ACCS

Acute Care Common Stem

2021 Curriculum for Acute Care Common Stem Training Version 1.3 August 2021

Contents

Change log

This document outlines the curriculum to be used by doctors completing Acute Care Common Stem (ACCS) training in the UK. It is accompanied by the *Assessment strategy for ACCS*.

Version 1.0 was published in August 2021. As the document is updated, version numbers will be changed, and content changes noted in the table below.

Version number	Date issued	Summary of changes
Version 1.1	10 December 2021	Addition of key descriptor so that it aligns to key capabilities in Stage 1 ICM curriculum
		Addition of 'HALO' to clarify that this is an assessment tool to complete ACCS Learning Outcome 8
		Amendments to ensure consistency with title of ACCS Learning Outcome 2
		Addition of 'EPA 1 & 2' to clarify that this is the assessment tool to complete the 'Initial Assessment of Competence' in the anaesthetic placement
Version 1.2	01 February 2023	Supervision level for learning outcome 3 corrected from 2b to 2a.
		Supervision levels for learning outcome 5 corrected from 2b to 2a.
Version 1.3	01 August 2025	Sedation moved from LO7 to LO5 and Programme of Assessment expanded to all four placements using ACCS Sedation Assessment Tool (ASAT) instead of HALO
		Title of LO7 amended to remove the sedation part
		Programme of assessment for LO5 expanded to include additional options
		Pleural aspiration of fluid added as alternative to aspiration of air in LO5
		For LO10 further examples added in the "Excellence" section
		For SLO11 further example added in the "Acceptable/good" section
		Tables in Appendix 2 that pertain to the generic LOs amended to clarify where the listed elements should all be achieved or where they represent alternatives

1. Introduction to the Acute Care Common Stem curriculum

This document identifies the purpose, content of learning, process of training, and the programme of assessment for Acute Care Common Stem training.

2. Purpose

2.1. Purpose statement

This purpose statement addresses the requirements of the GMC *Excellence by design: standards for postgraduate curricula* to include a clear statement, addressing patient and service needs, and the scope of practice and level expected of those completing training.

CS1.1 The curriculum has a stated and clear purpose based on scope of practice, service, and patient and population needs.

The purpose of the Acute Care Common Stem (ACCS) curriculum is to equip the trainee doctor with the skills and competences required to recognise and undertake initial management of the acutely unwell patient. Trainees will be able to define the nature of the specialist intervention required and will have training in four complementary specialties.

The curriculum provides trainees with the generic professional and specialty specific capabilities required to manage patients presenting with a wide range of acute medical symptoms and conditions, so they can:

- deliver appropriate and timely care to all patients who become acutely unwell in all clinical settings within an acute care facility; and
- work as part of and communicate effectively with the multidisciplinary team managing these situations.

The ACCS curriculum provides a framework for training in four areas closely involved with managing the acutely unwell patient: Anaesthesia, Internal Medicine, Intensive Care Medicine and Emergency Medicine. The knowledge and skills of these specialties are closely related and interface in the care of every acutely ill patient. By working in these specialties, the ACCS trainee will become familiar with common acute and life-threatening presentations, their rapid initial assessment and treatment, how to determine what definitive care is needed and where it is best provided.

The ACCS curriculum is recognised as an exemplar of broad-based, general training with many common learning outcomes. The universally accepted service model for provision of care in Acute NHS Trusts necessitates and promotes the requirement for such a programme of learning. In addition, recent workforce analysis has identified numerous vacancies in Internal, Emergency and Intensive Care Medicine and Anaesthesia across the UK: the expansion of acute services and increasing demands of an ageing population will place further demands over the coming decade on all ACCS specialties.

It is widely acknowledged that the broader range of competences obtained by trainees completing the ACCS curriculum enhances patient care, particularly in the provision of emergency out-of-hours work. In addition, the skills gained through ACCS are transferable to training in Intensive Care Medicine, as part of both single and dual CCT programmes.

This curriculum provides the first two years of training in Emergency Medicine and delivers an alternative route into training in Anaesthesia, Intensive Care Medicine and Internal Medicine. The ACCS curriculum includes mandatory training placements in all of the ACCS 'partner specialties', that is, Anaesthesia, Emergency Medicine Intensive Care Medicine and Internal Medicine. The ACCS curriculum provides a broad-based, attractive programme for doctors. The programme will help doctors develop knowledge, skills and attitudes to allow them to:

- assess any acutely ill patient and begin appropriate resuscitation

- diagnose the most important underlying problem(s)
- initiate appropriate investigations and start appropriate immediate treatment
- provide safe basic anaesthetic care
- manage critically unwell patients in conjunction with critical care teams
- identify and liaise with other teams to ensure appropriate definitive care
- understand the importance of patient flow through the acute services and within the wider health community.

Generic Professional Capabilities, clinical skills and knowledge will be developed and evidenced through achievement of 'ACCS Learning Outcomes' (ACCS LOs) across eleven domains. The ACCS LOs to be achieved by trainees in each training placement capture the skills, knowledge and behaviours required to fulfil the General Medical Council's (GMC) Generic Professional Capabilities[1] for all trainees, and are described at a high level in the table below:

Figure 1 – ACCS Learning Outcomes

A trainee completing ACCS will be able to:		
	ACCS Learning Outcome Title	**GPCs**
1	Care for physiologically stable adult patients presenting to acute care across the full range of complexity	1,2,3,4,5,6,7
2	Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	1,2,3,4,6,7
3	Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	1,2,3,4,5,6,7,8,9
4	Care for acutely injured patients across the full range of complexity	1,2,3,4,6,7
5	Deliver key ACCS procedural skills	1,2,3,4,5,6,7,8,9
6	Deal with complex and challenging situations in the workplace	1,2,3,4,5,6,7,8
7	Provide safe basic anaesthetic care	1,2,3,5,6,7
8	Manage patients with organ dysfunction and failure	1,2,3,5,6,7
9	Support, supervise and educate	8
10	Participate in research and manage data appropriately	9
11	Participate in and promote activity to improve the quality and safety of patient care	6

Training and assessment in the areas outlined in the ACCS LOs will take place throughout the four specialty training placements. On completion of the two generic years of the ACCS curriculum, a trainee will be equipped with the competence and confidence to manage

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uncertainty, to deal with comorbidities and to recognise when specialty opinion or care is required. The ACCS curriculum focuses on initial assessment and management of patients in a variety of acute hospital settings. The content of the curriculum reflects the wide range of clinical and professional skills required to meet the needs of clinical services.

In order to demonstrate completion of the ACCS *training programme* in its entirety, trainees are first required to complete this ACCS curriculum in full, as this is a critical progression point for further training in each of the parent specialties. At this point trainees will continue to train as detailed for the relevant level of training (ie 'Stage 1' or 'Intermediate') as defined in the curriculum of the respective Royal College.

In order to progress into further training at 'Stage 2' or 'Higher' level in each of the parent specialties, trainees must demonstrate achievement of all of the learning outcomes as detailed for the relevant level of training in their respective parent specialty's curriculum (ie 'Stage 1' or 'Intermediate').

Therefore, in addition to the ACCS LOs, completion of the ACCS (Anaesthetics) training programme requires achievement of the learning outcomes for completion of 'Stage 1' of the Anaesthetics curriculum.

In addition to the ACCS LOs, completion of the ACCS (Emergency Medicine) training programme requires achievement of the learning outcomes for completion of 'Intermediate' of the Emergency Medicine curriculum.

In addition to the ACCS LOs, completion of the ACCS (Internal Medicine) training programme requires achievement of the learning outcomes for completion of 'Stage 1' of the Internal Medicine curriculum. It is not expected that trainees who choose ACCS core training will apply for non-acute (group 2) physician specialties. However, if they wish to, they will be eligible to apply for a group 2 specialty if they complete three years of the ACCS-IM programme (equivalent to IM year 1 and IMY year 2).

Trainees who choose ACCS core training will be eligible to apply for ICM recruitment after three years of the ACCS programme, as long as they have the respective route's exam by the time of appointment.

CS1.2 The curriculum considers interdependencies across related specialties and disciplines. It demonstrates that it has addressed the expectations of the service and healthcare system.

The ACCS curriculum will produce a trainee workforce that reflects current trends of increasing patient attendances to both primary care and emergency departments. This workforce will have the skills to begin to manage complex multimorbidity in an ageing population, and to liaise with all acute hospital specialties.

During its development, the ACCS curriculum has been presented to and discussed with stakeholders including colleges and faculties, trainees, trainers, heads of schools, educational and employer organisations in each of the four nations, COPMeD, patients and protected characteristics groups. Each College/Faculty has consulted on the ACCS curriculum as part of its engagement strategy for the respective parent specialty.

CS1.3 The curriculum supports the flexibility and transferability of learning.

The ACCS curriculum provides trainees with competences that are designed to be appropriate and transferable to all acute care training programmes. A mapping exercise has been conducted across the ACCS two-year curriculum and the curricula of all four parent specialties to ensure that this can be easily facilitated.

By making the Generic Professional Capabilities explicit within the curriculum design, this eases transfer of capabilities between specialties. ACCS LOs can be evidenced by experiences in a wide range of posts and environments, allowing flexibility to meet the needs of both the service and individual trainees.

This purpose statement has been endorsed by the GMC's Curriculum Oversight Group and confirmed as meeting the needs of the health services of the countries of the UK.

2.2. Rationale

The Shape of Training Review[2] and the GMC's *Excellence by design: standards for postgraduate curricula[3]* provide an opportunity to reform postgraduate training to produce a workforce fit for the needs of patients, producing a doctor who is more patient focused, more general and has more flexibility in career structure. The GMCs introduction of updated standards for curricula and assessment processes laid out in *Excellence by design*, requires all medical curricula to be based on high-level outcomes and to incorporate the GPCs framework[4]. The curriculum is constituted of eleven learning outcomes, eight clinical and three generic to be achieved by all ACCS trainees as they progress before appointment to and commencement of Higher Training in their core speciality.

