Royal College of Anaesthetists | The Royal College of Emergency Medicine | JRCPTB Joint Royal Colleges of Physicians Training Board | The Faculty of Intensive Care Medicine

INTERCOLLEGIATE COMMITTEE FOR ACUTE CARE COMMON STEM TRAINING (ICACCST)

ACCS Educational Supervisor Handbook 2024-25

Introduction

This handbook is intended as a supporting reference guide for trainers who have an Educational Supervisor role for ACCS Post-Graduate Doctors in Training (PGDiTs). It covers all the main aspects of training and supervision and should be the first port of call for any queries you may have along the way.

Whilst there is a lot to digest here it is advisable to ensure familiarity with the contents at the start of the training year as this often saves a lot of time later on. For trainers who are relatively new to educational supervision this handbook covers all you need to know to get started. For more experienced supervisors, some of the content may already be familiar, however there are changes and updates every year so you are advised to check through this latest edition at the beginning of the training year.

Please note, some aspects of training are likely to be updated during the year (eg we are expecting a new edition of the Gold Guide), so please refer to the HEE website for the most up-to-date information.

If you require further information not contained within this handbook, or if you have any particular queries, issues, problems etc. that you cannot resolve then please contact your Training Programme Director/ACCS Lead.

CONTENTS

1. ACCS – Definition and Structure
2. Induction
3. Supervision
4. Curriculum and Assessments
5. Teaching and Training
6. Portfolio
7. Exams
8. ARCP
9. Leave and Courses
10. ACCS Events
11. Social Media
12. Time Out of Programme (OOP)
13. Changing Specialty – Moving Region
14. Part time Working (less than full time training)
15. PGDiTs in difficulty
16. Contacts and Who's Who?
17. Key Links
18. Timeline

Appendix A: ARCP Checklists

Appendix B: Doctors In Difficulty

Appendix C: Acronyms

ACCS: Definition and Structure

ACCS is a two-year core training programme that normally follows Foundation Year 2. It is the only core training programme for PGDiTs wishing to enter higher specialty training in Emergency Medicine. It is an alternative core training programme for PGDiTs wishing to enter higher specialty training in Internal Medicine (IM) or Anaesthetics. It delivers all elements of the specialty-specific core training curricula, with additional augmented outcomes, i.e. capabilities beyond those areas covered by Stage 1 training in IM or Anaesthesia. The two years are spent rotating through six-month placements in Emergency Medicine (EM), Internal Medicine (IM), Anaesthetics and Intensive Care Medicine (ICM).

Specialty Specific Objectives for ACCS training

Emergency Medicine:

ACCS constitutes the first two years of the CCT in EM in a pre-planned and structured manner. ACCS training is then followed by a year in Intermediate training further developing clinical capabilities in adult EM (including musculoskeletal emergencies) and Paediatric Emergency Medicine as well as generic capabilities. Achievement of the requisite degree of independence by the end of Intermediate training – a key milestone point – confers eligibility for PGDiTs to progress to Higher training in EM.

Acute Internal Medicine:

ACCS is one of the training options available for delivering the core competencies required for a CCT in IM or one of the JRCPTB specialties in a pre-planned and structured manner. The two core years of ACCS training are followed by a further two years in acute medical specialties. Achievement of the requisite degree of independence by the end of this Stage 1 training – a key milestone point – confers eligibility for PGDiTs to progress to Stage 2 training in IM and the specialties managed by the JRCPTB.

Anaesthetics:

Anaesthetics offers career opportunities in a wide range of subspecialty areas, all of which can be achieved by direct entry to an Anaesthetic CCT programme. For those Anaesthetic PGDiTs with an interest in the ‘acute’ end of the spectrum, ACCS provides a more widely-based experience than is available via the Core Anaesthesia programme. The two core years of ACCS training are followed by a further two years of Anaesthetic experience. Achievement of the requisite degree of independence by the end of this Stage 1 training – a key milestone point – confers eligibility for PGDiTs to progress to Stage 2 training in Anaesthetics.

Intensive Care Medicine:

ACCS allows PGDiTs who wish to obtain the single CCT in ICM or a dual CCT in Internal Medicine & ICM, Anaesthetics & ICM or Emergency Medicine & ICM, to obtain the competences of the complementary specialties in a pre-planned and structured manner.

2. Induction

PGDiTs are required to attend Trust/Corporate Induction at the first hospital they work at in August. They should also receive the necessary departmental/specialty induction in the first days of each post.
All new ACCS PGDiTs are invited to attend a half day generic induction, usually held on a Wednesday afternoon in mid-August. This year it is being held on Wednesday 14th August. Please ensure that your PGDiTs are able to attend this- it will provide essential information for their training.

The Severn School of ACCS also offers 3 novice courses which are relevant to any ACCS PGDiT (regardless of parent speciality) when they start each of their rotations. These are:

- New-2 ICM: 14th August 2024 (CT/ST2s only)
- New-2 EM: 30th August 2024 (tbc)
- Novice Anaesthesia:
    - Cohort 1: September 5-6th, 24th October 2024
    - Cohort 2: September 12-13th, 25th October 2024

These New-2 and Novice courses are repeated in February/ March for their next rotations, exact dates tbc.
New-2 AM are carried out locally.

These courses are mandatory and are by invitation only. More information can be found here: https://accs.severndeanery.nhs.uk/events

3. Supervision

There are two main supervisor roles for PGDiTs which may be carried out by different trainers, though in some instances the same trainer may undertake both roles for part of a PGDiT's time in ACCS. More information on these roles can be found in the Gold Guide here.

Please note that Educational Supervisors require Deanery recognition and GMC approval.

Placement Educational Supervisor

Assigned from their current clinical post and oversees their time in that post.

- Provides induction
- Carries out some of the WPBAs
- Handles immediate clinical issues, rota issues etc
- Provides feedback and oversees the generation of the panel-based judgement (Faculty Educational Governance Statement/Multi-Trainer Report/Multi-Consultant Report)
- Completes Placement Educational Supervisor's End of Placement Report form at the end of the six-month placement
- Liaises with Specialty Educational Supervisor and informs the decisions about the PGDiT's overall progress.

Specialty Educational Supervisor

Should be assigned from their parent specialty for a minimum of one year (but ideally for the full ACCS programme) and are responsible for the overall supervision and management of a PGDiT's trajectory of learning and educational progress during ACCS.

- Sets up Learning Agreement
- Helps plan their training and agreed learning outcomes
- Reviews their Portfolio, Clinical Supervisor's Reports, panel-based judgements and WPBAs
- Prepares them for ARCP
- Brings together all relevant evidence to form a summative judgement at the end of the placement
- Provides the end of year Educational Supervisors Report (ESR) for the ARCP panel
- Offers career guidance and support
- Assists with issues and problems
- Liaises with the TPD/ACCS Lead.

As an Educational Supervisor you should ensure that you remain up to date in your role. This includes being aware of how to support PGDiTs, how to give feedback and having knowledge of their curriculum, WPBAs, e-portfolio and requirements for ARCP. Educational Supervisors should work closely with the TPD/ACCS Lead and should sit on ARCP panels regularly.

As an educational supervisor you must ensure that the PGDiT:

- is aware of their responsibility to initiate workplace-based assessments, compile evidence towards the curricular learning outcomes and provide the requisite evidence as set out in the ARCP Decision Aid
- is supported in preparing for those assessments
- is aware of the requirement to maintain an up-to-date educational portfolio
- is aware of the requirements to undertake and succeed in all assessments of knowledge (usually examinations) and performance in a timely fashion based on the recommended timescale set out in the specialty curriculum
- is aware of the need to engage in processes to support revalidation

4. Curriculum and Assessments

You can find the ACCS Curriculum as well as a number of related resources on the ACCS website here.

The curriculum covers the overall purpose, the content of learning and the programmes of learning and assessment in ACCS. ***It is vital that you familiarise yourself with the curriculum and in particular the learning outcomes and assessment framework in order to support your PGDiTs.***

The content of ACCS training is described as a set of high-level learning outcomes (ACCS LOs) – eight clinical and three generic – that incorporate the GMC's Generic Professional Capabilities. These eleven ACCS Learning Outcomes describe the professional tasks or work within the scope of the ACCS specialities. Each ACCS LO has a set of key capabilities associated with that activity or task. Key capabilities are intended to help PGDiTs and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made.

Some of the clinical learning outcomes are covered and evidenced during a particular placement, whilst the rest are applicable to all the ACCS placements. This is all detailed in the curriculum. In addition, to assist PGDiTs and trainers in navigating the requirements, the ARCP Decision Aid *(Appendix A)* set out clearly the evidence required from each placement and at the end of each year of ACCS training.

Overall, it will require planning and organisation on the part of the PGDiT in order to demonstrate the requisite level of independence in the clinical LOs and to show satisfactory progress towards the generic LOs. Failure to achieve this will make if difficult for you as an Educational Supervisor to ascertain whether they have satisfactorily completed their placements, which may affect the outcome of their ARCP. It is therefore vital that you work closely with your supervisee and their Placement Supervisor to support them in achieving the necessary requirements.

The ACCS LOs are assessed in two ways:

1) *Workplace-based assessments (WPBAs):*

- Mini-Clinical Evaluation Exercise (M-CEX)
- Direct Observation of Procedural Skills (DOPS)
- Multi-Source Feedback (MSF)- minimum 12 responses with at least 3 consultants
- Case-Based Discussions (CBD)
- Acute Care Assessment Tool (ACAT and ACAT-EM)
- Patient Survey
- Audit Assessment
- Teaching Observation

2) *Panel-based judgements*

- *Faculty Education Governance Statement (FEGS) - EM placement, all PGDiTs*
- *Multi-Trainer Report (MTR) and Holistic Assessment of Learning Outcome (HALO) - Anaesthesia placement, all PGDiTs*
- *Multi-Consultant Report (MCR) - IM and ICM placements, all PGDiTs*

Entrustment (Supervision Levels)

Assessment in each of the ACCS specialties is built around preparing PGDiTs for thresholds in training. To that end, assessments in the workplace and are also aligned to entrustment i.e independence using a simple rating scale:

1	Direct supervisor observation/involvement, able to provide immediate direction or assistance
2a	Supervisor on the 'shop-floor' (eg ED, theatres, AMU, ICU), monitoring at regular intervals
2b	Supervisor within hospital for queries, able to provide prompt direction or assistance and PGDiT 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 PGDiTs practice with a consultant taking overall clinical responsibility)

Please note, this is the entrustment level that the PGDiT would be at if they were to repeat this activity next time. It is not the supervision level which they actually had for the case.

This scale is used for individual WPBAs and for overall entrustment decision at end of placement and end of year for each of the clinical Learning Outcomes.

Please note, an EL of 4 is essentially what a consultant would be at- it is therefore highly unlikely that your PGDiT would achieve this level!

