



ACCS Assessment Strategy

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1. The Acute Care Common Stem (ACCS) curriculum and its Programme of Assessment

The Acute Care Common Stem (ACCS) curriculum is outcome based. That means its focus is on the things an ACCS clinician needs to be able to **do** to deliver safe care to ill and injured adults presenting to acute care in the NHS. The ACCS Learning Outcomes (LOs) reflect the scope of practice, and reflect not only the need to be a safe and reliable clinician, but also a scholar, teacher and someone able to contribute effectively to change. The ACCS LOs are listed below in table 1.

Figure 1 – ACCS Learning Outcomes

Clinical ACCS LOs
<ol style="list-style-type: none">1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop4. Care for acutely injured patients across the full range of complexity5. Deliver key ACCS procedural skills6. Deal with complex and challenging situations in the workplace7. Provide safe basic anaesthetic care including sedation8. Manage patients with organ dysfunction and failure
Generic ACCS LOs
<ol style="list-style-type: none">9. Support, supervise and educate10. Participate in research and manage data appropriately11. Participate in and promote activity to improve the quality and safety of patient care

The ACCS training programme takes a clinician with foundation competencies through to someone who can be relied upon to assess and manage acutely ill and injured adults, knowing when and who to ask for help.

The ACCS curriculum clearly lays out trainees' professional responsibilities in each of the ACCS LOs. Each of the LOs has Key Capabilities which describe the essential activities within each of the LOs. Helping trainees to develop towards these and deciding if they have met the requirements forms the basis of the ACCS assessment programme.

2. Assessment, as an integral part of curriculum, is intended to...

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

Assurance:

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

Regulating progression & targeting remediation:

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

Fostering self-regulated learners:

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

3. The ACCS assessment strategy

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

1. A programme of workplace based assessments (WPBAs)
2. A programme of regular, panel-based, information-rich, individualised judgements that regulate each trainee's progression and remediation (where necessary)

3.1. Workplace based assessments

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

WPBA provides a structure for observing the individualised and contextualised application of learning. By providing feedback and encouraging reflection it also helps trainees develop self-regulated learning skills. The transparent links between the WPBAs, the entrustment judgements made by Faculty Educational Governance (FEG) panels and in Multiple Consultant Reports (MCRs), Multiple Trainer Reports (MTRs) and the levels of independence expected in each of the LOs orientates learners to what is expected of them. This will give them both the stimulus and the data that they need to regulate their own learning.

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

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

3.2. Panel-based judgements

FEG statements, MCRs, MTRs and Holistic Assessment of Learning Outcome (HALO) work with the ARCP process to provide regular, panel-based, information-rich, individualised judgements that regulate each trainee's progression and remediation (where necessary). Like the WPBA programme, they are designed to foster **self-regulated learners** and to **regulate trainees' progression** through the programme. The faculty will collate and interpret information about the trainee's workplace performance and provide a summative recommendation about whether a trainee has met the standard in the LOs relevant to their stage of training. This information is combined with other evidence in an Educational Supervisor's annual report (ES annual report) that is completed by the trainee's educational supervisor at the end of a block of training. This, in turn, is reviewed by the ARCP panel who will make a decision regarding progression.

4. Background to the Programme of Assessment

In reviewing the prior ACCS WPBA programme it has become clear that:

1. Asking trainees and trainers to complete too many WPBAs meant that few of them were done properly.
2. Sampling a comprehensive list of presentations using WPBAs led to a tick box approach.
3. We could find no evidence that variation in performance (case specificity) was condition specific...
4. ...and therefore WPBA was best used to cover generic, tacit aspects of cases. (However, this required the instruments and the sampling approach to be redesigned.)