The curriculum for ACCS incorporates and emphasises the importance of the GPCs, which provide the educational articulation of Good Medical Practice[5]. Such common capabilities will promote flexibility in postgraduate training in line with the recommendations set out in the GMC's report to the four UK governments[6], ensuring a sustainable model for training in each of the parent specialties agile enough to respond to evolving patient need and service opportunities, as well as resulting in a more flexible, adaptable workforce.

The curriculum provides further detail and guidance as to how the ACCS learning outcomes can be achieved and demonstrated in section 5.

2.3. High level curriculum outcomes: ACCS Learning Outcomes (ACCS LOs)

The 11 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 trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated for an entrustment decision to be made.

The eight clinical ACCS LOs describe the clinical tasks or activities which are essential to the care of acutely ill and injured adults presenting to acute care. The clinical ACCS LOs have also been mapped to the GPC domains and subsections to reflect the professional generic

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[2] https://www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf

[3] https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/excellence-by-design

[4] https://www.gmc-uk.org/education/standards-guidance-and-curricula/standards-and-outcomes/generic-professional-capabilities-framework

[5] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

[6] https://www.gmc-uk.org/-/media/documents/adapting-for-the-future-a-plan-to-improve-postgrad-med-training-flexibility_pdf-69842348.pdf

capabilities required to undertake the clinical tasks. Satisfactory sign off requires demonstration that, for each of the clinical ACCS LOs, the trainee's performance meets or exceeds the minimum expected level of performance expected for completion of this stage of training, as defined in the curriculum (see section 5.3 ACCS Entrustment Requirements which outlines the levels expected for each clinical ACCS LO in both years of ACCS training).

The three generic ACCS LOs cover universal requirements of all specialties, as described in GPC framework. Assessment of the generic ACCS LOs will be underpinned by the relevant GPC descriptors. Satisfactory sign off will indicate that the ACCS trainee has achieved these LOs before they can progress.

2.4. Development

Responsibility for the ACCS curriculum rests with the Intercollegiate Committee for ACCS Training (ICACCST), which has representation from all four parent specialities. The ICACCST established the ACCS Curriculum Review Group (ACCSCRG) with delegated responsibility for setting the direction of the curriculum revisions and overseeing and approving the review work. The group's membership represents a wide range of stakeholders including the four parent specialty representation, the Lead Dean for ACCS, trainees and lay/patient groups.

The curriculum for ACCS has been developed with the support and input of trainees, consultants actively involved in delivering teaching and training across the UK, service representatives and lay persons. This has been through the work of the ACCSCRG and its subgroups and at regular stakeholder engagement events.

2.4.1. *Ongoing curriculum review*

The curriculum will be reviewed regularly with an implementation date for any changes being not less than six months after their publication date. All changes to the curriculum are prospectively approved by the GMC before publication. When published, the curriculum document will be annotated with the same version number and will be available on the ACCS website, with a summary of changes also published.

Occasionally the ICACCST may have to take decisions that may affect the immediate interpretation or application of specific items in this curriculum document or supporting guidance manuals. These will be published as an update circular to all ACCS programme directors and Heads of Schools [or Deanery equivalent], as well as being cascaded to trainee groups and published on the ACCS website.

2.5. Training Pathway

The ACCS training pathway is entered following completion of the foundation programme and its purpose is to ensure doctors demonstrate the ability to learn in the workplace and develop their clinical and professional skills in readiness for higher specialty training.

On successfully completing the ACCS generic two-year curriculum, ACCS trainees continue to train in their chosen specialty (Anaesthetics, Emergency Medicine [EM], or Internal Medicine [IM]) for a further period (see diagram below); until the completion of Stage 1 training in Anaesthetics, Stage 1 training in IM or Intermediate training in EM.

ACCS has a common aim, but each specialty has specific objectives for ACCS training:

2.5.1. *Emergency Medicine*

The first two years of ACCS training (EM, IM, Anaesthetics and ICM) are followed by a further year gaining additional competences in adult EM (including musculoskeletal emergencies) and Paediatric Emergency Medicine; thus fulfilling the requirements to progress to higher training in EM.

2.5.2. *Internal Medicine*

ACCS is one of the training options available for delivering the core competences required for a CCT in one of the acute medical specialties (group 1) managed by the Joint Royal Colleges of Physicians Training Board (JRCPTB). The first two years of ACCS training (IM, EM, Anaesthetics and ICM) are followed by a further two years in IM training. The trainee should take part in shifts of acute medical take monthly to acquire evidence equivalent of 100 patients seen with acute medicine problems by the end of ACCS. It is anticipated that this will be at least 4 shifts of acute medical take per month during the six month period of training in medicine. The trainee should also gain experience in managing patients with ambulatory medical conditions in an area such as a Same Day Emergency Care (SDEC) unit. This four-year training programme fulfils the requirements for progression to higher training in a group 1 specialty.

2.5.3. *Anaesthetics*

The training programme leading to a CCT in Anaesthesia can be entered directly via the Core Anaesthetic Training (CAT) programme. However, those Anaesthetic trainees with an interest in the 'acute' end of the Anaesthetic spectrum will find ACCS an ideal career starting point. It provides trainees with more widely based experience than is available solely within the CAT programme. The first two years of ACCS training (IM, EM, Anaesthetics and ICM) are followed by a further two years spent gaining additional capabilities in Anaesthetics to complete Stage 1 of the Anaesthesia Training Programme and allow competitive entry into Stage 2.

It is widely acknowledged that the broader range of competences achieved by those on an ACCS programme, compared to those pursuing CAT, enhances patient care particularly in the provision of emergency out-of-hours work. This enables supervisors more discretion in the deployment of trainees with wider-ranging skillsets. For example, the additional knowledge and skills gained within the ACCS programme may enable trainees to work with lower supervision levels where appropriate, in areas such as perioperative medicine, trauma management and critical care. In addition, the skills gained as part of this four-year training programme are transferable to training in ICM, either as part of a single or dual programme.

2.5.4. *Dual CCT in Intensive Care Medicine (ICM)*

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

Figure 2 - The ACCS training pathways

ACCS Training Pathways
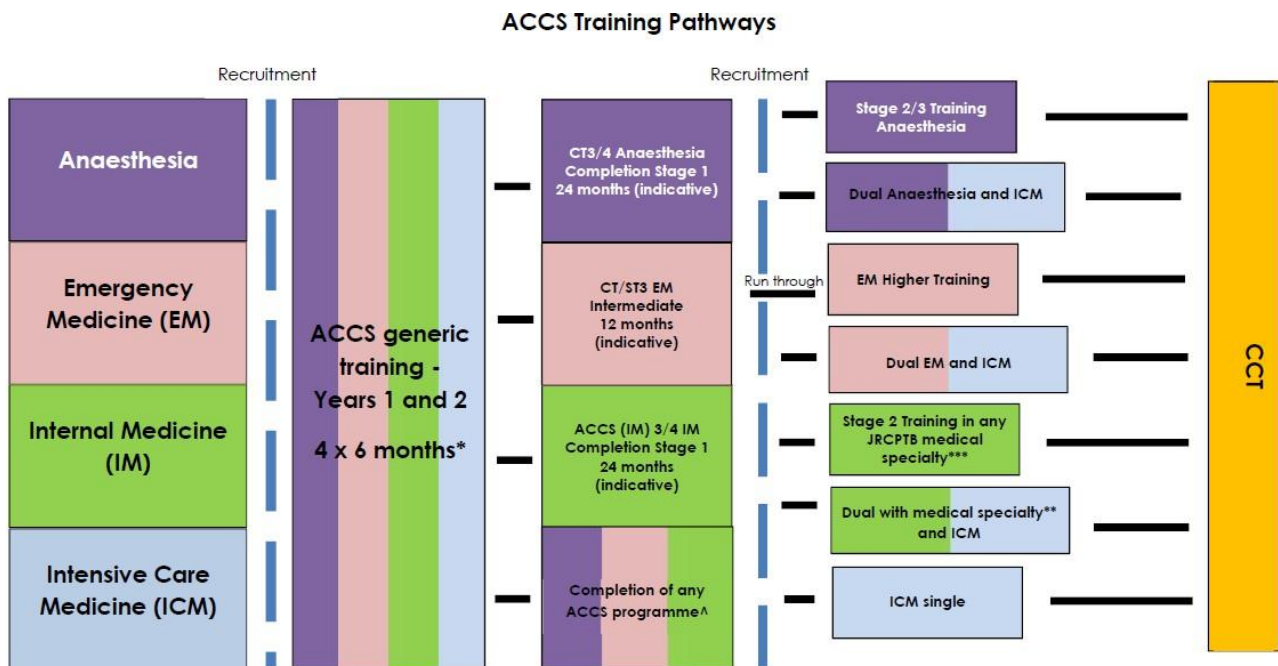
*Placements may be in any order over an indicative 24 months
** Acute Medicine, Renal Medicine, Respiratory Medicine
*** It is not expected that trainees who choose ACCS core training will apply for non-acute (group 2) physician specialties. However, if they wish to, they will be eligible to apply for a group 2 specialty if they complete three years of the ACCS-IM programme (equivalent to IM year 1 and IM year 2).
^ Trainees who choose ACCS core training will be eligible to apply for ICM recruitment after three years of the ACCS programme, as long as they have the respective route's exam by the time of appointment.

2.6. Duration of training

The ACCS training programme covered by this curriculum will usually be completed in two years of full time training. Duration of specialty training to CCT will vary by specialty. It may be possible for those trainees who demonstrate exceptionally rapid development and acquisition of capabilities, to complete training more rapidly than the current indicative time of two years. However, it is recognised that clinical experience is a fundamental aspect of development as a good clinician. There may be a small number of trainees who develop more slowly and will require an extension of training in line the Reference Guide for Postgraduate Specialty Training in the UK (The Gold Guide)[7].