For the purposes of ACCS, most LOs expect a PGDiT to achieve an Entrustment (supervision) Level of either 2a or 2b:

Learning Outcome	Entrustment requirements			
	EM	IM	An	ICM
1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	2b	2b		
2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	2a	2a		
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	2a	2a	2a	2a
4. Care for acutely injured patients across the full range of complexity	2b			
5. Deliver key ACCS procedural skills	*See LO5 Checklist*	*See LO5 Checklist*	*See LO5 Checklist*	*See LO5 Checklist*
6. Deal with complex and challenging situations in the workplace	2a	2a	2a	2a
7. Deliver safe anaesthesia and sedation			2b (HALO 2a)	
8. Manage patients with organ dysfunction and failure				2a
9. Support, supervise and educate	Satisfactory progress	Satisfactory progress	Satisfactory progress	Satisfactory progress
10. Participate in research and manage data appropriately	Satisfactory progress	Satisfactory progress	Satisfactory progress	Satisfactory progress
11.Participate in and promote activity to improve the quality and safety of patient care	Satisfactory progress	Satisfactory progress	Satisfactory progress	Satisfactory progress

In addition to these LOs, a PGDiT must also prove that they achieve the following Entrustment Levels in the following practical procedures:

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 iliaca nerve block	2a *for both*
Lumbar puncture	2a

In EM, the PGDiT needs to demonstrate that they have achieved the relevant Entrustment Levels in LOs 1-6 and 9-11.

In AM, the PGDiT needs to demonstrate that they have achieved the relevant Entrustment Levels in LOs 1-3, 5, 6 and 9-11.

In anaesthetics, the PGDiT needs to demonstrate that they have achieved the relevant Entrustment Levels in LOs 3, 5-7 and 9-11.

In ICM, the PGDiT needs to demonstrate that they have achieved the relevant Entrustment Levels in LOs 3, 5, 6 and 8-11.

Documentation

PGDiTs use the e-portfolio of their parent specialty which links to the ACCS and parent specialty curricula and contains the necessary WPBA and other assessment forms. Each time the PGDiT completes a placement within the ACCS programme an Educational Supervisor End of Placement Report should be completed by their Placement Educational Supervisor.

Assessment is the same for all PGDiTs regardless of parent specialty and all three e-portfolios hold the necessary forms for all placements which have the same overall content and which can be linked to the Learning Outcomes/Key Capabilities.

5. Teaching and Training

Attending teaching and training sessions is an important aspect of curriculum delivery for PGDiTs and they should ensure they maximise their attendance at teaching.

Who should go to what

	AM Placement	EM Placement	Anaes Placement	ICU Placement
AM Trainees	Regional ACCS New 2 AM GIM (CMT)	Regional ACCS New 2 EM GIM (CMT)	Regional ACCS Novice Anaes Course GIM (CMT) (Primary FRCA)	Regional ACCS New 2 ICM GIM (CMT) (Primary FRCA)
EM Trainees	Regional ACCS New 2 AM	Regional ACCS New 2 EM	Regional ACCS Novice Anaes Course (Primary FRCA)	Regional ACCS New 2 ICM (Primary FRCA)
Anaesthetic Trainees	Regional ACCS New 2 AM Primary FRCA FICM	Regional ACCS New 2 EM Primary FRCA FICM	Novice Anaes Course Primary FRCA FICM	New 2 ICM Primary FRCA FICM

The Severn School of ACCS also runs a “Clinical Skills” simulation day, which is free for all ACCS PGDiTs to attend- once only, usually in their second year (must be booked).

In addition, there is also a Sedation Course, a Tracheostomy Course and a Severn ACCS PGDiT Conference organised by the Severn School of ACCS.

All PGDiTs are entitled to Educational Development Time (EDT), in order to achieve LOs 9-11 (audit, research, QIPs, teaching and management). In the Severn School of ACCS this will be allocated as 4 hours (one afternoon) per fortnight for each PGDiT, regardless of placement.

This policy is supported by both the RCEM, which recommends the requirement for average three hours per week EDT; and the RCoA, which states:

Anaesthetists in training in stages 1 and 2 of the curriculum on both core Anaesthetic training and ACCS pathways should be allocated up to 2 hours of EDT per week. EDT should be allocated pro rata for those in less than full-time training.

Time should be spent on site unless there are specific agreed reasons such as involvement in research projects on different sites or a lack of suitable facilities and space to support the work being undertaken. During the initial period of training when the Initial Assessment of Competence is being undertaken EDT should support this activity in areas such as simulation and tailored educational sessions.

As a school of ACCS, we would therefore expect all anaesthetic departments to allocate EDT to all novice DiTs, regardless of whether or not they are pre-IAC. We would however expect all novice anaesthetists to direct their EDT appropriately, which prior to the IAC being achieved may be in seeking out specific theatre lists.

Portfolio

PGDiTs should ensure they are registered with their parent specialty College and that they have access to the relevant e-portfolio which they should use throughout their training in ACCS. They should ensure they provide your details as Educational Supervisor to allow you the necessary access to their e-portfolio.

All three parent specialty e-portfolios have been designed around the new curriculum and enable PGDiTs to access all the necessary information and record their progress. It is important that you encourage your PGDiT in keeping their e-portfolio up to date and support them in developing a sufficient body of evidence against each Learning Outcome/Key Capability in order that you can make judgements about their progress for ARCP.

Anaesthetics LLP:

There are a number of things to remember when using the LLP as an ACCS Anaesthetics trainees

a) Remember to cross link SLEs/Personal activities to the Stage 1 anaesthetics. A table of which domains from ACCS cross link to Stage 1 Anaesthetics is on the ACCS Website at https://www.accs.ac.uk/anaesthetics-all-trainees

b) Once you have placed any SLE/Personal activity in a Domain you should press “Create HALO”. This will then change to HALO in Progress. The advantage of doing this is that the SLEs etc are now placed with their associated Key Capabilities so makes it easier to see which areas have been completed and which need more evidence

c) Ensure that for MTR/MCR you create the ACCS MTR/MCR which relates to the ACCS domains rather than the plain MTR which pertains to the Core Anaesthetics domains.

d) The End of Placement Supervisor’s form and the End of Year reports are not on the LLP but are editable Word documents which can be found here.

In addition all ACCS PGDiTs, regardless of parent specialty, are advised to register for the e-Learning For Health website at: http://portal.e-lfh.org.uk/.

6. Examinations

The PGDiT's parent specialty determines their exam requirements for satisfactory progression through training. *The current requirement is that no exam progress is required during the two core years of ACCS training*. After this the following requirements are in place:

ACCS Internal Medicine PGDiTs: must achieve the full MRCP (UK) Diploma to successfully complete Stage 1 Internal Medicine training.

ACCS Anaesthesia PGDiTs: must achieve the full Primary FRCA to successfully complete Stage 1 Anaesthetics training.

ACCS Emergency Medicine PGDiTs: must achieve the full MRCEM to successfully complete Intermediate Emergency Medicine training.

It is vital that your PGDiTs familiarise themselves with the exam regulations for the relevant exam, in particular when they can first sit the various parts, when to apply etc.

7. Annual Review of Competency Progression (ARCP)

The ARCP is the annual review of PGDiTs' progress.

Detailed information relating to the Annual Review of Competency Progression, (ARCP) is documented in the Gold Guide. All supervisors and PGDiTs should make themselves familiar with this document as well as local Deanery processes.

The Decision Aid as well as a PGDiT ARCP checklist detailing the overall requirements for ARCP are found at the end of this Handbook in *Appendix A*.

The ARCP process has three different and distinct aims:

a. **Revalidation** (fitness to practice)- this is the Form R. Please make sure that it is completed accurately and fully. Failure to do so will not result in an adverse outcome at ARCP, however it might affect the PGDiT's revalidation in the future as it is their official record of work undertaken. The ACCS ARCP gives advice to the Deanery Revalidating Officer about their revalidation to enable a recommendation to the GMC.

b. **Appraisal** (fitness to progress)- are they making satisfactory progress? This decision will be based on all the evidence that they present from the previous year to now. It doesn't matter how far through they are in their current placement, we just want to see that they are progressing. The ACCS ARCP is the mechanism for reviewing and recording evidence and a means whereby the evidence of the outcome of assessments is recorded to provide a record of their progress within their training post including Out Of Programme Training (OOPT). It makes judgements about the competencies acquired by a PGDiT and their suitability to progress to the next stage of training and provides a final statement of the PGDiT's attainment of the curricular competencies and thereby the completion of the stages of the training programme.

c. **Completion of placements**- can we sign them off for the placements they have done? Logically, this can only be done once they have actually finished (or almost finished) their placements, so we can sign off their 1st or 3rd placements (completed in January), but not their 2nd or 4th ones (which they are just halfway through).

ARCP Panel

The ARCP panel reviews the evidence submitted by each PGDiT on a set, pre-agreed date. The panel should consist of a minimum of 3 members and include representatives from each of the four ACCS placements (Anaesthetics, ICM, EM and IM). The Chair of the panel should be trained for their role and is usually a TPD or Postgraduate Dean's representative. The panel should include Educational Supervisors, and others who are involved in medical education. A proportion of the panels will involve either a lay representative and/or an external representative from the appropriate Royal College(s). All panel members should have Equality and Diversity training.

The Evidence

Please familiarise yourself with the ARCP decision aid. Make sure that your PGDiT submits all the required evidence that is requested.

It is each PGDiT's responsibility to submit the required evidence by a set date before the ARCP panel convenes. This should include:

- The Educational Supervisor's Report (ESR or EYR) covering a full training year and completed by the Specialty Educational Supervisor.
- End of Placement Clinical Supervisor Reports (CSR or EPR) for each of the placements covered during the year and completed by the Placement Educational Supervisor. This means that they should have one EPR for their first placement, and then one for the placement they are currently in.
- Evidence of progress against each of the ACCS Learning Outcomes including FEG/MTR/HALO/MCRs and WPBAs
- Enhanced Form R (a form giving demographic details, a description of their scope of practice and a self-declaration statement for revalidation purposes).

The panel reviews the evidence provided and awards an ARCP outcome, which is then communicated to the PGDiT. *Only the pre-agreed documentary evidence can be considered* so it is vital that the Educational Supervisor provides a full and detailed ESR.

Of course, it is unlikely that all the Learning Outcomes (LO) for their current placement will be signed off for the expected Entrustment Levels (EL) required by the end of the post. That is fine- we just want to see that they are making progress. So for instance, for LO #1 in their current placement (EM), they might be at EL 2a. That is fine- we do not expect them to be at level 2b as they are only halfway through their post. But we do need to see the form as we need to see that they are on target for completion by the end of their placement.

In summary, the following evidence is required for the ARCP:

1. Educational Supervisor Report (x1)
2. End of Placement Reports (x2)
3. MSF (x1)
4. Clinical Learning Outcomes- progress to satisfactory Entrustment Level in each placement (reported by MTR/ MCR or by FEG)
5. Practical Procedures (LO 5)- progress to satisfactory Entrustment Level (reported by MTR/ MCR or by FEG)
6. Generic Learning Outcomes- satisfactory progress (reported by ESR)
7. Revalidation- Form R

Specialty Educational Supervisor's Report (ESR or EYR)

The Specialty Educational Supervisor will write a structured report for the ARCP panel. The ESR must:

- reflect the learning agreement and objectives developed between the PGDiT and their Educational Supervisor
- be supported by evidence from the panel-based judgements and WPBAs
- make a definitive statement regarding entrustment level for each of the clinical LOs and progress against the generic LOs
- take into account any modifications to the learning agreement or remedial action taken during the training period for whatever reason
- provide a summary comment regarding overall progress during the period of training under review, including where possible an indication of the recommended outcome supported by the views of the training faculty

The report and any discussion which takes place following its compilation must be evidence-based, timely, open and honest. The discussion and actions arising from it should be documented. The Educational Supervisor and PGDiT should each retain a copy of the documented discussion. If there are concerns about their performance, based on the available evidence, they must be made aware of these prior to ARCP. PGDiTs are entitled to a transparent process in which they are assessed against agreed published standards, told the outcome of assessments, and given the opportunity to address any shortcomings. PGDiTs are responsible for listening, raising concerns or issues promptly and for taking the agreed action.