The Royal College of Emergency Medicine (RCEM) and the Royal College of Anaesthetists (RCOA) have introduced independence as the anchor for assessor feedback, in WPBA in training beyond ACCS, in recent years, as this had been shown to yield more reliable and meaningful data in a wide range of contexts.¹ We therefore consider it time to stop asking for summative pass/fail data on individual cases, but introduced a requirement that the training faculty offer summative evidence about whether a trainee is ready to progress based on the entirety of their performance in post. The training faculty will use all their knowledge of the trainee in the workplace to inform their opinion. This allows for individualised decision-making and attention to progress (direction of travel) and profile (pattern of strengths and weaknesses) as well as 'overall' attainment.

4.1. How are these changes being introduced in the ACCS Programme of Assessment?

The current ACCS assessment strategy builds on previous changes, to meet its stated purposes, in a number of ways.

1. The FEG decisions/Multiple Consultant Reports/Multiple Trainer Reports about progression are directly linked to the **clinical LOs** - offering clear guidance to trainees and trainers as to the standards required.
2. The educational supervisor's assessments of LOs that do not involve direct patient care (**generic LOs**) are based on evidence collated by the trainee. Clear guidance over standards ensures consistency whilst allowing for individual variation.
3. There is no 'number' of WPBAs or a list to tick off. **Trainees are given a clear description of the standard and advice on how that may be evidenced. It is for them to seek and reflect on feedback, encouraging the development of self-regulatory approach for consultant life.**

The flow of information in the new programme of assessment is shown in Figure 2.

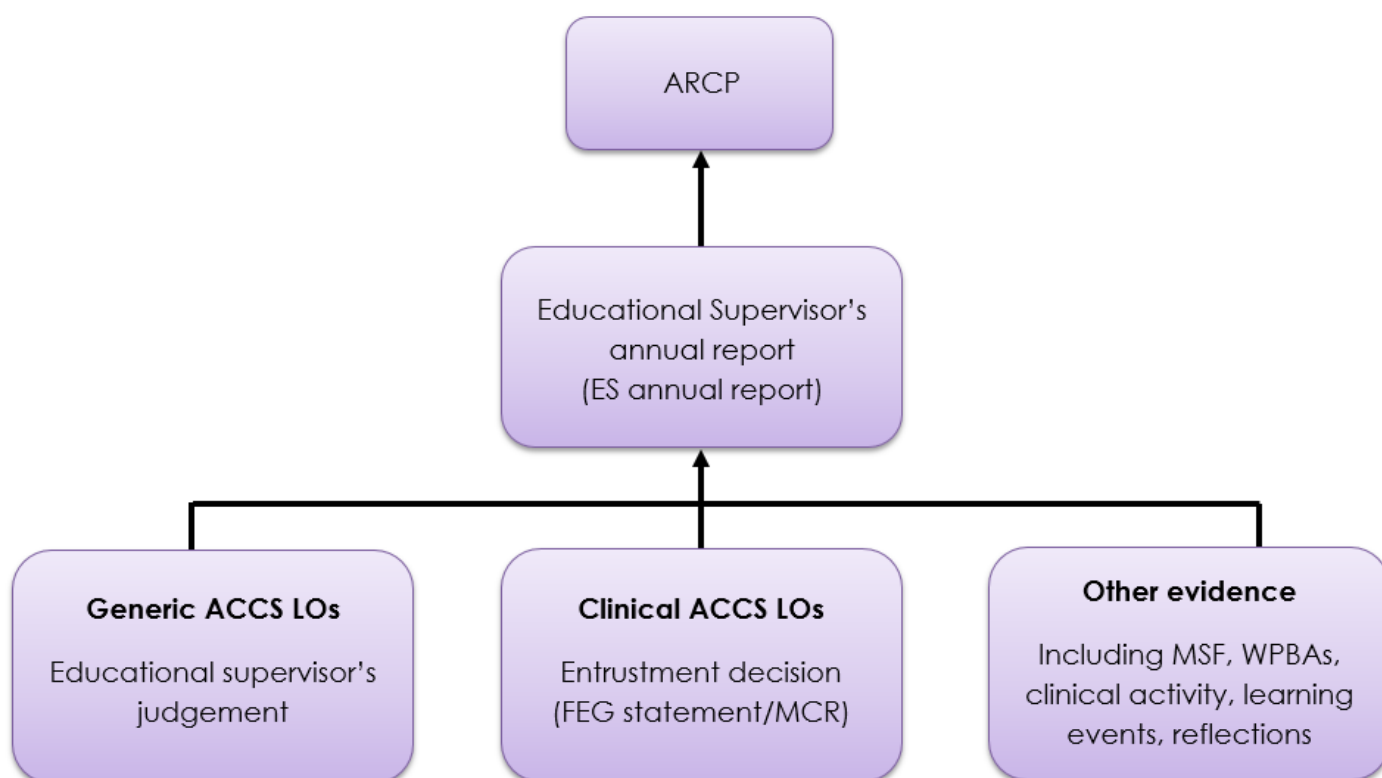
- a The Training Faculty will deliver a summative recommendation on each of the **clinical LOs** that are relevant to the trainee's stage of training, ie have they met the standard for entrustment. This is summarised within an FEG statement or MCR/MTR.
- b The educational supervisor reviews the evidence collated for each of the **generic LOs** and offers a judgement on progress in these. A matrix providing guidance for educational supervisors in the generic LOs is available.