2.7. Less than Full Time Training

Trainees are entitled to request less than full time training programmes. Less than full time trainees should undertake a pro rata share of the out-of-hours duties (including on-call and other out-of-hours commitments) required of their full-time colleagues in the same programme and at the equivalent stage.

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[7] A Reference Guide for Postgraduate Specialty Training in the UK

Less than full time trainees should assume that their clinical training will be of a duration pro-rata with the time indicated/recommended, but this should be reviewed in accordance with the Gold Guide.

2.8. Generic Professional Capabilities and Good Medical Practice

The GMC has developed the Generic Professional Capabilities (GPC) framework[8] with the Academy of Medical Royal Colleges (AoMRC) to describe the fundamental, career-long, generic capabilities required of every doctor. The framework describes the requirement to develop and maintain key professional values and behaviours, knowledge, and skills, using a common language. GPCs also represent a system-wide, regulatory response to the most common contemporary concerns about patient safety and fitness to practise within the medical profession. The framework will be relevant at all stages of medical education, training and practice.

The nine domains of the GMC's Generic Professional Capabilities

Professional knowledge

Professional skills

Health promotion and illness prevention

Research and scholarship

Professional values and behaviours

Leadership and team

Education and training

Patient safety and quality improvement

Safeguarding vulnerable groups

Figure 3 – the GMC's Generic Professional Capability Framework

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[8] Generic professional capabilities framework

Good medical practice (GMP)[9] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors the GPC framework articulates GMP as a series of achievable educational outcomes to enable curriculum design and assessment.

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

The 20 domains and subsections of the GPC framework are directly identifiable in the ACCS curriculum. They are mapped to each of the clinical and generic ACCS LOs, which are, in turn, mapped to the assessment blueprints. This is to emphasise those core professional capabilities that are essential to safe clinical practice and that they must be demonstrated at every stage of training as part of the holistic development of responsible professionals.

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

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[9] Good Medical Practice

3. Content of learning

The practice of medicine in ACCS requires the generic and specialty specific knowledge, skills, and attitudes to manage adult patients presenting acutely with a wide range of presentations or conditions. It involves particular emphasis on diagnostic reasoning, managing uncertainty, dealing with comorbidities, managing emergencies and recognising when specialty opinion or care is required.

3.1. Clinical ACCS Learning Outcomes

The ACCS Learning Outcomes describe the professional tasks or work within the scope of ACCS. The clinical ACCS Learning Outcomes are based on the concept of Entrustable Professional Activities[10] which are a method of using the professional judgement of appropriately trained, expert assessors as a key aspect of the validity of assessment and a defensible way of forming global judgements of professional performance.

Each clinical ACCS LO has **Key Capabilities** described. These are statements that are used to frame entrustment decisions about the particular learning outcome. They are prefixed by *'at the end of ACCS'* to give clear guidance to trainees and faculty what is expected. Trainees will have collated evidence against each of these, and the training faculty will make a recommendation based on their answer to the question about whether these have been met.

A set of **descriptors** are also associated with that activity or task. Descriptors are intended to help trainees and trainers recognise the minimum level of knowledge, skills and attitudes which should be demonstrated by ACCS trainees. They will provide evidence of how their performance meets or exceeds the minimum expected level of performance for their year of training. The knowledge skills and behaviour are listed for each, but these are not a comprehensive list and there are many more examples that would provide equally valid evidence of performance.

Many of the clinical ACCS LO descriptors refer to patient centred care and shared decision making. This is to emphasise the importance of patients being at the centre of decisions about their own treatment and care, by exploring care or treatment options and their risks and benefits and discussing choices available.

Additionally, the clinical ACCS LOs repeatedly refer to the need to demonstrate professional behaviour with regard to patients, carers, colleagues and others. Good doctors work in partnership with patients and respect their rights to privacy and dignity. They treat each patient as an individual. They do their best to make sure all patients receive good care and treatment that will support them to live as well as possible, whatever their illness or disability. Appropriate professional behaviour should reflect the principles of GMP and GPC (see section 2.6).

By the end of training, and in order to be recommended to the GMC for the award of CCT and entry to the specialist register, the doctor must demonstrate that they are capable of unsupervised practice in all generic and clinical Learning Outcomes. The ACCS training programme, as the first stage of training for the constituent specialties, gives a sound

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[10] Nuts and bolts of entrustable professional activities

foundation for trainees to achieve this with expected performance levels for the clinical LOs commensurate with this stage of training.

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

Figure 4 – Clinical ACCS Learning Outcomes

	1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity
Key ACCS Capabilities	At completion of ACCS a trainee: • will be able to gather appropriate information, perform a relevant clinical examination and be able to formulate and communicate a management plan that prioritises patient's choices and is in their best interests, knowing when to seek help • will be able to assess and formulate a management plan for patients who present with complex medical and social needs. These capabilities will apply to patients attending with physical and psychological ill health.
Descriptors	• Demonstrate professional behaviour with regard to patients, carers, colleagues and others • Deliver patient centred care including shared decision making • Take a relevant patient history including patient symptoms, concerns, priorities and preferences • Perform accurate clinical examinations • Show appropriate clinical reasoning by analysing physical and psychological findings • Formulate an appropriate differential diagnosis • Formulate an appropriate diagnostic test and management plan, taking into account patient preferences, and the urgency required • Explain clinical reasoning behind diagnostic and clinical management decisions to patients/carers/guardians and other colleagues • Appropriately select, manage and interpret investigations • Recognise need to liaise with specialty services and refers where appropriate • Demonstrate awareness of the needs of vulnerable adults attending the acute care sector • Demonstrate professional behaviour with regard to patients, carers, colleagues and others
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge

	• professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement
Evidence to inform decision includes	Mini-CEX CbD ACAT Logbook E-learning module completion/self-directed learning Entrustment decision MSF

2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	
Key ACCS capabilities	At completion of ACCS a trainee: • will understand how to apply clinical guidelines • will understand how to use diagnostic tests in ruling out key pathology, and be able to describe a safe management plan, including discharge where appropriate, knowing when help is required • will be aware of the human factors at play in clinical decision making and their impact on patient safety.
Descriptors	• Proficient in ECG and plain film interpretation, as relevant to acute care • Aware of the cognitive psychology of decision making • Understand basic diagnostic test methodology • Understand the fundamentals of decision rule design • Aware of the strengths and limitations of using guidelines eg NICE • Demonstrate capabilities in dealing with complexity and uncertainty • Share decision making by informing patients, prioritising patient's wishes, and respecting their beliefs, concerns and expectations
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries

	Domain 4: Capabilities in health promotion and illness prevention
	Domain 5: Capabilities in leadership and teamworking
	Domain 6: Capabilities in patient safety and quality improvement
	• patient safety
Evidence to inform decision includes	Mini-CEX CbD ACAT Logbook Entrustment decision MSF Feedback from patients

	3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop
Key ACCS capabilities	At completion of ACCS a trainee: • will recognise and manage the initial phases of any acute life threatening presentation including cardiac arrest and peri-arrest situations • will be able to provide definitive airway, respiratory and circulatory support to critically ill patients • will be able to establish the most appropriate level of care for critically unwell patients - including end-of life decisions - and support their needs as well as those of their loved ones.
Descriptors	• Identify an acutely ill patient by taking account of their medical history, clinical examination, vital signs and available investigations • Integrate clinical findings with timely and appropriate investigations to form a differential diagnosis and an initial treatment plan • Institute definitive airway management and initiate and maintain advanced respiratory support • Utilise intravenous fluids and inotropic drugs as clinically indicated, using central venous access where required and monitored by invasive monitoring techniques • Manage life-threatening cardiac and respiratory conditions including peri-arrest and arrest situations • Formulate and initiate ongoing treatment plan for a critically ill acute surgical or acute medical patient post resuscitation, including those with sepsis and institute timely antimicrobial therapy with an aim for ongoing stabilisation • Communicate effectively and in a timely manner with fellow members of the multidisciplinary team including those from other specialties and completing accurate legible and contemporaneous entries in the medical record • Arrange escalation of care when required and provide a succinct structured handover of the relevant patient details including treatment to that point • Recognise a patient who is in danger of deterioration or who requires further treatment and provide explicit instructions regarding an ongoing treatment plan and contact details should a further review be required

	• Decide when it is appropriate to end resuscitation, and be cogniscent of the specific care needs of patients and their loved ones when this decision has been made • Respect patient autonomy and understand when and how they should use advance directives and living wills • Recognise the potential for organ donation in certain end of life situations and be aware of associated best practice guidelines and legislation • Demonstrate effective consultation skills in challenging circumstances • Demonstrate compassionate professional behaviour and clinical judgement
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 4: Capabilities in health promotion and illness prevention Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety • quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision includes	Mini-CEX CbD ACAT DOPS Logbook Entrustment decision MSF Feedback from patients

4. *Care for acutely injured patients across the full range of complexity*	
Key ACCS capabilities	At completion of ACCS, a trainee: • will be an effective member of the multidisciplinary trauma team • will be able to assess, investigate and manage low energy injuries in stable patients.
Descriptors	• Able to perform primary/secondary trauma survey • Have examination skills required to identify/diagnose injury including vascular and neurological consequences