The Educational Supervisors should also support the PGDiT to **develop an action plan** to tackle any concerns and deficiencies and objectives should always be written using **SMART** objectives or another validated educational method.

ARCP Outcomes (From the Gold Guide)

The following outcomes can occur after an ARCP panel:

- **Outcome 1: Satisfactory Progress** - Achieving progress and the development of competencies at the expected rate
- **Outcome 2: Development of specific competences/capabilities required – Additional training time not required** - The PGDiT's progress has been acceptable overall but there are some competences/ capabilities that have not been fully achieved and need to be further developed. It is not expected that the rate of overall progress will be delayed or that the prospective date for completion of training will need to be extended or that a period of additional remedial training will be required.
- **Outcome 3: Inadequate progress – Additional training time required -** The panel has identified that a formal additional period of training is required that will extend the duration of the training programme. Where such an outcome is anticipated, the PGDiT must be informed in advance. The PGDiT, Educational Supervisor and employer will need to receive clear recommendations from the panel about what additional training is required and the circumstances under which it should be delivered (e.g. concerning the level of supervision).
- **Outcome 4: Released from training programme – With or without specified competences/ capabilities** - The panel will recommend that the PGDiT is released from the training programme if there is still insufficient and sustained lack of progress despite having had additional training to address concerns over progress. The panel should document relevant competences/capabilities that have been achieved by the PGDiT and those that remain outstanding. The PGDiT will have their National Training Number (NTN)/ Dean's Reference Number/training contract withdrawn and may wish to seek further advice from the Postgraduate Dean or their current employer about future career options, including pursuing a non-training, service-focused career pathway.
- **Outcome 5: Incomplete evidence presented – Additional training time may be required** - The panel can make no statement about progress or otherwise where either no information or incomplete information has been supplied and/or is available to the ARCP panel. The panel should agree what outstanding evidence is required from the PGDiT and the timescale in which it must be provided to be able to issue an outcome.

For outcomes 2 - 4 the PGDiT is required to meet with the panel after the panel has reached their decision.

PGDiTs on Outcomes 2, 3 and 4 should meet with their Specialty Educational Supervisor and TPD afterwards, and a written educational plan should be agreed. The educational plan should be written using SMART objectives, and should be agreed by all parties.

9. Leave and courses

The arrangements for study leave are detailed on the Deanery website here.

Courses are classified in 3 categories:

Cat 1: Required within the curriculum and unable to achieve competences through their training programme or regional teaching. These courses are fully funded.

The only Cat 1 courses approved for ACCS PGDiTs are the New-2 courses, the Novice anaesthesia course, the Clinical Skills course, the Sedation course, the Tracheostomy Course, Life Support courses and the Severn ACCS PGDiT Conference.

Cat 2: Enhanced knowledge – not recognised as a requirement for the PGDiT's curriculum, however activities will help the PGDiT complete parts of the curriculum. It is expected that those applying for these courses will have met their core curriculum competencies for their stage of training.

A course must be on the approved course list to be fully funded. Course fees over £1000 will be by exception and require HEE sign-off.

Approval for cat 2 courses is primarily governed by the parent specialty of each individual PGDiT as these vary from specialty to specialty. Courses that are approved for CT/ST 1-2s in their parent specialty are therefore also approved for ACCS PGDiTs.

Cat 3: Career Progression - these courses should only be required at the latter stage of training and are not applicable for ACCS PGDiTs.

Retrospective applications in all 3 Categories will not be reimbursed under any circumstances.

As Educational Supervisor you should support your PGDiT(s) in making decisions about best use of study leave time and funding to ensure they complete all mandatory courses as well as have the opportunity to explore areas of particular individual interest.

10. ACCS events

Information on ACCS events and the annual Trainers and PGDiTs Days plus any other events will be posted on the Severn ACCS website.

ACCS Teaching Hub

The ACCS teaching hub is an online education platform for CT/ST1&2 PGDiTs in the South West. The hub has been established to provide PGDiTs in the South West with a central platform to store resources and access information about teaching days. The ACCS hub will act as their one stop shop to view teaching day programmes and access links.

Although they can access links to the teaching days on the events page, please ensure they still register via the deanery website. This is integral to ensure organisers know who is attending their teaching day and enable them to prepare.

The link for the training hub is
https://healtheducationengland.sharepoint.com/sites/SPGMESACCS-SW?e=1%3A0add1f29ba6341038f95d1f3c210a7ef
They will only be able to access the site with a valid NHS email address.

11. Social Media

Please see the BMA's guidance on the use of social media here and that of the GMC here.

There is a PGDiT WhatsApp group, organised by the ACCS PGDiT rep.

12. Out of programme time (OOP)

PGDiTs may, subject to the approval of the Deanery, spend some time out of the specialty training programme to which they were appointed. This can be for a career break or educational/ training opportunities elsewhere. Whilst occasions where OOP is granted to core PGDiTs are likely to be exceptional given the short length and the nature of their training, these opportunities are explained in detail in the Gold Guide and by the GMC here.

Time Out of Programme (OOP) allows PGDiTs to gain experiences outside of their planned programme of training. There are several reasons for which PGDiTs may wish to spend time out of programme:

OOPC – Career Break: To take a planned career break from the specialty training programme.

OOPE – Experience: To gain clinical experience which is not approved by the GMC but which may benefit the doctor (i.e. working in a different health environment/country) or help to support the health needs of other countries.

OOPT – Training: To gain clinical experience which is not a part of the PGDiT's specialty training programme in undertaking GMC prospectively approved clinical training which will count towards CCT.

OOPP – Pause: To allow PGDiTs to step out of formal training for up to one year. To undertake a UK-based, non-training post in the NHS or other patient facing clinical setting. This flexibility initiative can be a vital tool to support wellbeing.

OOPR – Research: To undertake a period of research (up to a maximum of 3 years)

Before applying for OOP, PGDiTs must discuss their plans with their Educational Supervisor and/or Training Programme Director. This discussion will determine the suitability of the out of programme experience and ensures the proposed post will meet the educational needs of the PGDiT.

Time out of programme will not normally be agreed until a PGDiT has been in a training programme for at least a year. They will need to give a minimum of 3 months' notice.

PGDiTs are normally expected to be on an ARCP outcome 1 to be eligible to apply.

Further information from the Deanery is found here.

13. Changing specialty and moving region

Changing Parent Specialty

It is not possible for ACCS PGDiTs to automatically switch from one parent specialty programme to another (e.g. Internal Medicine to Anaesthesia). The ICACCST have previously had discussions with the GMC, Health Education England and the UK's Deans to try and find some way of resolving this, but there has been no change to the current situation.

PGDiTs wishing to change ACCS specialty should apply for an ACCS CT1 post within the specialty that they wish to change to. If successful, the Deanery/School may approve the counting of competencies already gained towards the new specialty. Please note: this would be entirely at the Deanery's discretion, and it is therefore not guaranteed that this will occur.

Inter Deanery Transfer (IDT)

The National Inter Deanery Transfer (IDT) process has been established to support PGDiTs who have had an unforeseen and significant change in their personal circumstances since the commencement of their current training programme which requires a move to a different region. The process is managed by the National IDT team (Health Education South London) on behalf of the Conference of Postgraduate Medical Deans (COPMeD), Health Education England (HEE) and all UK regions.

In order to provide a consistent, transparent and robust process for all PGDiTs, the National IDT team will make all decisions on eligibility and allocations in accordance with the published guidelines and criteria. You can read these guidelines and criteria as well as find out more about the process here. You can also contact the National IDT team directly with any queries you may have.

As part of the application process, all PGDiTs are required to submit a 'Deanery Document'. This form can be found on the National IDT website above and should be sent to their current region's administrative team for completion.

Local information is found here:

https://severndeanery.nhs.uk/about-us/policies-and-procedures/peninsula-idt/

14. Part time working (Less Than Full Time Training)

All employees have a legal right to request flexible working – not just parents and carers. Therefore, all doctors in training can apply for LTFT training and section 3.123 of the Gold Guide provides a list of illustrative examples for requesting LTFT training:

- Doctors in training with a disability or ill health – This may include ongoing medical procedures such as fertility treatment.

- Doctors in training with caring responsibilities (e.g. for children, or for an ill/disabled partner, relative or other dependant).

- Welfare and wellbeing – There may be reasons not directly related to disability or ill health where doctors in training may benefit from a reduced working pattern. This could have a beneficial effect on their health and wellbeing (e.g. reducing potential burnout).

- Unique opportunities – A doctor in training is offered a unique opportunity for their own personal/professional development and this will affect their ability to train full time (e.g. training for national/international sporting events, or a short-term extraordinary responsibility such as membership of a national committee or continuing medical research as a bridge to progression in integrated academic training).

- Religious commitment – A doctor in training has a religious commitment that involves training for a particular role and requires a specific time commitment resulting in the need to work less than full time.

- Non-medical development – A doctor in training is offered non-medical professional development (e.g. management courses, law courses or fine arts courses) that requires a specific time commitment resulting in the need to work less than full time.

- Flexibility for training and career development with the option to train less than full time with flexibility that might enable development of a broad career portfolio.

Those applying due to a disability / ill health or caring responsibilities (1 and 2 above) will be accommodated.

Requests to train LTFT for other well-founded reasons will be dependent on the capacity of the programme and the effect the request may have on the training of other doctors on the training programme. It will therefore be subject to the agreement of the employer / host training organisation before the placement can commence.

Application

Those applying due to a disability / ill health or caring responsibilities will need an application form together with a letter of support or other supporting information to back up their application. If they wish to apply on these grounds they must show that training on a full-time basis would not be practical for them for well-founded individual reasons. In practice, if they feel that either of these categories apply to their circumstances, please chat to one of the TPDs so that we can understand and support their application.

For all other applications, they should complete the free text boxes on the application form detailing the nature of their request.

PGDiTs should allow 16 weeks for their application to be considered, however requests to train LTFT received at short notice on health grounds will be considered on a case-by-case basis.

Rotations

PGDiTs generally choose to work at 60% LTFT or at 80% LTFT. Other options may be possible subject to agreement.

Whichever they choose and for however long, all PGDiTs applying to work LTFT must understand that this will delay their rotation dates and ultimately their completion date for ACCS.

Broadly speaking, if they work at 80%, 4 weeks equates to 5 weeks whole time equivalent (WTE). This means that 4 months spent at 80% will delay their rotation date by one month. 6 months at 80% will delay things by 6-7 weeks. However, out of respect for the rota writers of our host Trusts, we do not allow PGDiTs to rotate halfway through a month, so they should therefore expect to spend 8 months in that specialty. 6 months working at 60% LTFT equates to 10 months WTE.