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

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

These three elements form the basis of the ES annual report. This, in turn, is reviewed by the ARCP panel. The panel will have access to all the relevant source material and will be able to provide oversight and ensure a nationally consistent approach and standard. The ARCP panel will make the final summative decision about progression.

Figure 2 – information flow in the ACCS Programme of Assessment



5. ACCS Assessment Blueprint

The ACCS assessment blueprint maps the programme of assessment to the wider curriculum and is shown in table 2. It shows that each of the LOs is assessed in a number of ways.

For the WPBA programme, it is not necessary to use each of the tools shown in the blueprint table for each of the LOs. These are examples of tools that might be used to provide evidence of learning in each of these. The 'summative' element of the WPBA programme is the entrustment decision for the clinical LOs and the educational supervisor's review of the generic LOs.

The table below shows the possible methods of assessment for each ACCS Learning Outcome. It is not expected that every method will be used for each one and additional evidence may be used to help make a judgement on capability.

Figure 3 – ACCS assessment blueprint

Learning Outcome	Mini-CEX	CbD	ACAT	DOPS	Logbook	Teaching/presentation feedback tool	QIPAT	Portfolio/self-directed learning	Entrustment decision/FEG/MCR/MTR	MSF	HALO	IAC (EPA 1 & 2)
1. Care for physiologically stable adult patients presenting to acute care across the full range complexity	X	X	X		X			X	X	X		
2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	X	X	X		X				X	X		
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	X	X	X	X	X				X	X		
4. Care for acutely injured patients across the full range of complexity	X	X	X	X	X				X	X		
5. Deliver key ACCS procedural skills				X	X				X	X		

6. Deal with complex and challenging situations in the workplace	X				X				X	X		
7. Deliver safe anaesthesia and sedation	X	X		X	X				X	X	X	X
8. Manage patients with organ dysfunction and failure	X	X		X	X				X	X	X	
Generic ACCS LOs												
9. Support, supervise and educate						X			X	X		
10. Participate in research and manage data appropriately						X		X	X	X		
11. Participate in and promote activity to improve the quality and safety of patient care						X	X	X	X	X		

KEY

ACAT	Acute Care Assessment Tool	CbD	Case-based Discussion
DOPS	Direct Observation of Procedural Skills	FEG	Faculty Educational Governance
HALO	Holistic Assessment of Learning Outcome	IAC	Initial Assessment of Competence (EPA 1 & 2)
MCR/MTR	Multiple Consultant Report/Multiple Trainer Report	Mini-CEX	Mini-Clinical Evaluation Exercise
MSF	Multi-Source Feedback	QIPAT	Quality Improvement Project Assessment Tool

6. Entrustment Decisions

Transitions and the crossing of thresholds are about taking on new responsibilities with a higher degree of independence. Knowing whether a trainee is ready to do so is complex. It requires a clear working knowledge of what the responsibilities involve, and the ability to predict how a trainee will respond when given responsibility. An example is the care of patients in the resuscitation room (ACCS LO 3) when the trainee is on duty and the on-call consultant is at home.