	- Appropriately use investigations including XR/CT/US/MRI to confirm presence/consequences of injury - Provide basic management of wounds, soft tissue injuries, fractures and dislocations including local anaesthetic techniques - Provide safe use of basic local anaesthetic techniques eg ring block, fascia iliaca block - Use a range of techniques for wound closure (simple dressing, suturing, skin adhesive, steri-strips). - Know the fundamentals of management of fractures and dislocations (slings, splints, basic plastering, manipulation as appropriate) - Able to remove foreign bodies from the eye and ear - Provide opportunistic advice on accident prevention - Understand the pathophysiology and management of injury (including specific populations eg elderly, paediatric and pregnancy) - Understand the social/economic consequences of injury upon individuals - Estimate a timeline of healing and give general and specific safety net advice on concerning features of potential complications - Understand the importance of considering safeguarding of vulnerable patients - Apply CT guidelines for suspected head and cervical spine injuries - Provide initial care for patients with fractured neck of femur - Understand the impact of injury on patients with markers of frailty
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills - practical skills - communication and interpersonal skills - dealing with complexity and uncertainty - clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge - professional requirements - national legislation - the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement - Safety Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision includes	Mini-CEX CbD ACAT DOPS Logbook Entrustment decision MSF Feedback from patients

5. Deliver key ACCS procedural skills	
Key ACCS capabilities	At completion of ACCS a trainee: • will have the clinical knowledge to identify when key practical emergency skills are indicated • will have the knowledge and psychomotor skills to perform the skill safely and in a timely fashion.
Descriptors	• Pleural aspiration of air or fluid • Chest drain: Seldinger and open technique • Establish invasive monitoring (CVP and Art line) • Vascular access in emergency- IO, femoral vein • Lumbar puncture • Fracture/dislocation manipulation • External pacing • Direct current cardioversion • Point of care ultrasound- Vascular access and Fascia iliaca block • Procedural sedation for ASA 1-3 patients
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty
Evidence to inform decision includes	DOPs ASAT Simulation/courses Logbook Entrustment decision MSF

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

Descriptors	• Know how to safely deal with violent or threatening situations
	• Able to handle common but challenging situations:
	   o self-discharge against advice
	   o capacity assessment
	   o adult safeguarding issue
	   o Police/FME enquiries
	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups
	• Behave in accordance with ethical and legal requirements
	• Demonstrate ability to offer an apology or explanation when appropriate

	• Demonstrate ability to lead the clinical team in ensuring that medical legal factors are considered openly and consistently • Interact effectively with hospital colleagues when handing over the care of patients including in complex situations. • Liaise effectively with healthcare professionals outside the hospital about patient care.
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 5: Capabilities in leadership and team-working Domain 6: Capabilities in patient safety and quality improvement • patient safety Domain 7: capabilities in safeguarding vulnerable groups
Evidence to inform decision includes	Mini-CEX Logbook Entrustment decision MSF Feedback from patients

7. Provide safe basic anaesthetic care	
Key ACCS capabilities	At completion of ACCS a trainee will be able to: • pre-operatively assess, optimise and prepare patients for anaesthesia • safely induce, maintain and support recovery from anaesthesia including recognition and management of complications • provide urgent or emergency anaesthesia to ASA 1-3 patients requiring uncomplicated surgery including stabilisation and transfer
Descriptors	• Understand the risks, aetiology, treatment and control processes of infection including the need for and ability to perform an aseptic non-touch technique • Pre-operatively assess patients' suitability for anaesthesia, prescribe suitable pre-medication, recognise when further investigation or optimisation is required prior to commencing surgery and adequately communicate this to the patient or their family • Safely induce anaesthesia in ASA 1-3 patients, recognise and deal with common and important complications associated with induction • Maintain anaesthesia for the relevant procedure, utilise appropriate monitoring and effectively interpret the information it provides to ensure the safety of the anaesthetised patient, as a member of the multidisciplinary theatre team

	• Safely care for a patient recovering from anaesthesia, recognise and treat the common associated complications and manage appropriate post-operative analgesia, anti-emesis and fluid therapies • Provide urgent or emergency anaesthesia to ASA 1-3 patients requiring uncomplicated surgery • Plan and deliver safe sedation using appropriate agents for ASA 1-3 patients requiring procedures
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries Domain 5: Capabilities in leadership and teamworking Domain 6: Capabilities in patient safety and quality improvement • patient safety Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision includes	Mini-CEX CbD DOPS Logbook Entrustment decision MSF IAC (EPA 1 & 2)

8. *Manage patients with organ dysfunction and failure*	
Key ACCS capabilities	At completion of ACCS a trainee: • will be able to provide safe and effective care for critically ill patients across the spectrum of single or multiple organ failure • will be able to plan and communicate effectively with patients, relatives and the wider multi-professional team when attending to the clinical and holistic needs of patients.
Descriptors	• Recognise the limitations of intensive care and employ appropriate admission criteria • Recognise, assesses and initiate management for acutely ill adults across the spectrum of single or multiple organ failure • Recognise and manage the patient with sepsis and employ local infection control policies

	• Recognises the acutely ill child and initiates management of paediatric emergencies • Perform safely and effectively the clinical invasive procedures to maintain cardiovascular, renal, and respiratory support • Undertake and evaluate laboratory and clinical imaging investigations to manage patients during their intensive care stay • Manage the ongoing medical/surgical needs and organ support of patients during a critical illness, including the holistic care of patients and relatives • Plan and communicate the appropriate discharge of patients from intensive care to health care professionals, patients and relatives • Support the management of end of life care within the intensive care environment with patients, relatives and the multi-professional team • Understand the role of transplant services when appropriate and the principles of brain-stem death testing • Support clinical staff outside the ICU to enable the early detection of the deteriorating patient
GPCs	Domain 1: Professional values and behaviours Domain 2: Professional skills: • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) Domain 3: Professional knowledge • professional requirements • national legislation • the health service and healthcare systems in the four countries • Capabilities in health promotion and illness prevention • Capabilities in leadership and team-working • Capabilities in patient safety and quality improvement Domain 7: Capabilities in safeguarding vulnerable groups
Evidence to inform decision includes	Mini-CEX CbD DOPS Logbook Entrustment decision MSF HALO

3.2. Generic ACCS Learning Outcomes

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

In order to ensure consistency and transferability, the generic ACCS LOs have been grouped under GPC-aligned categories.

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

Figure 5 – Generic ACCS Learning Outcomes

9. Support, supervise and educate	
Key ACCS capabilities	At completion of ACCS a trainee: • will be able to set learning objectives for and deliver a teaching session • will be able to deliver effective feedback to a junior colleague or allied health professional with an action plan.
Descriptors	• Delivers effective teaching and training to medical students, junior doctors and other health care professionals • Delivers effective feedback with action plan • Able to supervise less experienced trainees in their clinical assessment and management of patients • Able to supervise less experienced trainees in carrying out appropriate practical procedures • Able to act as a clinical supervisor to doctors in earlier stages of training
GPCs	Domain 8: Capabilities in education and training
Evidence to inform decision includes	TO MSF Educational supervisor report Relevant training course End of placement reports

	10. Participate in research and managing data appropriately
Key ACCS capabilities	At completion of ACCS a trainee: • will be able to search the medical literature effectively and know how to critically appraise studies.
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	Domain 9: Capabilities in research and scholarship
Evidence to inform decision includes	e-Learning module completion/self-directed learning MSF MRCP(UK) Educational supervisor annual report GCP certificate (if involved in clinical research) or equivalent Evidence of literature search and critical appraisal of research Use of clinical guidelines Quality improvement and audit Evidence of research activity End of placement reports

	11. Participate in and promote activity to improve the quality and safety of patient care
Key ACCS capabilities	At completion of ACCS a trainee: • will be able to contribute effectively to a departmental quality improvement project.
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to and delivers quality improvement • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments

GPCs	Domain 6: Capabilities in patient safety and quality improvement
	• patient safety quality improvement
Evidence to inform decision includes	QIPAT e-Learning module completion/self-directed learning MSF ES annual report
	End of placement reports

KEY

ACAT	Acute Care Assessment Tool	ALS/ ATLS	Advanced Life Support/ Advanced Trauma Life Support
ASAT	ACCS Sedation Assessment Tool	**CbD**	Case-based Discussion
DOPS	Direct Observation of Procedural Skills	**GCP**	Good Clinical Practice
GPC	General Professional Capabilities	**HALO**	Holistic Assessment of Learning Outcome
IAC	Initial Assessment of Competence (EPA 1 & 2)	**Mini- CEX**	Mini-Clinical Evaluation Exercise
MTR/MCR	Multiple Trainer Report/ Multiple Consultant Report	**MSF**	Multi-Source Feedback
QIPAT	Quality Improvement Project Assessment Tool	**TO**	Teaching Observation

3.3. Presentations and conditions

The scope of ACCS is broad and cannot be encapsulated by a finite list of presentations and conditions. Any attempt to list all relevant presentations, conditions and issues would be extensive but inevitably incomplete.

The table below details key presentations and conditions in ACCS. Each of these should be regarded as a clinical context in which trainees should be able to demonstrate the clinical ACCS LOs and GPCs. Trainees will need to become familiar with the knowledge, skills and attitudes around managing patients with these conditions and presentations. The patient should always be at the centre of knowledge, learning and care.

Trainees must demonstrate core clinical skills, including information gathering through history and physical examination and information sharing with patients, families and colleagues.

Treatment care and strategy covers how a doctor selects drug treatments or interventions for a patient. It includes discussions and decisions as to whether treatment should be active or palliative, and also broader aspects of care, including involvement of other professionals or services.

Particular presentations, conditions and issues are listed either because they are common (therefore the ACCS clinician must be familiar with them) or serious (having high morbidity, mortality and/or serious implications for treatment or public health).

The table of systems/specialties, presentations and conditions of ACCS is to be interpreted with common sense. Each condition and presentation appears once in the syllabus, or on a limited number of occasions, eg chest pain is listed as a cardiology and respiratory medicine presentation. The fact that chest pain is not listed as a rheumatological presentation does not mean that the ACCS curriculum does not require that the trainee recognises that there can be musculoskeletal causes of chest pain.