WTE	6 months	12 months	18 months	24 months	30 months	36 months
F5 (50% WTE)	12 months	24 months	36 months	48 months	60 months	72 months
F6 (60% WTE)	10 months	20 months	30 months	40 months	50 months	60 months
F7 (70% WTE)	9 months	17 months	26 months	34 months	43 months	51 months
F8 (80% WTE)	8 months	15 months	23 months	30 months	38 months	45 months

On some occasions, it might be appropriate for them to rotate in sync with their colleagues in August or February, even if they still have some time outstanding. This may be the case, for instance, if they are due to start anaesthetics, as there are certain advantages to starting this specialty with other novices. However, this is generally only possible if the time outstanding is in their parent specialty, as this can be tacked on to the end of their ACCS programme just before they commence CT/ST3 in that specialty.

There may be other occasions where it is appropriate for them to rotate after a slightly shorter time period than their WTE, but this will be determined on an individual basis in consultation with the Training Programme Directors / Head of School.

Other Considerations

PGDiTs should be aware of the financial implications of working LTFT as their salary will be pro-rata and there will be a delay to their incremental pay points.

PGDiTs who are due to rotate to a specialty within 4 months of their FT colleagues' start date are encouraged to attend the relevant induction days and the novice/ new-to courses, as these only run twice a year.

It is possible that their ARCP date will need to be moved, as they may not have collected sufficient evidence by the June ARCP round. As a School, we run an additional ARCP round in September for those who are LTFT, as well as in January. They will be advised which of these dates is most appropriate for them on an individual basis.

Occasionally PGDiTs need to take a prolonged period of sick leave. We have found that in practice it is difficult even for the best motivated PGDiT to catch up if they miss more than about 5-6 weeks training in any rotation, so under those circumstances we might also need to extend their training. This would only be after full discussion with all concerned and is at the discretion of the HoS/ TPDs.

For more information, please visit here and ensure that you are fully aware of all the implications of LTFT training before they apply.

15. PGDiTs in difficulty

Medicine is a stressful profession, and core training can be particularly difficult because of frequent changes of post, a steep learning curve, and exam pressures. The GMC makes clear that a good doctor looks after their own health and well-being as well as that of their patients.

Supporting PGDiTs in difficulty can be a very challenging and a very rewarding part of the role of a named Clinical or Educational Supervisor. The difficulties a PGDiT experiences may be many and varied, and may impact on their work, and patient safety. One of the roles of an Educational Supervisor or teacher is to provide 'pastoral' care for students and PGDiTs. This sometimes extends outside the normal educational or clinical role and impinges on an individual's personal life.

Sometimes PGDiTs will find themselves in a situation where their performance falls below required standards. In most cases the individual recognises the problem and is able to solve it. However, a small number of PGDiTs will get into difficulty which they either fail to recognise or acknowledge, or which they are unable or unwilling to seek help for.

Any issues that have the potential to impact on training progression or which may require additional evaluation/support should be alerted to the Training Programme Director at the earliest opportunity.

Notes should be kept from all relevant PGDiT/trainer meetings and necessary information handed over as a PGDiT rotates through their ACCS placements.

Information about South West PGDiT support can be found here.

Please see Appendix B for detailed guidance on how to deal with the doctor in difficulty.

16. Contacts and Who's Who?

Head of School ACCS: Dr Jo Kerr, jo.kerr@somersetft.nhs.uk

ACCS Training Programme Director Anaesthesia: Dr Judith Stedeford, judith.stedeford@nhs.net

ACCS Training Programme Director EM/ AM: Dr Marianne Gillings, marianne.gillings@nhs.net

ACCS Training Programme Director ICM: Dr Dominic Janssen, Dominic.Janssen@nbt.nhs.uk

HEE Severn ACCS Team: David Warren and Pinar Preston, SevernACCS.SW@hee.nhs.uk

PGDiT Representative: tbc

17. Key links

Severn ACCS website:
https://accs.severndeanery.nhs.uk/

Severn PGDiT Training Hub:
https://healtheducationengland.sharepoint.com/sites/SPGMESACCS-SW

National ACCS website:
https://www.accs.ac.uk/

Royal College/Faculty websites:
http://www.rcoa.ac.uk/
http://www.rcem.ac.uk/
http://www.rcplondon.ac.uk/Pages/index.aspx

Joint Royal Colleges of Physicians Training Board
https://www.jrcptb.org.uk/

Faculty of Intensive Care Medicine:
http://www.ficm.ac.uk/

Gold Guide 2022:
https://www.copmed.org.uk/gold-guide/gold-guide-9th-edition

ACCS Curriculum:
https://www.rcoa.ac.uk/sites/default/files/documents/2021-06/2021%20Curriculum%20for%20ACCS%20Training%20v1.0.pdf

RCEM Curriculum:
https://rcemcurriculum.co.uk/

JRCPTB Internal Medicine & Curriculum:
https://www.jrcptb.org.uk/internal-medicine

Anaesthetics Curriculum:
https://rcoa.ac.uk/training-careers/training-anaesthesia/2021-anaesthetics-curriculum

Health Education England Specialty Training website:
https://hee.nhs.uk/our-work/doctors-training

GMC website:
https://www.gmc-uk.org/

RCEM Learning website:
https://www.rcemlearning.co.uk/

e-Learning For Health:
https://portal.e-lfh.org.uk/

e-Portfolios:

Anaesthesia
https://lifelong.rcoa.ac.uk/login

Emergency Medicine:
https://auth.kaizenep.com/interaction/HZfzoMBtZ0vEgLnIZIy5F

Acute Medicine:
http://www.jrcptb.org.uk/ePortfolio/Pages/Introduction.aspx

Timeline

August changeover	First day, local (Trust/Corporate) Induction.
1st few days	Meeting with Placement Educational Supervisor, departmental/clinical Induction.
1st 2 weeks	Initial meeting with Specialty Educational Supervisor (PGDiT to arrange).
Late October	Midpoint meeting with Specialty Educational Supervisor (PGDiT to arrange); review of progress against LOs.
January	MSF takes place (via e-Portfolio).
January	End of placement meetings with Placement and Speciality Educational Supervisors (PGDiT to arrange); Placement Supervisor completes End of Placement report and liaises with Speciality Educational Supervisor as required.
February changeover	First day, local (Trust/Corporate) Induction (as necessary).
1st few days	Meeting with Placement Educational Supervisor, departmental/clinical induction.
1st 2 weeks	Meeting with Specialty Educational Supervisor (PGDiT to arrange); MSF review.
Late March	Midpoint meeting with Specialty Educational Supervisor (PGDiT to arrange); review of progress against LOs.
Early June	End of placement meetings with Placement and Specialty Educational Supervisors (PGDiT to arrange); End of Placement report and liaises with Speciality Educational Supervisor as required.
Early June	Pre-ARCP meeting with Specialty Educational Supervisor; review of clinical supervisor reports, WPBAs, FEG/MTR/HALO/MCRs, MSF and other evidence with reference to ARCP Decision Aid. Speciality Educational Supervisor completed ESR form.
Late June	PGDiT ensures all necessary evidence is on e-portfolio prior to ARCP.
Late June/early July	ARCP panel meetings and issuing of outcomes.

Appendix A: ACCS ARCP DECISION AID

This document summarises the evidence that ACCS PGDiTs of all parent specialties must provide for ARCP and the standards expected in order to achieve satisfactory ARCP outcome.

REQUIREMENT	EVIDENCE REQUIRED	CT1	CT2
Educational Supervisor Report (ESR)	One per year to cover the training year since last ARCP	Confirms meeting or exceeding expectations and no concerns	Confirms meets minimum requirements for progress into next stage of training *(see checklist also)*
MSF	MSF in e-Portfolio, minimum 12 respondents	1 for the year (minimum)	1 for the year (minimum)
End of Placement (Clinical Supervisor) Reports	One for each placement in year	Confirm meeting or exceeding expectations and no concerns	Confirm meeting or exceeding minimum requirements for progress into next stage of training
ACCS Clinical Learning Outcomes	Faculty Educational Governance (FEG) statement and/or Multi-Consultant/Trainer Report (MCR/MTR) for placements in year	Minimum levels achieved/exceeded for each ACCS Clinical LO for placements in year	Minimum levels achieved/exceeded for all ACCS Clinical LOs
Practical Procedures (ACCS LO 5)	Faculty Educational Governance (FEG) statement and/or Multi-Consultant Report (MCR) for placements in year – *refer to LO5 practical procedure checklist*	On track for minimum levels to be achieved/exceeded	Minimum levels achieved/exceeded for each procedure
ACCS Generic Learning Outcomes	Educational Supervisor Report	Satisfactory progress	Satisfactory progress
Revalidation	Form R/SOAR declaration (Scotland)	Fully completed and submitted	Fully completed and submitted

ACCS Learning Outcomes: Requirements by Placement

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

Entrustment level descriptors:

Level 1: Direct supervisor observation/involvement, able to provide immediate direction or assistance

Level 2a: Supervisor on the 'shop-floor' (e.g. ED, theatres, AMU, ICU), monitoring at regular intervals

Level 2b: Supervisor within hospital for queries, able to provide prompt direction or assistance and PGDiT knows reliably when to ask for help

Level 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

Level 4: Would be able to manage with no supervisor involvement (all PGDiTs practice with a consultant taking overall clinical responsibility)

Learning Outcome	Entrustment requirements			
	EM	IM	An	ICM
1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	2b	2b		
2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	2a	2a		
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	2a	2a	2a	2a
4. Care for acutely injured patients across the full range of complexity	2b			
5. Deliver key ACCS procedural skills	*See LO5 Checklist*	*See LO5 Checklist*	*See LO5 Checklist*	*See LO5 Checklist*
6. Deal with complex and challenging situations in the workplace	2a	2a	2a	2a
7. Deliver safe anaesthesia and sedation			2b (HALO 2a)	
8. Manage patients with organ dysfunction and failure				2a
9. Support, supervise and educate	Satisfactory progress	Satisfactory progress	Satisfactory progress	Satisfactory progress
10. Participate in research and manage data appropriately	Satisfactory progress	Satisfactory progress	Satisfactory progress	Satisfactory progress
11.Participate in and promote activity to improve the quality and safety of patient care	Satisfactory progress	Satisfactory progress	Satisfactory progress	Satisfactory progress
Other evidence	**Requirements**			
	EM	**IM**	**An**	**ICM**
Faculty Educational Governance (FEG) statement	1			
Multi-Consultant Report (MCR)		1		1
Multi-Trainer Report (MTR)			1	
HALO			1 (Sedation)	1
IAC (EPA 1 and 2)			1	
Clinical Supervisor End of Placement Report	1	1	1	1

ACCS LO5 Practical Procedures: Entrustment Requirements

ACCS PGDiTs 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 PGDiT must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

ACCS PGDiTs 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.

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 iliaca nerve block	2a *for both*
Lumbar puncture	2a

When an ACCS PGDiT 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.