This is an example of 'judgement-based' assessment. Scholarship in this field has seen a major transition from reductionism (breaking the assessment down to multiple 'objective' elements and assessing these) to entrustment (making the most of the sophisticated, contextual, individualised global judgements of which clinician trainers are capable.)^{2, 3}

Key features of good judgement-based assessment are *asking the right people* and *asking the right questions*.² The FEG panels are composed of staff who know the trainee well and know the responsibilities of the job well. This provides us with the best chance of meaningful FEG judgements. Critically, the judgements are framed in terms of entrustment and independence. [ten Cate, 2013] This aligns with the natural decision-making heuristics of clinician supervisors, and there is good empirical evidence that that such 'construct aligned' judgements are significantly more dependable than judgements framed in terms of training stage or merit (eg poor, satisfactory, or good.)^{4, 5}

The WPBA approach is built around preparing trainees for thresholds in training. To that end, assessments in the workplace are also aligned to entrustment/independence. The ACCS entrustment scale is shown in table 3.

² Crossley J, Jolly B Making sense of work-based assessment: ask the right questions, in the right way, about the right things, of the right people. Medical Education 2012 46(1):28-37

³ Learning and Teaching in Clinical Contexts: A Practical Guide Delaney and Molloy 2018 ISBN 9780729542722

⁴ Assessing the surgical skills of trainees in the operating theatre: a prospective observational study of the methodology JD Beard, J Marriott, H Purdie and J Crossley Health Technology Assessment 2011; Vol. 15: No. 1

⁵ Weller JM, Misur M, Nicolson S, Morris J, Ure S, Crossley J, Jolly B. Can I leave the theatre? A key to more reliable workplace-based assessment. Br J Anaesth 112(6):1083-1091 2014

Figure 4 – ACCS entrustment 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 trainee knows reliably when to ask for help
3	Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision
4	Would be able to manage with no supervisor involvement (all trainees practice with a consultant taking overall clinical responsibility)

The expectation on ACCS trainees is shown in table 4. This ensures that the requirements are transparent and explicit for all – trainers, trainees and the public. Making these expectations transparent for trainees is one of the ways our assessment scheme is designed to foster self-regulating learners. By providing a common and transparent map of what is expected from start to finish over the training journey, we give trainees the best chance of orienting themselves in terms of the progress so far and their next steps. We also unify consistency of feedback across the whole learning journey making it more credible to learners.⁶

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

⁶ Crossley J (2014) Addressing learner disorientation: Give them a roadmap, *Medical Teacher*, 36:8, 685-691

Figure 5 – ACCS entrustment requirements

Learning Outcome	EM	AM	Anaes	ICM
1. Care for physiologically stable adult patients presenting to acute care across the full range 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	2b	2b	2b	2b
4. Care for acutely injured patients across the full range of complexity	2b			
5. Deliver key ACCS procedural skills	Refer to Clinical ACCS LO 5 table*	Refer to Clinical ACCS LO 5 table*	Refer to Clinical ACCS LO 5 table*	Refer to Clinical ACCS LO 5 table*
6. Deal with complex and challenging situations in the workplace	2a	2a	2a	2a
7. Deliver safe anaesthesia and sedation			2b	
8. Manage patients with organ dysfunction and failure				2a
9. Support, supervise and educate	ES review	ES review	ES review	ES review
10. Participate in research and manage data appropriately	ES review	ES review	ES review	ES review
11. Participate in and promote activity to improve the quality and safety of patient care	ES review	ES review	ES review	ES review