It is not felt necessary to document the specific attributes of each presentation and condition with which trainees need to be familiar as this will vary between conditions and presentations. However, for each condition/presentation, trainees will need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management and prognosis. The ACCS approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

Figure 6 - Clinical presentations and conditions of ACCS by system/specialty

System/specialty	Clinical presentations	Conditions/issues
Resuscitation	Acute airway obstruction Anaphylaxis/anaphylactoid reactions Cardiorespiratory arrest Major trauma Respiratory failure Sepsis Shock Unconsciousness	Choking Stridor Organ donation
Allergy	Acute allergy Anaphylactoid reactions Angioedema Urticaria	Drug allergy
Cardiology	Chest pain Breathlessness Palpitations Transient loss of consciousness	Acute coronary syndromes Myocardial infarction Arrhythmias Cardiac failure Cardiac tamponade Congenital heart disease Diseases of the arteries, including aortic dissection Diseases of myocardium Hypertensive emergencies Pacemaker function and failure Pericardial disease Sudden cardiac death Valvular heart disease
Dermatology	Dermatological manifestations of systemic illness Rashes	Cutaneous drug reactions Eczema Erythroderma Infections of skin and soft tissues Necrotising fasciitis Pressure ulcers Purpuric rash including Stevens-Johnson syndrome Toxic-epidermal necrolysis Urticaria

System/specialty	Clinical presentations	Conditions/issues
Ear, nose and throat	ENT foreign bodies ENT injuries Epistaxis Hearing loss Painful ear Sore throat Vertigo	Epiglottitis Glandular Fever Lower motor neurone (LMN) facial nerve palsy Meniere's disease Nasal fractures Otitis externa Otitis media Pharyngitis Tonsillitis Tracheostomy emergencies Quinsy Salivary gland disease Vestibular neuritis
Elderly care	Delirium Deterioration in mobility Falls Fragility fractures Frailty Hypothermia Incontinence Increasing care needs Memory loss Unsteadiness/balance disturbance	Comprehensive geriatric assessment Acute confusion Ceiling of care Dementia – cognitive impairment Fragility fractures Mobility Osteoporosis Pharmacology considerations in the older patient
Endocrinology	Addisonian crisis Hyperglycaemia Hypoglycaemia	Adrenal disorders Diabetic ketoacidosis Diabetes mellitus and complications, including diabetic foot Hyperosmolar hyperglycaemic state Pituitary disorders Thyroid emergencies
Environmental emergencies		Heat stroke and heat exhaustion Drug-related hyperthermia Hypothermia and frost bite Decompression sickness Near-drowning Radiation exposure and safety Industrial chemical incidents Bites and envenomations typical for the UK Acid attacks
Gastroenterology and hepatology	Abdominal and loin pain Abdominal swelling or mass Ascites Constipation Diarrhoea Haematemesis and melaena Jaundice Anal pain and rectal bleeding Nausea and vomiting Dysphagia	Alcohol related liver disease including withdrawal Decompensated cirrhosis Functional bowel disorders Gastrointestinal infections Hepatitis Inflammatory bowel disease Peptic ulcer disease

System/specialty	Clinical presentations	Conditions/issues
Haematology	Anaemia Bruising and spontaneous bleeding Massive haemorrhage	Anti-coagulant reversal Disseminated intravascular coagulation (DIC) Haemophilia Immune thrombocytopenic purpura (ITP) Leukaemia Lymphoma Marrow failure Sickle cell disease/crisis Transfusion reactions
Infectious diseases	Fever Pyrexia in travellers Sepsis Needlestick injury/exposure to blood borne viruses	Influenza Infection in immunocompromised patients Infestations Notifiable diseases Pyrexia of unknown origin – different age groups
Maxillofacial/dental	Dental pain Facial swelling Avulsed or fractured teeth Facial bone injury	Dental abscess Facial wounds Post extraction complications Temporomandibular joint (TMJ) dislocation
Mental Health	Aggressive or disturbed behaviour Anxiety/panic Physical symptoms unexplained by organic disease Self-harm Refusal of treatment	Alcohol and substance misuse Depression Eating disorders Personality disorders Acute psychosis including bipolar, schizophrenia Somatic symptom disorders Suicide
Musculoskeletal (non-traumatic)	Acute back pain Limb pain and swelling Neck pain Joint swelling Acute hot swollen joint	Cauda equina syndrome Crystal related arthropathies Septic arthritis Limb pain and swelling - bursitis and tendonitis in the upper and lower limb including ruptured biceps, achilles tendonitis, plantar fasciitis, metatarsalgia, carpal tunnel and other entrapment neuropathies plus sinister causes bone tumour, stress fracture Spinal pain and radiculopathy Risks of rheumatological disease modifying drugs Spinal infections
Nephrology	Electrolyte disorders Oliguria	Acute kidney injury Drugs and the kidney Electrolyte disorders Fluid balance disorders Renal replacement therapy

System/specialty	Clinical presentations	Conditions/issues
Neurology	Acute confusion Headache Seizures/status epilepticus Speech disturbance Hemiparesis/hemiplegia Gait abnormality Visual disturbance Weakness/paralysis Dizziness and vertigo	Botulism Cerebral venous sinus thrombosis Functional illness Guillian-Barre Meningitis and encephalitis Multiple sclerosis Myasthenia gravis Parkinson's disease and other movement disorders Peripheral neuropathy (acute) Subarachnoid haemorrhage Stroke and transient ischemic attack (TIA) Tetanus Tumours involving the brain and spinal cord Ventriculoperitoneal (VP) Shunts
Obstetrics and Gynaecology	Pelvic pain Vaginal bleeding Pregnancy Genital injury/assault Vaginal discharge Foreign bodies Patient in labour	Ante-partum haemorrhage Bleeding in early pregnancy Exposure to infections during pregnancy eg chickenpox Ectopic pregnancy Genital injury/Female Genital Mutilation Haemolysis, elevated liver enzymes and low platelet count (HELLP) Heavy menstrual bleeding Hyperemesis gravidarum Maternal collapse Post-partum haemorrhage Pre-eclampsia/eclampsia Pelvic infection Post-menopausal bleeding Prescribing in pregnancy Rhesus D prophylaxis Sepsis in and following pregnancy Thrombosis during and following pregnancy

System/specialty	Clinical presentations	Conditions/issues
Oncological Emergencies	Presentations of undiagnosed cancer that may present to acute care	Complications related to local tumour progression eg acute cord compression, upper airway obstruction, pericardial and pleural effusions, superior vena cava (SVC) compression syndrome, raised intracranial pressure Complications relating to cancer treatment including - neutropenic sepsis, anaemia and thrombocytopenia and immunotherapy Biochemical complications of malignancy- hypercalcaemia, Syndrome of inappropriate antidiuretic hormone (SIADH), adrenocortical insufficiency
Ophthalmology	Diplopia Eye trauma including foreign bodies Painful eye Red eye Sudden visual loss	Acute glaucoma Cranial nerve palsy orbital and per-orbital cellulitis Inflammatory eye disease Temporal arteritis
Pain and sedation		Analgesics Non-pharmacological methods of pain management Pain assessment Sedation
Palliative and end of life care	Advanced malignancy	Advanced care planning Anticipatory medications End stage organ failure Pain management Physical symptoms other than pain Psychosocial concerns including spiritual care and care of the family The dying patient
Pharmacology and poisoning	Medication side effects/interactions Overdose	Overdose of prescription and non-prescription medications including legal and non-legal drugs Poisoning – carbon monoxide, cyanide, organo-phosphate Toxidromes Use of antidotes
Respiratory	Chest pain Breathlessness Haemoptysis Cough	Asthma Chronic obstructive pulmonary disease (COPD) Foreign body inhalation Pertussis Pleural effusion Pneumonia Pneumothorax Pulmonary Aspiration Pulmonary embolus

System/specialty	Clinical presentations	Conditions/issues
Sexual health	Genital discharge Genital lesions Emergency contraception Post-exposure prophylaxis	HIV infection Sexual assault Sexually transmitted infections
Surgical emergencies	Abdominal pain Abdominal swelling/mass Constipation Diarrhoea Gastrointestinal bleeding Anal/rectal pain Nausea/vomiting	Ano-rectal abscesses Appendicitis Biliary colic Bowel obstruction Breast abscess Cholangitis Cholecystitis Diverticular disease Haemorrhoid disease Hernias Ischaemic Bowel Lower gastrointestinal and rectal bleeding Pancreatitis Viscus perforation Volvulus
Trauma	Head injury Spinal injury Chest and lung injury Major vascular injury Abdominal injury Pelvic injury Limb and joint injury Burns Inhalational injury Wounds	Compartment syndrome Limb and joint injury including bony, musculo-tendinous and complications Electrical burns Salter- Harris classification Infection - paronychia, pulp space, flexor sheath, nail bed, amputations etc Human bites Injury to bladder, urethra, testes or penis
Urology	Dysuria Injury to bladder, urethra, testes or penis Urinary retention Testicular pain/swelling Loin pain Haematuria	Epididymo-orchitis Renal stone disease Phimosis/paraphimosis Priapism Testicular torsion Prosatatis Urinary tract infection (UTI)/Pyelonephritis
Vascular		Acute limb ischaemia Aortic aneurysmal disease Deep vein thrombosis (DVT)
Other clinical presentations/issues		Safeguarding in adults

4. Learning and teaching

The organisation and delivery of postgraduate training is the responsibility of Health Education England (HEE) and its Deaneries, NHS Education for Scotland (NES), Health Education and Improvement Wales (HEIW) and the Northern Ireland Medical and Dental Training Agency (NIMDTA) – referred to from this point as 'deaneries'. A training programme director will be responsible for coordinating the ACCS training programme.

Progression through the ACCS curriculum will be determined by the Annual Review of Competency Progression (ARCP) process (section 5.6) and the training requirements for each training placement are summarised in the ACCS ARCP decision aid (available on the ACCS Website). The successful completion of ACCS will be dependent on achieving the expected level in all ACCS LOs. The programme of assessment will be used to monitor and determine progress through the programme.