Key resource

"ARCP requirement guide" https://www.accs.ac.uk/2021-curriculum/resources

SINGLE-PAGE PRINTABLE ARCP CHECKLIST

TICK ✓ OR N/A	REQUIREMENT	FREQUENCY/ROTATION
	Form R – parts A and B (Revalidation declaration)	1x annually Within 30 days of ARCP date
	Educational Supervisor Report (ESR)	1x annually Towards time of ARCP date **Fill in for ARCP even if LTFT and not at end of placement!**
	End of Placement Reports (EPR) (AKA Clinical Supervisor Reports)	1 for each rotation **Fill in for ARCP even if LTFT and not at end of placement!**
	Multi-Source Feedback (MSF)	1 per year (minimum) 1 per rotation (preferred)
	Faculty Educational Governance Statement (FEG)	***EM** placement only
	Multi-Consultant Report (MCR)	***AM** placement ***ICM** placement
	Multi-Trainer Report (MTR)	***An** placement only
	Initial Assessment of Competence (IAC)	***An** placement only
	Sedation HALO	***An** placement only
	ICM HALO	***ICM** placement only
↾ LO1 ↾ LO2 ↾ LO3 ↾ LO4 ↾ LO5* ↾ LO6 ↾ LO7 ↾ LO8	**ACCS Clinical Learning Outcomes 1-8 (LO 1-8)** *LO5 specifically outlined in box below	**ST1:** minimum levels achieved/exceeded for ACCS clinical LOs for placements that year **ST2:** minimum levels achieved/exceeded for all 8 ACCS clinical LOs LO1 ***EM + AM** LO2 ***EM + AM** LO3 ***EM, AM, An, ICM** LO4 ***EM** LO5 ***EM, AM, An, ICM** LO6 ***EM, AM, An, ICM** LO7 ***An** LO8 ***ICM**
↾ PA ↾ SCD ↾ OCD ↾ IM ↾ VA ↾ F/D ↾ EP ↾ DCCV ↾ US ↾ LP	**ACCS Clinical Learning Outcome 5 (LO5) - Procedural Skills** - **PA** Pleural aspiration air: 2a - **SCD** Seldinger chest drain: 2a - **OCD** Open chest drain: 1 - **IM** Invasive monitoring CVP & art line: 2a for both - **VA** Vasc access in emergency - IO & femoral vein: 1 for both - **F/D** Fracture/dislocation manipulation: 1 - **EP** External pacing: 2a - **DCCV** DC cardioversion: 2a - **US** Point of care ultrasound: vascular access & FIB: 2a for both - **LP** Lumbar puncture: 2a	**ST1:** on track for minimum levels to be achieved **ST2:** minimum levels achieved/exceeded for each procedure LO5 ***EM, AM, An, ICM** If struggling to achieve these, book onto the ACCS clinical skills day and write a detailed reflection on any procedures that you cover in the course that you haven't managed to do clinically.
↾ LO9 ↾ LO10 ↾ LO11	**ACCS Generic Learning Outcomes 9-11 (LO 9-11)**	CT1: 'satisfactory' progress for each LO CT2: 'satisfactory/good' or 'excellent' for all 3 LOs

EMERGENCY MEDICINE PGDiTs: CHECKLIST + EXPLANATIONS

TICK ✓ or N/A	REQUIREMENT	EVIDENCE ON KAIZEN	COMMON PITFALLS/HOW TO/FAQS
	Form R (parts A and B) (Revalidation declaration)	1x Form R (part B) Form R fully completed and submitted with part B uploaded to portfolio	**When:** form R part B needs is completed close to the time of your ARCP. It should be submitted no more than 30 days before your ARCP date. **Finding the form:** found via the HEE website: https://heeoe.hee.nhs.uk/revalidation/form-r-part-and-part-b You fill in form R via the 'Trainee Self Service' or 'TSS' platform. The instructions for accessing this are all found on the webpage above. **Parts A+B explained:** form R is made up of two parts which may be requested from you at different times in the year. Part A: a registration form ensuring HEE have up-to-date information about you. Part B: a self-declaration revalidation form which you must fill out and upload to your portfolio for ARCP. **Important:** you must upload the completed Form R part B to Kaizen before your ARCP. You cannot be revalidated without Form R!
	Educational Supervisor Report (ESR)	1 per year to cover training since last ARCP, complete in Kaizen **ST1:** Confirms meeting or exceeding expectations and no concerns **ST2:** Confirms meets minimum requirements for progress into next stage of training	**Finding the form**: This form needs to be completed in Kaizen by your Educational Supervisor before your ARCP. You will not have access to the form until it has been completed and released by your supervisor. **Less than full time**: if you are LTFT you may be at the start or middle of your placement. You STILL NEED TO ENSURE THIS FORM IS COMPLETED.
	End of Placement Reports (EPR) **AKA Clinical Supervisor Reports**	1 for each placement, complete in Kaizen **ST1:** Confirms meeting or exceeding expectations and no concerns **ST2:** Confirms meets minimum requirements for progress into next stage of training	**Finding the form**: This form needs to be completed in Kaizen by your Clinical Supervisor before your ARCP. You will not have access to this on your portfolio until it has been completed and released by your supervisor. **Less than full time**: if you are LTFT you may be at the start or middle of your placement. You STILL NEED TO ENSURE THIS FORM IS COMPLETED despite it being called an end of placement report, as it provides an overview of your progress.
	Multi-Source Feedback (MSF)	1 per year (minimum) 1per placement (preferred)	Minimum of 12 respondents. Aim for a range of job roles and seniority. You need to include a minimum of 3 consultants.
	Faculty Educational Governance (FEG) Statement	FEG ***EM** placement only	**FEGS explained:** it is a feedback statement from a group of senior EM clinicians who have worked closely with you during your placement. It documents whether they feel you have met the ACCS EM learning objectives. Ask your clinical supervisor to initiate this towards the end

			of your EM placement. You will not have access to the FEGS form on Kaizen until it has been completed and released by your supervisor.
	Multi-Consultant Report (MCR)	MCR ***AM** placement ***ICM** placement	**MCR explained:** this is a summary of feedback on your progress from consultants. It needs to be completed during your ICM and AM placements. **Finding the form:** On Kaizen, select "Assessments" from the Timeline drop-down menu. Click on "Create new". Then select "MCR/MTR ACCS" from the Educational Review and Meetings section. You need to send this to a minimum of 3 consultants towards the end of your placements in both ICM and AM. You will not be able to read what the consultants have written until the form is released by your clinical supervisor.
	Multi-Trainer Report (MTR)	MTR ***An** placement only	**MTR explained:** This needs to be completed during your anaesthetics placement. It is a summary of feedback on your progress from a group of senior anaesthetists. This needs to be completed during your novice period as it forms part of the initial assessment of competence (IAC) sign off. **Finding the form:** On Kaizen, select "Assessments" from the Timeline drop-down menu. Click on "Create new". Then select "MCR/MTR ACCS" from the Educational Review and Meetings section. You need to send this to a minimum of 3 anaesthetists.
	Initial Assessment of Competence (IAC)	IAC ***An** placement only	**IAC explained:** period of time during anaesthetics block, usually 3-6 months, where you are working towards entrustment level 2B for - EPA 1: anaesthetic preoperative assessment - EPA 2: anaesthesia for ASA I/II (uncomplicated surgery) **Requirements to pass the IAC:** See RCOA full guidance here: https://www.rcoa.ac.uk/sites/default/files/documents/2022-09/EPA-1-2-2022%20v1.2.pdf **TOP TIP for anaesthetics block:** You will need to keep a logbook for all your cases. Create one using an online anonymous app such as https://anaesthetics.app/ (free, others are available) or create an excel document. At the end of your placement before your final clinical supervisor meeting, upload this as a PDF to Kaizen.
	Sedation HALO	Green sedation HALO ***An** placement only	**Sedation HALO explained:** This needs to be completed during your anaesthetics placement. Each Trust has a specific anaesthetist whose role it is to sign off the sedation HALO. They will consider all the sedation evidence in your portfolio when signing this off, including your number of sedation cases (keep a logbook), your reflections, CBDs and any teaching you have attended. **TOP TIP:** Find out who signs off the sedation HALO in your Trust and discuss with them early on in your placement what evidence they require.
	ICM HALO	Green ICM HALO ***ICM** placement only	**ICM HALO explained:** This needs to be completed during your ICM placement. Each Trust has a specific consultant whose role it is to sign off your ICM HALO. Towards the end of the ICM rotation they will look at evidence in your portfolio including your logbook, reflections, SLEs and MSF. **TOP TIP:** Find out who signs off the ICM HALO in your Trust and discuss with them early on in your placement what evidence they require.

	ACCS Clinical Learning Outcomes (LO 1-8)	Based on supervisor reports, FEG/MTR/MCR LO1 ***EM + AM** LO2 ***EM + AM** LO3 ***EM, AM, An, ICM** LO4 ***EM** LO5 ***EM, AM, An, ICM** LO6 ***EM, AM, An, ICM** LO7 ***An** LO8 ***ICM** See purple table in section 1 for more detail **ST1:** minimum levels achieved/exceeded for ACCS clinical LOs for placements that year **ST2:** minimum levels achieved/exceeded for all 8 ACCS clinical LOs	**What are LO1-8:** The ACCS Clinical learning outcomes (purple table section 1) Some LOs can only be achieved in certain rotations: e.g. LO4 can only be achieved in emergency medicine, LO7 can only be achieved in anaesthetic rotation **How are they assessed:** It is decided whether you are at the expected entrustment level based on your supervisor reports and your FEGS/MTR/MCR.
	ACCS Clinical Learning Outcome 5 (LO5) **ACCS Procedural Skills**	LO5 ***EM, AM, An, ICM** Although certain skills are more rotation specific e.g. fractures/dislocations in *EM **ST1:** on track for minimum levels to be achieved **ST2:** minimum levels achieved/exceeded for each procedure	**What entrustment level do I need to achieve for each skill:** ϒ Pleural aspiration air: 2a ϒ Seldinger chest drain: 2a ϒ Open chest drain: 1 ϒ Invasive monitoring CVP & art line: 2a for both ϒ Vascular access in emergency (IO & femoral vein): 1 for both ϒ Fracture/dislocation manipulation: 1 ϒ External pacing: 2a ϒ DC cardioversion: 2a ϒ Point of care ultrasound US: vascular access & FIB: 2a for both ϒ Lumbar puncture: 2a **What if I am struggling to achieve a skill:** The skills are covered in the ACCS clinical skills course held twice a year. Acceptable evidence includes certificate of attendance PLUS meaningful reflection of each skill covered. A reflection on each procedure that you've not done on real patients is crucial to achieving sign-off. **Skills that are acceptable to do via SIM:** The only sign off that it is mandatory to achieve on real patients is fracture/dislocation manipulation during your EM placement. All others are acceptable via simulation providing you've written a reflection. However, you should attempt to achieve as many as possible on real patients.
	ACCS Generic Learning Outcomes 9-11 (LO 9-11)	**ST1:** 'satisfactory' progress **ST2:** 'satisfactory/good' or 'excellent' for all 3 LOs	9. Support, supervise and educate 10. Participate in research and manage data appropriately 11. Participate in and promote activity to improve the quality and safety of patient care More information can be found at: https://www.accs.ac.uk/2021-curriculum/accs-los

AT A GLANCE

Contact your Educational and Clinical Supervisors a few weeks before your ARCP to finalise forms. Review your portfolio and make sure you've got evidence for all the required learning outcomes.