* Clinical ACCS LO 5 table found on page 47 of the 2021 Curriculum for ACCS Training

6.1. Faculty Educational Governance (FEG) Statement (Emergency Medicine placement)

6.1.1. What is it?

This is a statement that summarises the collated views of the training faculty as to the progress of a trainee, specifically, their suitability to move to the next stage of training. This judgement is based on the observation of the trainee in the workplace, on feedback from staff and patients and what faculty members have learned about trainee's performance in conducting WPBAs. (Individual WPBAs and reflections need not be reviewed by the training faculty at each FEG meeting but they are available for review if the faculty judges that they need more data to make their judgement.)

Within this statement, the strengths of the trainee are also summarised as well as areas to develop thus giving the opportunity to reflect and encourage excellence. The FEG panel can also offer a suggestion for how the trainee might address any on-going training needs, potentially making the FEG an 'adaptive' or individualised assessment.

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

The FEG statement serves a summative purpose within our assessment programme. It is then triangulated with other information in the ES annual report to inform ARCP decision making. The FEG statement is usually held on the trainee's e-portfolio and is accessed by the educational/clinical supervisor and training programme director only.

The FEG process provides the opportunity for deeper, more timely, and more information-rich scrutiny of progress towards the key workplace LOs than the old Supervisor Report was able to deliver.

6.1.2. How is it done?

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

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

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

The final meeting is for the purposes of FEG statement completion. A quorate meeting would include **at least three consultants, who must be trained educational supervisors.**

Other centres have a designated training faculty from among their consultant body that perform this function at a formal educational governance meeting comprised of the College Tutor (or equivalent), educational/clinical supervisor and at least two other consultant trainers. At this meeting, the progress of each trainee against each LO is discussed and the output of this meeting is the FEG statement.

6.1.3. Example:

ACCS LO 1: Care for physiologically stable adult patients presenting to acute care across the full range complexity

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

This is the key capability for ACCS LO 1 and describes entrustment level 2b.

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

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

The FEG statement is recorded in the trainee's e-portfolio by their educational or clinical supervisor. The FEG statement also includes general feedback on trainee strengths and areas to develop.

6.1.4. When is it done?

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

6.1.5. What if a trainee is deemed not ready to progress?

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

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

6.2. Multiple Consultant Report (MCR) (Intensive Care Medicine/Internal Medicine)

Multiple Trainer Report (MTR) (Anaesthetics)

Consultant feedback is a mandatory part of completing a learning outcome, and should assure whoever signs the HALO form that the trainee is considered competent to provide anaesthesia and peri-operative care to the required level in this learning outcome.

The MCRs/MTRs differs from an MSF as they concern a trainee's progress with key capabilities and learning outcomes. MSFs seek feedback from the multidisciplinary team, including consultants, on overall professional behaviour and attitude.

Consultant feedback will be collated through the trainee's respective e-portfolio and will form part of the ES annual report. At least one MCR/MTR will be required in each six-month block in anaesthesia, intensive care medicine and acute medicine. The consultant supervisor gives their summative judgement on the trainee's performance during the placement but formative feedback is also made available to the trainee.

Consultant feedback will be collated, linked to the ACCS LOs and presented in the ES annual report at ARCP. It should be discussed with the trainee during or at the end of a learning outcome prior to sign-off.

6.3. Holistic Assessment of Learning Outcome (HALO) (Anaesthetics)

A satisfactorily completed HALO form provides evidence that a trainee has achieved the key capabilities required to demonstrate attainment of particular elements in training. In ACCS these are:

1. Procedural sedation in adults
2. Basic anaesthetic care

Supervisors should draw upon a range of evidence including the logbook of cases completed, WPBAs, illustrations set out in the curriculum document, and consultant feedback from the MTR to inform their decision as to whether the element has been achieved. The logbook review should consider the mix of cases, level of supervision and balance of elective and emergency cases. Evidence for achievement of key capabilities and learning outcomes will be uploaded by the trainee to their respective e-portfolio and will be linked to the relevant stage learning outcome. The supervisor will be able to review this evidence at the end of a stage of training to complete the HALO but it is expected that the evidence will be collected and linked throughout the stage of training period so that educational supervisors and ARCP panels are able to review progress.