The training to be provided at each training site is defined to ensure that during the programme the entire ACCS curriculum is covered and also that unnecessary duplication and educationally unrewarding experiences are avoided. However, the sequence of training is flexible and will be determined locally on an individual basis: the trainees can do the indicative six-month attachments in any order.

Each ACCS trainee will be assigned a GMC approved named clinical supervisor for each six-month ACCS specialty placement: this will be a consultant in an acute specialty. In addition, ACCS trainees will have an overall educational supervisor, who will provide pastoral and educational support across the two years.

4.1. The training environment

This curriculum should be used to help design training programmes locally that ensure all ACCS trainees can develop their skills in a variety of settings and situations. It is designed to ensure that it can be applied in a flexible manner, meeting service needs as well as supporting each individual doctor- in-training's learning and development plan. The requirements for the provision of training have not changed as a result of this new curriculum. All training must comply with the GMC requirements presented in *Promoting excellence: standards for medical education and training* (2017)[11]. This stipulates that all training must comply with the following ten standards:

4.1.1. *Theme 1: Learning environment and culture*
S1.1   The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families.
S1.2   The learning environment and organisational culture value and support education and training, so that learners are able to demonstrate what is expected in Good Medical Practice and to achieve the learning outcomes required by their curriculum.

4.1.2. *Theme 2: Educational governance and leadership*
S2.1   The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability and responding when standards are not being met.

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[11] GMC Promoting excellence: standards for medical education and training (2017) https://www.gmc-uk.org/-/media/documents/Promoting_excellence_standards_for_medical_education_and_training_0715.pdf_61939165.pdf

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

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

4.1.3. *Theme 3: Supporting learners*

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

4.1.4. *Theme 4: Supporting educators*

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

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

4.1.5. *Theme 5: Developing and implementing curricula and assessments*

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

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

It is the responsibility of deaneries to ensure compliance with these standards for ACCS training, and to notify the appropriate college (RCoA, RCEM or JRCPTB) if further support is required in achieving this. Training delivery must also comply with the requirements of the latest edition of the COPMeD's 'Gold Guide'.

4.2. Teaching and learning methods

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

4.2.1. *Practice-based experiential learning*

ACCS specialty training is largely experiential in nature with any interaction in the workplace having the potential to become a learning episode. The workplace provides learning opportunities on a daily basis for ACCS trainees and the programme of placements is decided by the local faculty for education within a location. The nature of ACCS training in four closely related specialties provides opportunities to work in a variety of settings: the emergency department (ED) 'shop floor' (in the minor injuries area, trolley and seated areas for stable patients and the resuscitation room), on the emergency medical admissions unit, Clinical Decisions Units, on critical care and in theatres. It is essential that trainees spend an appropriate amount of time in each of these areas to meet their training needs and those of the programme.

Clinical experience should be used as an opportunity to undertake supervised learning events and reflection. Every patient seen in the emergency department, in theatre, on the

intensive care unit or in emergency admissions unit provides a learning opportunity that will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part both of the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems. Every time a trainee observes another doctor seeing a patient or their relatives, there is an opportunity for learning. Ward rounds (including post-take) should be led by a more senior doctor and include feedback on clinical and decision-making skills.

To ensure patient safety, ACCS trainees new to each specialty must be appropriately supervised, at all times, for their level of competence and entrustment. Trainees will need direct supervision for considerable periods in the ACCS programme: during the anaesthesia placement trainees require direct supervision until they have passed the Initial Assessment of Competence (IAC - EPA 1 & 2). These concentrated periods of supervision are essential to ensure that these trainees complete all the required learning outcomes in a very full programme.

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

4.2.2. *Independent self-directed learning*

ACCS trainees will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- audit, quality improvement and research projects
- achieving personal learning goals beyond the essential, core curriculum.

4.2.3. *Learning with peers*

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

4.2.4. *Multidisciplinary team meetings*

There are many situations where clinical problems are discussed with clinicians in other disciplines. These provide excellent opportunities for observation of clinical reasoning. Trainees have supervised responsibility for the care of in-patients. This includes day-to- day review of clinical conditions, note keeping, and the initial management of the acutely ill patient with referral to and liaison with clinical colleagues as necessary. The degree of responsibility taken by the trainee will increase as competency increases. There should be appropriate levels of clinical supervision throughout training, with increasing clinical independence and responsibility.

4.2.5. *Formal postgraduate teaching*

The content of formal postgraduate education sessions and access to other more formal learning opportunities are determined by the local faculty responsible for ACCS education along with the individual ACCS specialties, and will be based on the ACCS curriculum. There are many opportunities throughout the year for formal teaching locally and at regional,

national and international meetings. Formal teaching should be appropriate both to ACCS specialties, and also to the trainees chosen specialty.

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

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

4.2.6. *Simulation training*

Procedural competency training, using simulation aimed at achieving technical competence for certain procedures, should be provided as early as possible in ACCS training. Scenario-based immersive simulation training is expected to be undertaken in all relevant specialty specific learning outcomes, with human factors incorporated into the scenarios where appropriate.

Examples of simulation-based learning activities that should be used to deliver aspects of the curriculum include, but are not limited to:

- novice anaesthesia skills and drills
- assessment of failed intubation drill
- critical incident training
- vascular access
- transfer training courses
- advanced life support courses
- human factors
- clinical reasoning
- procedural skills.

4.2.7. *Formal study courses*

Time to be made available for formal courses is encouraged, subject to local conditions of service. Examples include life support and communication courses.

4.2.8. *Educational development time*

To facilitate the acquisition of the essential generic capabilities required for safe, effective and high quality medical care as prescribed by the GMC GPC framework, and to recognise the contribution trainees make outside of the clinical setting, it is recommended that local Schools of ACCS consider mechanisms to enable and encourage trainee involvement in research, audit and quality improvement, as well as allowing time for them to work on

publications and presentations and participate in teaching and aspects of hospital management.

4.2.9. *Academic training*

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

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

5. Programme of assessment

5.1. The purpose of the programme of assessment

The purposes of the programme of assessment fall into three broad categories:

5.1.1. *Assurance*

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

5.1.2. *Regulating progression and 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

5.1.3. *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
- reflecting excellence and supporting trainees to meet their potential

5.2. Programme design

The purposes above have driven the design of the ACCS assessment strategy from start to finish. The curriculum has 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)

5.2.1. *Workplace based assessments*

The workplace based assessment 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 panels and in Multiple Consultant Reports, 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.

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.

5.2.2. *Panel-based judgements*

Faculty Educational Governance (FEG) statements, Multiple Consultant Reports (MCRs), Multiple Trainer Reports (MTRs) and Holistic Assessment of Learning Outcome (HALO) work within 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 clinical ACCS 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 at the end of a block of training. This, in turn, is reviewed by the ARCP panel who will make a decision regarding progression.

The programme of assessment meets its stated purposes in a number of ways.

1. The entrustment decisions and MCRs/MTRs about progression are directly linked to the clinical ACCS LOs, offering clear guidance to trainees and trainers as to the standards required.
2. The educational supervisor's assessments of ACCS LOs that do not involve direct patient care (generic ACCS 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.

Figure 7 - Information flow in the ACCS Programme of Assessment
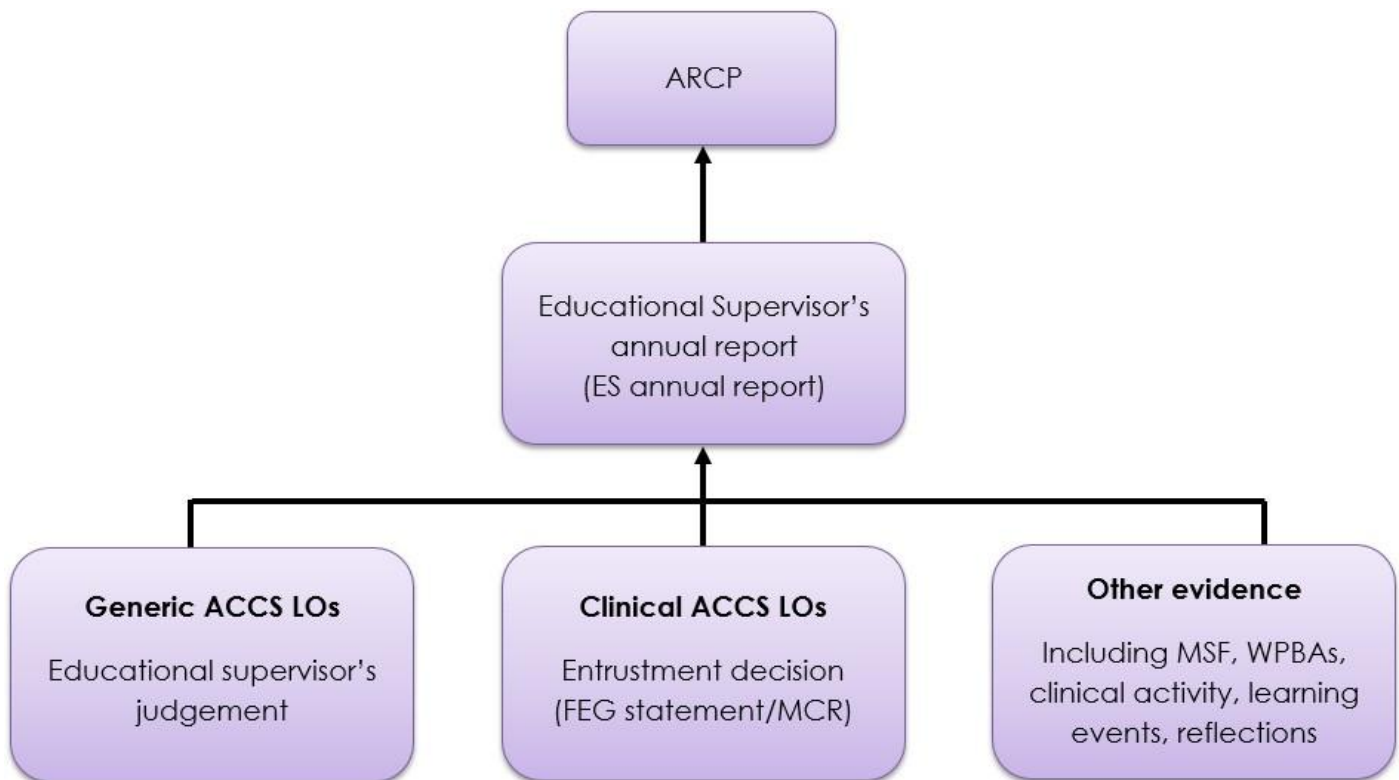
a. The Training Faculty will deliver a recommendation on each of the clinical ACCS LOs that are relevant to the trainee's stage of training, ie whether they met the standard for entrustment. This is summarised within a FEG, MCR or MTR.
b. The educational supervisor reviews the evidence collated for each of the generic ACCS LOs and offers a judgement on progress in these. A matrix providing guidance for educational supervisors on the generic ACCS LOs is available.
c. The educational supervisor also reviews WPBAs, multi-source feedback and other relevant data, such as caseload, critical incidents, 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, which, 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.