Ensure the following are clearly visible on Kaizen:

- Form R part B
- ESR
- MSF
- Specialty-specific documents listed below

EM

- EPR
- FEGS

AM

- EPR
- MCR

ICM

- EPR
- MCR
- ICM HALO

Anaesthetics

- EPR
- MTR
- Sedation HALO
- IAC

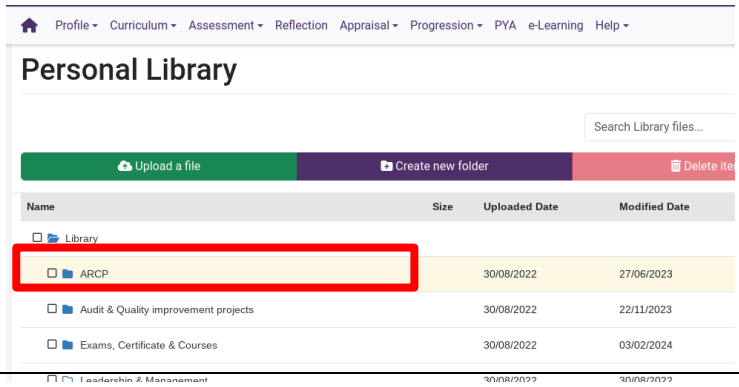
ANAESTHETICS PGDiTs: CHECKLIST + EXPLANATIONS

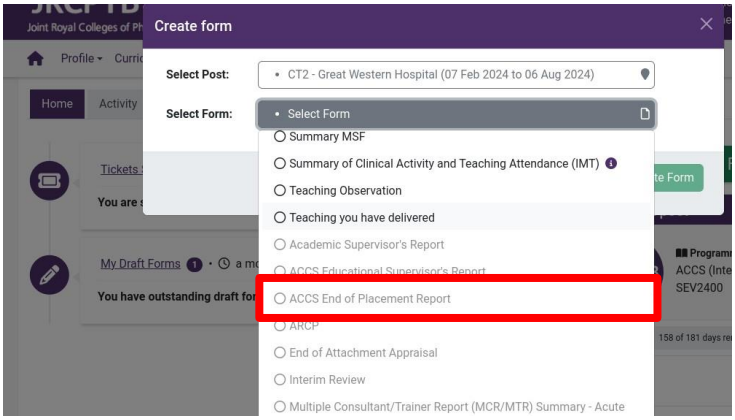
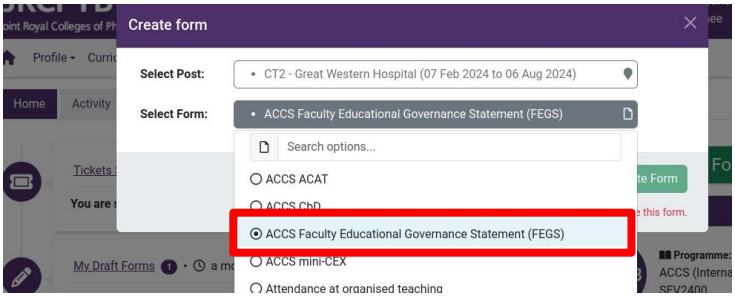
TICK ✓ or N/A	REQUIREMENT	EVIDENCE ON LLP	COMMON PITFALLS/HOW TO/FAQS 
	Form R (parts A and B) (Revalidation declaration)	1x Form R (part B) Form R full completed and submitted with part B uploaded to portfolio	**When:** form R part B needs is completed close to the time of your ARCP. It should be submitted no more than 30 days before your ARCP date. **Finding the form:** found via the HEE website: https://heeoe.hee.nhs.uk/revalidation/form-r-part-and-part-b You fill in form R via the 'Trainee Self Service' or 'TSS' platform. The instructions for accessing this are all found in the webpage above. **Parts A+B explained:** form R is made up of two parts which may be requested from you at diberent times in the year. Part A: a registration form ensuring HEE have up-to-date information about you. Part B: a self-declaration revalidation form which you must fill out and upload to your portfolio for ARCP. **Important:** do not forget to upload this, you cannot be revalidated without Form R!
	Educational Supervisor Report (ESR)	1 per year to cover training year since last ARCP, upload to LLP **CT1:** Confirms meeting or exceeding expectations and no concerns **CT2:** Confirms meets minimum requirements for progress into next stage of training	**Finding the form**: form is found here https://www.accs.ac.uk/2021-curriculum/resources It is under 'Educational Supervisors End of year report'. Fill it in with your ES and then upload it to your portfolio. **Less than full time**: if you are LTFT you may be at the start or middle of your placement. You MUST STILL FILL IN THIS FORM despite it being called an end of year report.
	End of Placement Reports (EPR) **AKA Clinical Supervisor Reports**	1 for each placement, upload to LLP **CT1:** Confirms meeting or exceeding expectations and no concerns **CT2:** Confirms meets minimum requirements for progress into next stage of training	**Finding the form**: form is found here https://www.accs.ac.uk/2021-curriculum/resources It is under 'End of placement report'. Fill it in with your CS and then upload it to your portfolio. **Less than full time**: if you are LTFT you may be at the start or middle of your placement. You MUST STILL FILL IN THIS FORM despite it being called an end of placement report.
	Multi-Source Feedback (MSF)	1 per year (minimum) 1per placement (preferred)	Minimum of 12 respondents Aim for a range of job roles and seniority Need a minimum of 3 consultants

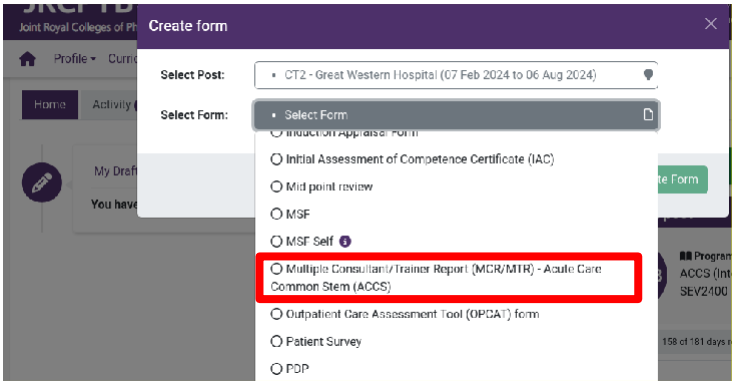
	Faculty Educational Governance (FEG) Statement	FEG ***EM** placement only	**What is a FEG:** it is a feedback statement from a group of senior ED clinicians who have worked closely with a trainee. **Who creates it on LLP:** The trainee needs to create the FEG document on the LLP and send it to their CS towards the end of the ED placement. The consultants in your ED department should automatically meet and discuss feedback for your FEG.
	Multi-Consultant Report (MCR)	MCR ***AM** placement ***ICM** placement	**What is an MCR:** the equivalent of the MTR but with the assessors consisting solely of consultants. It is carried out during ICM and acute med placements. **Number of responses:** minimum of 3 individual responses to be considered valid **Who creates it on LLP:** You should initiate your MCR on the LLP. You agree with your CS which consultants to circulate it to.
	Multi-Trainer Report (MTR)	MTR ***An** placement only	**What is an MTR:** feedback from a group of senior anaesthetists/trainers to assess progress being made **Number of responses:** minimum of 3 individual responses to be considered valid **Who creates it on LLP:** You should initiate your MTR on the LLP. You agree with your CS which consultants to circulate it to. It should be done during your novice period as this feedback forms part of the initial assessment of competence (IAC) sign ob (see later for details)
	Initial Assessment of Competence (IAC)	IAC ***An** placement only	**What is IAC:** period of time during anaesthetics block, usually 3-6 months, where you are working towards entrustment level 2B for - EPA 1: anaesthetic preoperative assessment - EPA 2: anaesthesia for ASA I/II (uncomplicated surgery) **What is required to pass IAC:** See RCOA full guidance here: https://www.rcoa.ac.uk/sites/default/files/documents/2022-09/EPA-1-2-2022%20v1.2.pdf **TOP TIP for anaesthetics block:** use your logbook in LLP to log every case from the start of your rotation, do this as you go along
	Sedation HALO	Green sedation HALO ***An** placement only	**Who signs this:** Each department will have a consultant whose role it is to sign ob the sedation HALO. Evidence they consider includes number of cases (keep a logbook), reflections, CBDs and teaching. **TOP TIP:** Find out who signs ob the sedation HALO in your trust and discuss with them early in the placement what evidence they require.
	ICM HALO	Green ICM HALO ***ICM** placement only	**Who signs this:** Each ICM department will have a consultant whose role it is to sign ob the ICM HALO. Towards the end of the ICM rotation they will look at your LLP including logbook, reflections, SLEs, MSF as evidence. **TOP TIP:** Find out who signs ob the ICM HALO in your trust and discuss with them early in the placement what evidence they require
	ACCS Clinical Learning Outcomes (LO 1-8)	Based on ES report, CS reports, FEG/MTR/MCR LO1 ***EM + AM** LO2 ***EM + AM**	**What are LO1-8:** The ACCS Clinical learning outcomes (purple table section 1) Some LOs can only be achieved in certain rotations: e.g. LO4 can only be achieved in emergency medicine, LO7 can only be achieved in anaesthetic rotation

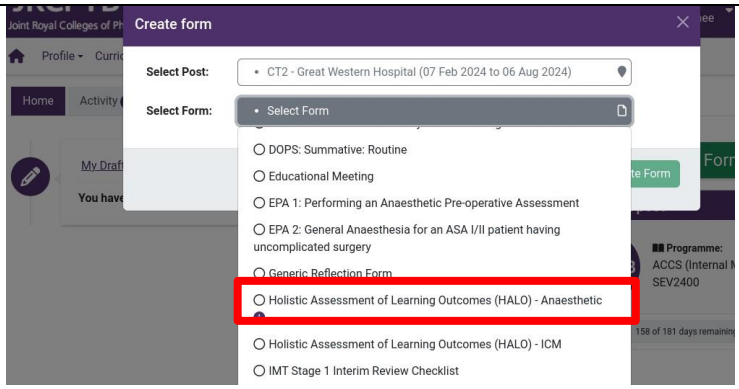
		LO3 ***EM, AM, An, ICM** LO4 ***EM** LO5 ***EM, AM, An, ICM** LO6 ***EM, AM, An, ICM** LO7 ***An** LO8 ***ICM** See purple table in section 1 for more detail **CT1:** minimum levels achieved/exceeded for ACCS clinical LOs for placements that year **CT2:** minimum levels achieved/exceeded for all 8 ACCS clinical LOs	**How are they assessed:** It is decided whether you are at the expected entrustment level based on your ES report, CS reports, FEG/MTR/MCR.
	ACCS Clinical Learning Outcome 5 (LO5) **ACCS Procedural Skills**	LO5 ***EM, AM, An, ICM** Although certain skills are more rotation specific e.g. fractures/dislocations in *EM **CT1:** on track for minimum levels to be achieved **CT2:** minimum levels achieved/exceeded for each procedure	**What entrustment level do I need to achieve for each skill:** □ Pleural aspiration air: 2a □ Seldinger chest drain: 2a □ Open chest drain: 1 □ Invasive monitoring CVP & art line: 2a for both □ Vascular access in emergency (IO & femoral vein): 1 for both □ Fracture/dislocation manipulation: 1 □ External pacing: 2a □ DC cardioversion: 2a □ Point of care ultrasound US: vascular access & FIB: 2a for both □ Lumbar puncture: 2a **What if I am struggling to achieve a skill:** The skills are covered in the ACCS clinical skills course held twice a year. Evidence includes certificate of attendance PLUS meaningful reflection of each skill covered. This reflection is crucial to achieving sign ob. **Which skills can I do via SIM:** The only sign ob that it is mandatory not to achieve through SIM is the fracture/dislocation manipulation which must be achieved on real patients during ED placement. This said, you will want to experience as many of these on real patients as possible so don't pass up opportunities!
	ACCS Generic Learning Outcomes 9-11 (LO 9-11)	**CT1:** 'satisfactory' progress **CT2:** 'satisfactory/good' or 'excellent' for all 3 LOs	9. Support, supervise and educate 10. Participate in research and manage data appropriately 11. Participate in and promote activity to improve the quality and safety of patient care More information can be found at: https://www.accs.ac.uk/2021-curriculum/accs-los