All hospitals must identify appropriate designated trainers to sign the HALO form for each stage learning outcome. Each trainer should be familiar with the requirements for the stage learning outcome and be able to provide guidance for trainees who have not yet achieved the learning outcomes. It is anticipated that the HALOs for the generic professional capability based stage learning outcomes will be signed by the trainee's supervisor during the anaesthetic placement. **The professional judgement of the supervisor will ultimately determine whether it is appropriate to sign the HALO form for a trainee.**

7. Assessment Methods

The following methods of assessment will provide evidence of progress in the integrated Programme of Assessment. The requirements for each training post are stipulated in the ACCS ARCP decision aid.

All individual assessments in the workplace are formative, assessment **for** learning, and therefore developmental in nature. That means they cannot be failed. These episodes are an opportunity for learners to receive feedback about progress towards key progression points. They are designed for that purpose.

WPBAs are anchored to the same entrustment scale that is used for summative decision making. In that way, each episode provides the opportunity for clear developmental feedback to be given across the clinical ACCS LOs.

Assessment in the workplace should start right at the beginning of training and continue regularly thereafter. It is the responsibility of the learner to seek out, with the full support of the training faculty, learning opportunities that allow progress against each of the relevant clinical ACCS Learning Outcomes to be reflected and recorded.

The collation of a range of evidence in formative assessment from the start of each placement is a clear indication of engagement in training and helps ensure the trainee gets full benefit from the learning opportunities in their placement. The formative WPBA tools in ACCS are listed below.

7.1. WPBA tools

7.1.1. Acute Care Assessment Tool (ACAT)

The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute medical take, and is used in AM. Any doctor who has been responsible for the supervision of the acute medical take can be the assessor for an ACAT. This tool can also be used to assess other situations where a trainee is interacting with a number of different patients (eg in a day hospital or a business ward round)

7.1.2. Case-based Discussion (CbD)

The CbD assesses the performance of a trainee in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record (such as written case notes, out-patient letter, discharge summary).

7.1.3. Mini-Clinical Evaluation Exercise (mini-CEX)

This tool evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available.

7.1.4. Direct Observation of Procedural Skills (DOPS)

A DOPS is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

7.1.5. Multi-Source Feedback (MSF)

This tool is a method of assessing skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. 'Raters' are individuals with whom the trainee works, and includes doctors, administrative staff, and other allied professionals. The trainee will not see the individual responses by raters. Feedback is given to the trainee by the educational supervisor.

7.1.6. Patient Survey (PS)

The PS addresses issues, including the behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee's performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation.

7.1.7. Quality Improvement Project Assessment Tool (QIPAT)

The QIPAT is designed to assess a trainee's competence in completing a quality improvement project. The QIPAT can be based on review of quality improvement project documentation or on a presentation of the quality improvement project at a meeting. If possible the trainee should be assessed on the same quality improvement project by more than one assessor.

7.1.8. Teaching Observation (TO)

The TO form is designed to provide structured, formative feedback to trainees on their competence at teaching. The TO can be based on any instance of formalised teaching by the trainee which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

7.2. Initial Assessment of Competence (IAC) for Anaesthetics

The IAC is the first component of training and in practice normally takes between three and six (indicative) months for most doctors to achieve. It is a summative assessment and trainees must complete it in its entirety before trainers consider whether it is acceptable for them to progress to undertake aspects of clinical anaesthetic practice without direct supervision. It is important that anaesthetists and their trainers recognise that possession of the IAC does not imply that an anaesthetist in training may deliver direct anaesthetic care to patients without continuing appropriate supervision but is the first milestone in the training programme.