5.3. The ACCS assessment blueprint

The ACCS assessment blueprint maps the programme of assessment to the wider curriculum. The ACCS assessment blueprint is shown in section 5.7. It shows that each of the LOs can be 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 ACCS LOs. These are examples of tools that might be used to provide evidence of learning in each of these.

It is important for the trainee to show their development as a self-regulating learner by recording and reflecting on evidence in each of the **Key Capabilities** of the relevant LOs

throughout each training attachment. Engagement in training is very important and a marker of a trainee who is seeking to develop beyond their current capabilities and is a key principle that underpins the ethos of assessment in the workplace.

5.4. Entrustment decisions

Transitions and the crossing of thresholds are about taking on new responsibilities with a higher degree of independence. Knowing whether a trainee is ready to do so is complex. It requires a clear working knowledge of what the responsibilities involve, and the ability to predict how a trainee will respond when given responsibility.

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

Figure 8 - 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 of ACCS trainees are shown in the ACCS entrustment scale table above. 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 the 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, trainees are given the best chance of orienting themselves in terms of the progress so far and their next steps. Feedback is consistent across the whole learning journey, making it more credible to learners.

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.

Figure 9 - 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	2a	2a	2a	2a
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			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 2021 Curriculum for ACCS Training

5.4.1. *Faculty Educational Governance (FEG) Statement (Emergency Medicine placement)*

<u>What is it?</u>

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 statement 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 ACCS Learning Outcomes. Anchoring this decision to independence with a clear description of what is required will be a significant benefit to trainees and trainers in making these decisions fairer and more transparent.

The FEG statement serves a summative purpose within our assessment programme. It is then triangulated with other information in the ES annual report, to inform ARCP decision making. The FEG statement is held on the 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 clinical ACCS LOs than has previously been the case.

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 understand 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 Learning Outcomes (ACCS LOs) at the level of independence specified for their stage of training. The decision will relate to the **Key Capabilities** for each ACCS 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 two- monthly) 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 ACCS 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 ACCS LO is discussed and the output of this meeting is the Faculty Education Governance Statement.

Example:

ACCS LO 1: Care for physiologically stable adult patients presenting to acute care across the full range of 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, and includes general feedback on trainee strengths and areas to develop.

When is it done?

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

What if a trainee is deemed not ready to progress?

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

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

5.4.2. *Multiple Trainer/Consultant Report-MTR/MCR (Anaesthesia/ICM/IM placements)*

In anaesthesia, ICM and acute medicine, panel opinion is collated using a Multiple Trainer or Consultant Report (MTR/MCR). These differ from a MSF as it concerns 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 ACCS e-portfolio and will form part of the Educational Supervisor's annual report (ES annual report). At least one MTR/MCR will be required in each six-month block in anaesthesia, ICM and IM.

Consultant feedback will be collated, linked to the ACCS LOs and presented in the STR at ARCP. It should be discussed with the trainee during or at the end of a training placement prior to sign-off.

5.4.3. *Holistic Assessment of Learning Outcome-HALO (Anaesthesia)*

The HALO assessment is a tool used in anaesthetic training. A satisfactorily completed HALO form provides evidence that a trainee has achieved the key capabilities required to demonstrate attainment of a particular element of training. *In ACCS, the HALO is used to assess the basic anaesthetic care element.*

Supervisors draw upon a range of evidence including the logbook of cases completed, Structured Learning Events (SLEs), examples of evidence set out in the curriculum document, and consultant feedback 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, if relevant. Evidence for achievement of key capabilities and learning outcomes will be uploaded to the trainee's 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 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.**

5.5. Assessment of ACCS practical procedures (Clinical ACCS LO 5)

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

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

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

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

When an ACCS trainee has been signed off as being able to perform a procedure independently, they are not required to have any further assessment (DOPS) of that procedure, unless they or their educational supervisor think that this is required (in line with

standard professional conduct). This also applies to procedures that have been signed off during other training programmes. They would be expected to continue to record activity in their logbook.

Figure 10 - Clinical ACCS LO 5: Deliver key ACCS procedural skills; Minimum standards for progression

Procedure	At completion of the first two generic years of ACCS
Pleural aspiration of air or fluid *Entrustment requirement: 2a*	Programme of learning e-learning module Simulated practice or supervised practice on patient Programme of assessment DOPS assessment OR Simulated practice with reflection recorded
Chest drain: Seldinger technique *Entrustment requirement: 2a*	Programme of learning e-learning module Simulated practice and/or supervised practice on patient Programme of assessment DOPS assessment OR Simulated practice with reflection recorded
Chest drain: open technique *Entrustment requirement: 1*	Programme of learning e-learning module Simulated practice and/or supervised practice on patient National Safety Standards for Invasive Procedures (NatSSIPs) checklist ATLS or equivalent trauma course Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded Simulated practice with reflection recorded OR ATLS, European Trauma Course (ETC) or equivalent course certificate
Establish invasive monitoring (central venous pressure and arterial line) *Entrustment requirement: 2a*	Programme of learning Simulated practice and/or supervised practice Programme of assessment (both to be evidenced) DOPS assessment for central venous pressure line AND DOPS assessment for arterial line OR Simulated practice with reflection recorded for one or both

Vascular access in emergency (intraosseous infusion and femoral vein) *Entrustment requirement: 1*	Programme of learning Simulated practice and/or supervised practice ATLS or similar trauma course Programme of assessment (both to be evidenced) DOPS assessment on either OR Supervised practice on patient with reflection recorded OR Simulated practice with reflection recorded for one or both
Fracture/dislocation manipulation *Entrustment requirement: 1*	Programme of learning Supervised practice on patient Programme of assessment DOPS assessment OR Supervised practice with reflection recorded
External pacing *Entrustment requirement: 2a*	Programme of learning e-learning module on bradyarrhythmias ALS course Simulated practice and/or supervised practice on patient Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded OR Simulated practice with reflection recorded
Direct current cardioversion *Entrustment requirement: 2a*	Programme of learning e-learning module on broad and narrow complex tachycardias Simulated practice and/or supervised practice ALS course Programme of assessment DOPS assessment OR Supervised practice on patient with reflection recorded OR Simulated practice with reflection recorded
Point of care ultrasound-guided vascular access and fascia iliaca nerve block *Entrustment requirement: 2a*	Programme of learning Simulated practice and/or supervised practice Modular level 1 theory training

	Programme of assessment
	DOPS assessment for vascular access AND
	DOPS assessment for fascia iliaca nerve block OR
	Simulated practice with reflection recorded for one or both
Lumbar puncture *Entrustment requirement: 2a*	Programme of learning e-learning module Simulated practice and/or supervised practice on patient Programme of assessment DOPS assessment OR Simulated practice with reflection recorded
Procedural sedation (ASA 1-3) *Entrustment requirement: 2a*	Programme of learning e-learning module Simulated practice and/or supervised practice on patient Programme of assessment ASAT assessment

5.6. 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.

5.6.1. *WPBA tools*

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)

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).

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.

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.

ACCS Sedation Assessment Tool (ASAT)

An ASAT is an assessment tool designed to evaluate the performance of a trainee in undertaking procedural sedation, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

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.

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.

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.

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).

5.7. Decisions on progress (ARCP)

5.7.1. *ARCP and progression decision making*

The ARCP is the formal process where training progress is reviewed, usually on an annual basis. This process should be used to collate and systematically review evidence about an ACCS trainee's performance and progress in a holistic way and make decisions about their achievement of expected outcomes and subsequent progression in training.

Throughout training, ACCS trainees should engage with the learning process by using their e-portfolio to demonstrate that they are meeting the requirements of the curriculum.

The evidence collected on the e-portfolio includes:

- placements in programme
- personal development plans
- logbook data
- evidence of supervisory meetings
- workplace based assessments
- MSFs
- Faculty Governance Statements (EM)
- MTR/MCRs (IM, Anaesthetics, ICM)
- HALO (Anaesthetics)
- evidence of reflection
- evidence of interaction with the Programme of Learning.

This evidence should form the basis of the ES annual report that is reviewed at the ARCP and considered when awarding an ARCP outcome. A satisfactory outcome at the ARCP is required in order to progress through the training programme. The ARCP process is described in the 'Gold Guide' and the Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee's e-portfolio.

The requirements for each of the ACCS LOs are listed in the ARCP decision guide. There is no absolute number or requirement for SLEs, but there are recommendations. Each trainee is different, and a bespoke programme will develop as supervisors learn more about strengths and areas to work on.