ACUTE MEDICINE PGDiTs: CHECKLIST + EXPLANATIONS

TICK ✓ or N/A	REQUIREMENT	EVIDENCE ON NHS e-Portfolio	COMMON PITFALLS/HOW TO/FAQS
	Form R (parts A and B) **(Revalidation declaration)**	1x Form R (part B) Form R full completed and submitted with part B uploaded to portfolio	**When:** form R part B needs is completed close to the time of your ARCP. It should be submitted no more than 30 days before your ARCP date. **Finding the form:** found via the HEE website: https://heeoe.hee.nhs.uk/revalidation/form-r-part-and-part-b You fill in form R via the 'Trainee Self Service' or 'TSS' platform. The instructions for accessing this are all found in the webpage above. **Parts A+B explained:** form R is made up of two parts which may be requested from you at different times in the year. Part A: a registration form ensuring HEE have up-to-date information about you. Part B: a self-declaration revalidation form which you must fill out and upload to your portfolio for ARCP. **Important:** do not forget to upload this to your portfolio, you cannot get an outcome 1 in ARCP without Form R! (You may need to put this in your document library in the ARCP folder.) (Profile → personal library → library → ARCP 
	Educational Supervisor Report (ESR)	1 per year to cover training year since last ARCP, upload to NHS-e-Portfolio **CT1:** Confirms meeting or exceeding expectations and no concerns **CT2:** Confirms meets minimum requirements for progress into next stage of training	**Finding the form**: form is found here https://www.accs.ac.uk/2021-curriculum/resources It is under 'Educational Supervisors End of year report'. Fill it in with your ES and then upload it to your portfolio as a PDF. On the ePortfolio, there are several similarly named forms which has created confusion in the past. We recommend you use the form instead. **Less than full Time**: if you are LTFT you may be at the start or middle of your placement. You STILL FILL IN THIS FORM despite it being called an end of year report.

	Clinical Supervisor Reports **AKA End of Placement Reports**	1 for each placement, upload to NHS-e-Portfolio **CT1:** Confirms meeting or exceeding expectations and no concerns **CT2:** Confirms meets minimum requirements for progress into next stage of training	**Finding the form**: form is found here https://www.accs.ac.uk/2021-curriculum/resources It is under 'End of placement report'. Fill it in with your CS and then upload it to your portfolio as a PDF. We recommend using this version rather than on your e-Portfolio. On the NHS-ePortfolio: It is labelled "ACCS End of Placement Report." DO NOT USE "End of attachment Appraisal."  **Less than full time**: if you are LTFT you may be at the start or middle of your placement. You STILL FILL IN THIS FORM despite it being called an end of placement report.
	Multi-Source Feedback (MSF)	1 per year (Minimum) 1per placement (preferred)	Minimum of 12 respondents AAM for a range of job roles and seniority Minimum of 3 consultant responses. Your CS will need to generate a "Summary MSF" form, for the trainee to be able to view MSF feedback on NHS-e-portfolio
	Faculty Educational Governance (FEG) Statement	FEG *EM placement only	**What is a FEG:** it is a feedback statement from a group of senior ED clinicians who have worked closely with a trainee. **Who creates it on NHS-e-portfolio:** You should initiate this and send a ticket to your CS towards the end of your placement. The consultants in your ED department should automatically meet and discuss feedback for your FEG, your CS will then complete the form. 

	Multi-Consultant Report (MCR)	MCR *AM placement *ICM placement	**What is an MCR:** the equivalent of the MTR but with the assessors consisting solely of consultants. It is carried out during ICM and acute med placements. **Number of responses:** minimum of 3 individual responses to be considered valid **Who creates it on NHS-e-portfolio:** For both the MCR and MTR, you will need to initiate the form, and send invites to the consultants. You should agree with your CS which consultants to invite. 
	Multi-Trainer Report (MTR)	MTR *An placement only	**What is an MTR:** feedback from a group of senior anaesthetists/trainers to assess progress being made **Number of responses:** minimum of 3 individual responses to be considered valid (it does not to be exclusively consultants). **Who creates it on NHS-e-portfolio:** Like with the MCR, you will need to invite trainers to fill in this form. Again, you should agree with your CS who to invite to avoid bias. It should be done during your novice period as this feedback forms part of the initial assessment of competence (IAC) sign off (see later for details).
	Initial Assessment of Competence (IAC)	IAC *An placement only	**What is the IAC:** period of time during anaesthetics block, usually 3-6 months, where you are working towards entrustment level 2B for - EPA 1: anaesthetic preoperative assessment - EPA 2: anaesthesia for ASA I/II (uncomplicated surgery) **What is required to pass IAC:** See RCOA full guidance here: https://www.rcoa.ac.uk/sites/default/files/documents/2022-09/EPA-1-2- 2022%20v1.2.pdf **Summary of steps for signoff:** 1. You initiate your MTR which is filled by minimum 3 trainers 2. Create a HALO with your CS covering EPA 1 and 2. (You can send a ticket request to your CS, or they can generate it themselves.) The logistics of this sign of may vary between trusts.

	Initial Assessment of Competence (IAC)		 **TOP TIP for anaesthetics block:** You will need to keep a logbook for all your cases. There is not one directly on your NHS e-portfolio. Create one using an online anonymous app such as "https://anaesthetics.app/" (free, others are available) or create an excel document. At the end of your placement before your final CS meeting, upload this as a PDF in your personal library under "logbook."
	Sedation HALO	*An placement only	**Who signs this:** Each department will have a consultant whose role it is to sign off the sedation HALO (this may be your CS). Evidence they consider includes number of cases (from your logbook), reflections, CBDs, and teaching. **TOP TIP:** Find out who signs off the sedation HALO in your trust and discuss with them early in the placement what evidence they require.
	ICM HALO	*ICM placement only	**Who signs this:** Each ICM department will have a consultant whose role it is to sign off the ICM HALO. Towards the end of the ICM rotation they will look at your LLP including logbook, reflections, SLEs, MSF as evidence. **TOP TIP:** Find out who signs off the ICM HALO in your trust and discuss with them early in the placement what evidence they require
	ACCS Clinical Learning Outcomes (LO 1-8)	Based on ES report, CS reports, FEG/MTR/MCR LO1 *EM + AM LO2 *EM + AM LO3 *EM, AM, An, ICM LO4 *EM LO5 *EM, AM, An, ICM LO6 *EM, AM, An, ICM LO7 *An LO8 *ICM See purple table in section 1 for more detail. **CT1:** Minimum levels achieved/exceeded for ACCS clinical LOs for placements that year **CT2:** Minimum levels achieved/exceeded for all 8 ACCS clinical LOs	**What are LO1-8:** The ACCS Clinical learning outcomes (purple table section 1) Some LOs can only be achieved in certain rotations: e.g. LO4 can only be achieved in emergency medicine, LO7 can only be achieved in anaesthetic rotation **How are they assessed:** It is decided whether you are at the expected entrustment level based on your ES report, CS reports, FEG/MTR/MCR

	ACCS Clinical Learning Outcome 5 (LO5) **ACCS Procedural Skills**	LO5 ***EM, AM, An, ICM** Although certain skills are more rotation specific e.g. fractures/dislocations in *EM **CT1:** on track for minimum levels to be achieved **CT2:** Minimum levels achieved/exceeded for each procedure.	**What entrustment level do I need to achieve for each skill:** - Pleural aspiration air: 2a - Seldinger chest drain: 2a - Open chest drain: 1 - Invasive monitoring CVP C art line: 2a for both - Vascular access in emergency (IO C femoral vein): 1 for both - Fracture/dislocation manipulation: 1 - External pacing: 2a - DC cardioversion: 2a - Point of care ultrasound US: vascular access C FIB: 2a for both - Lumbar puncture: 2a **What if I am struggling to achieve a skill:** The skills are covered in the ACCS clinical skills course held twice a year. Evidence includes certificate of attendance PLUS meaningful reflection of each skill covered. This reflection is crucial to achieving sign off. **Which skills can I do via SIM:** The only sign off that it is mandatory not to achieve through SIM is the fracture/dislocation manipulation which must be achieved on real patients during ED placement. This said, you will want to experience as many of these on real patients as possible so don't pass up opportunities!
	ACCS Generic Learning Outcomes G-11 (LO G-11)	**CT1:** 'satisfactory' progress **CT2:** 'satisfactory/good' or 'excellent' for all 3 LOs	9. Support, supervise and educate 10. Participate in research and manage data appropriately 11. Participate in and promote activity to improve the quality and safety of patient care More information can be found at: https://www.accs.ac.uk/2021-curriculum/accs-los

Appendix B: Doctors in Difficulty

Please note: the processes involved for dealing with a Doctor in difficulty may be Deanery/LETB-specific. Please undertake early discussion with senior educators to ensure you gain sufficient guidance and support.

Dealing with the doctor in difficulty can be broken down into the following stages:

1. Identifying the problem
2. Managing the problem in the workplace
3. Identifying the cause of the problem
4. Supporting the PGDiT in finding a solution

1. Identifying the problem

PGDiTs may struggle with the transition from undergraduate training to becoming more self-directed postgraduates, or the transitions from Foundation doctor to core PGDiT to higher PGDiT. PGDiTs often have to move geographical areas for work, and this may result in a disruption to their social support, relationships, friendships etc.

Signs of a PGDiT in difficulty may fall into the three following areas:

Behaviour

- Anger and verbal or physical aggression
- Rigidity/obsessionalism
- Bullying, arrogance, rudeness
- Emotional or volatile behaviour
- Failure to answer bleeps
- Lack of team working
- Avoiding feedback and/or defensive reactions to feedback
- Not engaging in the learning process via meetings or e-portfolio

Health

- Absenteeism
- High sickness record

Competence

- Poor time keeping, personal organisation and record-keeping
- Failure to prioritise
- Lack of insight and poor judgement
- Clinical mistakes
- Failing exams and work-based assessments
- Communication problems with patients, relatives, colleagues or staff
- Staff and/or patient complaints (360 degree assessments)

Addressing the problem:

PGDiT has insight

- If the PGDiT has insight into their problem then a discussion can take place about how best to fix the problem and support them (see later).