The purpose of the IAC is to signify that the anaesthetist in training has achieved a basic understanding of anaesthesia and is able to give anaesthetics at a level of supervision commensurate with the individual anaesthetist in training's skills and the clinical case; and the anaesthetist in training can be added to the on-call rota for anaesthesia. The IAC is not a licence for independent anaesthetic practice.

7.3. National Examinations

In order to complete the ACCS training programme pathway, trainees are also required to achieve their respective parent specialty examination of knowledge.

The principle of standard setting is to set the pass mark for an examination against a criterion-referenced standard by determining the minimum level of knowledge and/or skills required to pass

an examination. There are several recognised standard setting processes used in high-stake medical examinations, and different examination formats lend themselves to different standard setting methods.

Detailed descriptions of the format and approach to standard setting used for each of the examinations can be found in the respective parent specialty curricula and associated assessment strategies.

7.3.1. Fellowship of the Royal College of Anaesthetists (FRCA)

The FRCA examination is a two-part 'high-stakes' national assessment. Its major focus is on the knowledge required for practice but the structured oral examination [SOE] and objectively structured clinical examination [OSCE] test decision-making, understanding of procedure and practical elements (including the use of simulation).

The Primary examination is divided into two parts: the MCQ and the OSCE/SOE. Possession of the Primary FRCA is a mandatory requirement for entry into Stage 2 (ST4) Anaesthetics training.

Further details on the examinations are available on the *Examinations* pages on the RCoA website.

7.3.2. Membership of the Royal College of Emergency Medicine (MRCEM)

The MRCEM examination consists of three components: Two Single Best Answer (SBA) multiple-choice papers and an Objective Structured Clinical Examination (OSCE). All MRCEM components are blueprinted to the RCEM curriculum (years 1-3) and focussing on the EM SLOs 1-7 and 9. Questions used in each component are tagged to the RCEM basic science and clinical syllabi. The EM Speciality Learning Outcomes (SLOs) and the capabilities relevant to each SLO are set out in the assessment blueprint submitted as part of the EM CAG application. Successful completion of all three MRCEM components are required to complete EM Intermediate Training (end of CT3/ST3) as part of a programme of assessment designed to ensure readiness for Higher Training.

EM ACCS trainees are advised to successfully complete the MRCEM Primary by the end of ST2. The MRCEM Primary examination samples the Basic Science Syllabus, ensuring a sound background knowledge in the basic science underpinning EM care. It can be undertaken at any point post registration as a medical practitioner and comprises 180 questions, to be completed in three hours.

The EM CAG submission includes proposals to conduct all written examination in the single best answer format so there will only be one appropriate response. The format is appropriate for an item centred standard setting method and we use the Angoff approach. In following best practice, a dedicated Angoff referencing group of examiners use the Angoff process to determine a pass mark. Training is given to all members of the MRCEM and FRCEM Angoff reference groups, and to develop a collective understanding of the 'minimally competent' candidate. After each examination, item analysis provides the exam board with data on items with unexpected performance statistics. Highlighted items are reviewed, and if the item itself is problematic it is removed from the paper before scores are finalised.

Further details are contained in the EM CAG submission and programme of assessment for the 2021 curriculum.

7.3.3. Membership of the Royal College of Physicians of the United Kingdom (MRCP[UK])

The MRCP(UK) tests the acquisition of a representative sample of medical knowledge, skills and behaviour.

The full MRCP(UK) Diploma, consisting of Part 1, Part 2 Written and Part 2 Clinical (PACES), is the knowledge based assessment for Internal Medicine Training (IMT) and has been mapped to the IMT curriculum for this purpose.

Possession of the full MRCP(UK) Diploma is a mandatory requirement for ST3 and ST4 entry into any of the medical (physicianly) specialties.

Further details on the examinations are available on the MRCP UK website.