency Medicine, rcc59@cam.ac.uk
- Dr Linda Menadue, Anaesthetics TPD (ACCS & Core North) linda.menadue@nhs.net
- Dr Hasanthi Gooneratne, Director of Education and Deputy Regional Advisor, Anaesthesia Hasanthi.Gooneratne@esneft.nhs.uk
- Dr Nina Walton, Anaesthetics TPD - Core training (South) nina.walton@nhs.net
- Dr Kamal Patel, TPD In Internal Medicine kamal.patel@addnenbrookes.nhs.uk
- Dr James Edwards, Head of School for Medicine JAMES.EDWARDS@nnuh.nhs.uk
- Dr Emily Simpson, Head of School for Anaesthetics emily.simpson16@nhs.net

Resources

- For Emergency Medicine trainee's portfolio:
  https://rcem.ac.uk/eportfolio-access/

- For Anaesthetic training and LLP
  https://www.rcoa.ac.uk/lifelonglearning

- Specific ACCS website:
  https://rcoa.ac.uk/accs
  https://www.accs.ac.uk/

- HEEOE School of Emergency Medicine website:
  https://heeoe.hee.nhs.uk/em_home