PGDiT has little or no insight

- If there is no apparent insight then it is necessary to document the behaviour that is causing the problem.
- The PGDiT can then be given feedback on the basis of well documented observations of problematic behaviour (see later).

Documentation

It is important to start documenting as early as possible if you suspect a PGDiT is in difficulty. If other staff have reported concerns, they should be encouraged to write it down. However, what is required are objective descriptions of problematic behaviour *without* personal opinions. Feedback is much easier to give to a PGDiT when it is a description of behaviour and when it has caused concern for other staff or patients.

2. Managing the problem in the workplace

The first priority after identifying a problem PGDiT is to *ensure patient safety*. This will require an assessment of the PGDiT's ability to continue working safely in their particular role.

- How closely do they need to be supervised?
- Are they safe to continue prescribing?
- Are other members of the team 'carrying' the PGDiT?

When you have identified early signs that a PGDiT is in difficulty you should:

- Meet and discuss these openly with the PGDiT
- Talk to and give feedback to the PGDiT
    - This can be a difficult experience for both trainer and PGDiT, but the sooner it is done the better
    - Most PGDiTs who have insight into their problems will welcome the opportunity to bring them out into the open and to be given help and support in resolving them
    - Some PGDiTs with insight might deny there is a problem because of a defensive nature or because they fear the consequences
    - Some PGDiTs might completely lack insight
    - Use of a reflective template may help a PGDiT identify the key issues and options for improvement

In the latter two situations the supervisor should use the documented evidence acquired to make the PGDiT aware that problems have been identified but should try to reassure the PGDiT that help and support can be provided.

- Agree an educational plan – and document this. The plan should include some SMART objectives (Specific, Measurable, Achievable, Relevant, Timed)

- Make sure the feedback meeting and plan is documented and shared with appropriate people, including the PGDiT. These individuals might include:
    - Clinical Supervisor
    - Training Programme Director (TPD)
    - Head of School (HoS)

    - Clinical Managers/Directors
    - Directors of Medical Education

- If there are any patient safety concerns, or for any significant events, the practices/Trusts policy on Significant Untoward Events needs to be initiated and followed. The Educational Supervisor and TPD should not be the Trust's investigating officer. If there is a practice/Trust investigation, HEE needs to be made aware of this. The TPD and HoS should be notified.

- The educational plan should be shared with the TPD and a copy should be sent to the specialty school administrator so it can be held on the PGDiTs file.

- Finally set a review date/venue to meet to review the PGDiTs progress against the objectives made

Significant concerns

LETB Case Conference

These can be called for any PGDiTs causing significant concern, and are a useful way for trainers to meet and support one another and the PGDiT.

- Chance for all involved to meet including Head of School/TPD, APDs, PGDiT Support Service, and the Trust, (Clinical and Educational supervisors, Clinical Managers, DME, etc.)
- Chance to share information and review what has been tried/offered
- Action plan of where to go next to support the PGDiT and trainers and to ensure that patients are safe
- PGDiT may not be present for all of the meeting. The PGDiT should meet some or all of the panel to discuss the concerns openly, and agree a further action plan

3. Identifying the cause of the problem

In supporting a PGDiT with problems you should attempt to determine the underlying cause so that the situation can be managed in the most appropriate way. Some common situations that may lead to PGDiT problems are:

- Ill health – physical or mental
- Drug/alcohol abuse
- Family issues – e.g. the birth of a child
- Language barrier
- Attitudinal/personality problem
- Financial difficulties
- Relationship problems
- Poor interpersonal skills
- Lack of knowledge
- Lack of confidence
- Poor role models
- Cultural background
- Bullying/harassment
- Dysfunctional team working

4. Supporting the PGDiT in finding a solution

Assuming that problems have been acknowledged and the causes identified the PGDiT can work with the supervisor to create an action plan for remediation.

- PGDiTs can be reassured that their careers can be put on the right track and that solutions can be found.
- As much as possible the PGDiT should be given the responsibility for working out solutions and for providing an action plan.
- Sometimes solutions can be found via the supervisory relationship and within the working team but sometimes other agencies and professional advisors might need to be consulted.
- The supervisor should then have regular meetings with the PGDiT to ensure that problems and behaviour have been rectified.

Suggestions for Support – Competency issues

- Increase the number of WBAs above the minimum number – this should not be seen as punitive. The WBAs can be used as learning events, where PGDiTs can be given feedback, and can be used to document improvement in specific skills or competencies.
  - State exactly how many of each type of WBAs
  - With whom (variety of senior people – specify them)
  - Covering what topics
- Consider fitness for specific types of work. For example the decision may be made that the individual is safe to work during the day in specific locations where support is available, but it may not be safe for the individual to be on call. The Clinical Managers and Director of Medical Education make these decisions to amend a PGDiT's work, with input from the Clinical and Educational Supervisors, TPD etc. The reasons for this need to be documented, as well as what the PGDiT needs to demonstrate to return to work fully. This might include a period of shadowing, or discussing emergency situations as WBAs etc. PGDiTs may also require a period of working in a supernumerary capacity in some situations.
- Arrange for the individual to meet regularly with both their named Clinical and named Educational Supervisor. These individuals should also remain in close contact.
- Ensure the PGDiT uses reflection and a suitable template (*Appendix C*) to support their improvement efforts.
- An extra 360 appraisal may be helpful in certain situations. The supervisors should be clear who the PGDiT should ask if you want particular individuals to give feedback.

Suggestions for Support – Health issues

- All doctors should be registered with a GP and supervisors can encourage attendance.
- We must be mindful that we are supervisors of PGDiTs, and not be drawn into acting as a PGDiT's doctor. Whilst this might sound obvious it is something that as doctors we sometimes find difficult to avoid.
- Referral to Occupational Health – with specific questions:
  - Is Dr X medically fit for his/her current role?
  - If Dr X is not medically fit, can you give an indication of likely duration of absence?

- Is Dr X medically fit to be assessed in training?
- If Dr X is not medically fit to be assessed, can you indicate whether a period of training is likely to have been affected?
- Could Dr X's medical problems be contributing to problems with behaviour and/or performance at work?
- Can you make any recommendations regarding adjustments or modifications to his/her workplace/role?
- Can you recommend any help or support that the Department can offer Dr X?
- Are there any workplace factors contributing to Dr X's ill health?

Suggestions for Support – Behaviour issues

For inappropriate behavioural issues:

- Provide feedback, and use any appropriate trust policies
- Put concerns into writing to the PGDiT
- Agree clear SMART objectives with the PGDiT, and be clear what is expected of the PGDiT
- Involve management within the Trust whenever appropriate
- Supervisors never act as a formal Trust investigator as there may be a conflict of interests. You may need to give evidence to an investigation, but you may also have a role in supporting the PGDiT.

Training Support Services

Within the Deanery there are training support services

https://www.severndeanery.nhs.uk/about-us/professional-support-and-well-being-south-west

These services can:

- Assess need, provide support services and case management for PGDiTs in difficulty
- Signpost to specialist interventions where appropriate
- Aim to work together with training programmes to address performance and progress problems

Broadly speaking these services will:

- Gather feedback
- Meet with PGDiTs
- Access profiling tools if necessary
- Agree an action plan
- Identify clear objectives and ways of monitoring progress
- Make referrals to external providers for further assessment or support
- Monitor progress
- Provide regular updates to training programme
- Provide reports for ARCP panels on request

Examples of support options include

- Counselling

- Coaching
- Communication skills development
- Specialist Occupational Health
- Career guidance
- Occupational and/or Educational Psychology assessments
- Clinical Psychology
- 360 degree feedback assessments
- Leadership Judgement assessment and coaching
- Sensory Intelligence profiling and coaching
- Specific learning disability tutoring

Support for Supervisors/trainers

Supporting a PGDiT in difficulty can be extremely time consuming and can be very difficult for trainers. It is important that as trainers there is a mechanism where you can also get help and support. For Clinical and Educational Supervisors, the TPDs and/or Heads of Schools are there to support you. Organise to meet and share your concerns. Doctors in difficulty can cause a lot of distress to people with whom they work, and it is important that you are mindful of this. Some supervisors worry that they will be accused of bullying and harassment with PGDiTs in difficulty, and again we would encourage you to share these concerns with colleagues.

Appendix C: Acronyms

PGDiT – Post Graduate Doctor in Training

MTR/MCR -Multiple Trainer/ Consultant Report. This is a new assessment to assure whoever approves completion of domains that the PGDiT is considered competent to the required standard. Is used in AM, ICM and anaesthetics. It is different to the MSF which canvasses opinions from everyone the PGDiT has worked with. MTR is essentially the same as the MCR except that in anaesthetics, senior SAS doctors can contribute.

FEGS - Faculty Educational Governance Statement. Does the same job as the MTR / MCR, except used in EM. It consists of a panel of supervisors who meet regularly to discuss PGDiTs' progress. Recommended to set these up in AM, ICM and anaesthetics.

SLE -Supervised Learning Event. Essentially new name for WPBA, but takes the emphasis off "assessment". Can be formative eg DOPS, CBD, ACEX, ALMAT and Anaesthesia QI project assessment tool (AQIPAT) or summative IAC and HALO forms. Formative assessments will have an entrustment scale.

EPA -Entrustable Professional Activity. New holistic assessments to inform IAC in anaesthetics. There are two EPAs for the IAC, relating to pre-op as well as intra-operative care. Need to show that a PGDiT is capable of synthesising all skills required to achieve a stated outcome eg safely assess, anaesthetise an ASA 1-2 patient for appendicectomy and thus be capable of "being on call".

HALO -Holistic Assessment of Learning Outcomes. New CUT form for anaesthetics and ICM. Will need a HALO sign off at each stage for each domain in anaesthetics and ICM. The only HALOs required in ACCS are the HALO for sedation during the anaesthetics placement and one for ICM (stage 1).

GPC - Generic Professional Capabilities. These are 9 domains set out in a framework by the GMC that all doctors should become competent in during their training (regardless of specialty). All the ACCS LOs are mapped to these GPCs. Includes professional knowledge, skills, values and behaviours.

LO - Learning Outcomes. There are 8 clinical Learning Outcomes and 3 generic ones within the ACCS curriculum. Each LO is associated with a set of Key Capabilities so that PGDiTs can demonstrate that they have achieved that particular LO.

Key Capabilities - By the completion of the ACCS programme, a PGDiT will be able to perform these Key capabilities to a prescribed Entrustment Level. There are a set of Descriptors within the Key Capabilities associated with that activity or task.

Entrustment Level -Trainers make a decision about what level of supervision the PGDiT requires for each LO or Key Capability using the entrustment scale.

EYR- End of Year Report (also known as ESR, or Educational Supervisors Report), completed by the Speciality ES at the end of each year

EPR- End of Placement Report, completed by Placement ES at the end of each placement