ACCS trainees will be expected to seek opportunities to learn in each of the ACCS LOs from the outset of training and build a body of evidence that reflects their growing clinical ability and confidence. The inclusions should be meaningful and reflect episodes where the trainee learnt something important about acute care or themselves as a practitioner. Their training record should be a matter of professional pride and reflect the wide-ranging experience that ACCS offers across each of the ACCS LOs described.

Some ACCS LOs have a requirement for evidence of specific interaction with a particular learning element in the Programme of Learning, eg adult safeguarding or critical appraisal training for research. Otherwise, a checklist approach has been minimised.

5.8. Assessment blueprint

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 11 – the assessment blueprint

Learning Outcome	Mini-CEX	CbD	ACAT	DOPS /ASAT	Logbook	Teaching/presentation feedback tool	QIPAT	Portfolio/self-directed learning	Entrustment decision/FEG Statement/MTR/MCR	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	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	ASAT	ACCS Sedation 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)	**MTR/MCR**	Multiple Trainer Report/Multiple Consultant Report
MSF	Multi-source feedback	**Mini-CEX**	Mini-Clinical Evaluation Exercise
QIPAT	Quality Improvement Project Assessment Tool	**EPA**	Entrustable Professional Activity

6. Supervision and feedback

This section of the curriculum describes how ACCS trainees will be supervised, and how they will receive feedback on performance. Detailed guidance can be found by referring to the AoMRC guidance[12] on Improving feedback and reflection to improve learning.

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

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

6.1. Supervision

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

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

6.1.1. *Educational supervisor*

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

6.1.2. *Clinical supervisor*

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

The clinical and educational supervisors, when meeting with the trainee, should discuss issues of clinical governance, risk management and any report of any untoward clinical incidents involving the trainee. If the clinical directorate (clinical director) has any concerns about the performance of the trainee, or there were issues of doctor or patient safety, these would be discussed with the trainee's clinical and educational supervisors. These processes, which are integral to trainee development, must not detract from the statutory duty of the trust to

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

deliver effective clinical governance through its management systems. Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles.

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

6.1.3. *Trainees*

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

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

6.2. Appraisal

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

6.2.1. *Induction appraisal*

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

6.2.2. *Mid-point review*

This meeting between trainee and educational supervisor is not mandatory but is encouraged particularly if either the trainee or educational or clinical supervisor has training concerns or the trainee has been set specific targeted training objectives at their ARCP). At this meeting trainees should review their PDP with their supervisor using evidence from the e-portfolio. Workplace-based assessments and progress through the curriculum can be

reviewed to ensure trainees are progressing satisfactorily, and attendance at educational events should also be reviewed.

6.2.3. *End of attachment appraisal*

Trainees should review the PDP and curriculum progress with their educational supervisor using evidence from the e-portfolio. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal form should include an entrustment decision for each relevant ACCS LO and record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal, then the programme director should be informed. Information gathered from this meeting should be incorporated into the Educational Supervisor's Structured Report.

7. Quality management

The organisation and quality management of training programs for ACCS is the responsibility of the deaneries.

Deaneries will oversee programmes for postgraduate medical training in their regions. Deaneries together with the ACCS Specialty Training Committees (comprising representation from the Schools of Emergency Medicine, Anaesthesia and Medicine), will undertake the following roles:

- oversee recruitment and induction of trainees from foundation training into ACCS
- allocate trainees into ACCS rotations appropriate to their curriculum training needs
- oversee the quality of training posts provided locally
- interface with other specialty training faculties
- ensure adequate provision of appropriate educational events
- ensure curricula implementation across the training programme
- oversee the workplace-based assessment process within the programme
- coordinate the ARCP process for trainees
- provide adequate and appropriate career advice
- provide systems to identify and assist doctors with training difficulties
- provide flexible training
- recognise the potential of specific trainees to progress into an academic career

Educational programmes to train educational supervisors and assessors in workplace based assessment may be delivered by deaneries or by the colleges or both.

Development, implementation, monitoring and review of the curriculum are the combined responsibility of the Royal Colleges of Emergency Medicine, Anaesthesia, Physicians and the Faculty of Intensive Care via their Training Committees/Board and the Intercollegiate Committee for ACCS Training. This Committee is formally constituted with representatives from each ACCS specialty and with trainee and lay representation. It will be the responsibility of the Colleges to ensure that curriculum developments are communicated to heads of school, regional specialty training committees and TPDs.

The ICACCST provides its role in quality management by monitoring and driving improvement in the standard of all medical specialties on behalf of the three Royal Colleges and the Faculty of Intensive Care Medicine. The ICACCST, through its links with each parent college's standing bodies, actively involved in assisting and supporting deaneries to manage and improve the quality of education within each of their approved training locations. They are tasked with activities central to assuring the quality of medical education such as writing the curriculum and assessment systems, reviewing application for new post and programme, provision of external advisors to deaneries.

Quality criteria have been developed to drive up the quality of training environments and ultimately improve patient safety and experience.

8. Intended use of curriculum by trainers and trainees

This curriculum and ARCP decision aid are available from the ICACCST via the website.

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

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

8.1. Recording progress in the e-Portfolio

On enrolling with their parent specialities Royal College/Faculty, ACCS trainees will be given access to their respective e-Portfolio. The e-Portfolio allows evidence to be built up to inform decisions on a trainee's progress and provides tools to support ACCS trainees' education and development.

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

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

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

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

All appraisal meetings, personal development plans and workplace based assessments (including MSF) should be recorded in the e-Portfolio. ACCS trainees are encouraged to reflect on their learning experiences and to record these in the e-Portfolio. Reflections can be kept private or shared with supervisors.

Reflections, assessments and other e-Portfolio content should be used to provide evidence towards acquisition of curriculum capabilities. ACCS trainees should add their own self-assessment ratings to record their view of their progress. The aims of the self-assessment are:

- to provide the means for reflection and evaluation of current practice
- to inform discussions with supervisors to help both gain insight and assists in developing personal development plans.
- to identify shortcomings between experience, capability and areas defined in the curriculum so as to guide future clinical exposure and learning.

Supervisors can sign-off and comment on curriculum capabilities to build up a picture of progression and to inform ARCP panels.

9. Equality and diversity

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

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

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

Compliance with anti-discriminatory practice will be assured through:

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

10. Annex A – post-ACCS training programme requirements

In addition to the ACCS LOs, the learning outcomes to be achieved for completion of each of the ACCS training programme pathways are described below.

10.1. Anaesthetics

Title	Descriptor
Professional behaviours and communication	Demonstrates the professional values and behaviours that patients expect from their doctors
Management and professional/regulatory requirements	Undertakes managerial, administrative and organisational roles
Team Working	Contributes to teams to enhance patient care
Safety & Quality Improvement (QI)	Improves the quality and safety of patient care
Safeguarding	Identifies vulnerable people and takes appropriate action
Education and Training	Helps others to develop their professional practice
Research and managing data	Expands the understanding of anaesthetic practice
Perioperative medicine and healthcare promotion	Facilitates safe multi-disciplinary peri-operative care and promotes the principles of public health interventions and efficient use of healthcare resources
General anaesthesia	Provides safe and effective general anaesthesia
Regional anaesthesia	Provides safe and effective regional anaesthesia
Resuscitation & Transfer	Resuscitates, stabilises and transfers critically ill patients safely
Procedural Sedation	Provides safe & effective sedation
Pain	Manages pain
Intensive Care	Manages critical illness

10.2. Emergency Medicine

Specialty Outcome	Description
1. Care for physiologically stable adult patients presenting to acute care across the full range of complexity	Care for patients presenting with acute physical or mental health concerns and be able to manage the most complex presentations
2. Support the ED team by answering clinical questions and making safe decisions	Support the clinical team with a safe and comprehensive approach as an expert diagnostician
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	Resuscitate and stabilise critically ill adults, lead resuscitation teams, know when resuscitation is inappropriate or should be stopped and care for ED patients at the end of their life
4. Care for acutely injured patients across the full range of complexity	Manage all injured patients presenting to the ED, including major incidents
5. Care for children of all ages in the ED, at all stages of development and children with complex needs	Care for and resuscitate children in the ED
6. Deliver key procedural skills	Proficiently provide the full range of technical skills needed in Emergency Medicine
7. Deal with complex and challenging situations in the workplace	Be able to manage the wide variety of challenges, posed personally and to the ED team on the ED shift
8. Lead the ED shift	Provide leadership to the whole ED and link with the wider health community on shift
9. Support, supervise and educate	Support, supervise, mentor and educate the ED team
10. Participate in research and managing data appropriately	Understand and be able to utilise and participate in EM research
11. Participate in and promote activity to improve the quality and safety of patient care	Be able to deliver quality improvement in the ED
12. Lead & Manage	Deliver administrative tasks within the ED and as part of the wider NHS. Provide leadership and help set the culture in the ED

10.3. Internal Medicine

Generic Capabilities in Practice (shared across all physician specialties)
Able to function successfully within NHS organisational and management systems
Able to deal with ethical and legal issues related to clinical practice
Communicates effectively and is able to share decision making, while making appropriate situational awareness, professional behaviour and professional judgement
Is focussed on patient safety and delivers effective quality improvement in patient care
Carrying out research and managing data appropriately
Acting as a clinical teacher and clinical supervisor
Internal Medicine clinical Capabilities in Practice (shared across all group 1 specialties)
Managing an acute unselected take
Managing an acute specialty-related take
Providing continuity of care to medical in-patients, including management of comorbidities and cognitive impairment
Managing patients in an outpatient clinic, ambulatory or community setting, including management of long-term conditions
Managing medical problems in patients in other specialties and special cases
Managing a multidisciplinary team including effective discharge planning
Delivering effective resuscitation and managing the acutely deteriorating patient
Managing end of life and applying palliative care skills