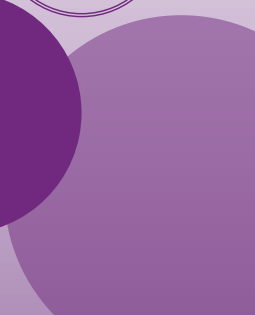
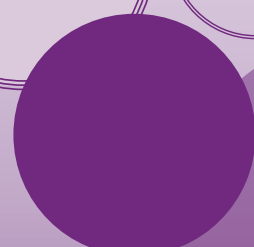
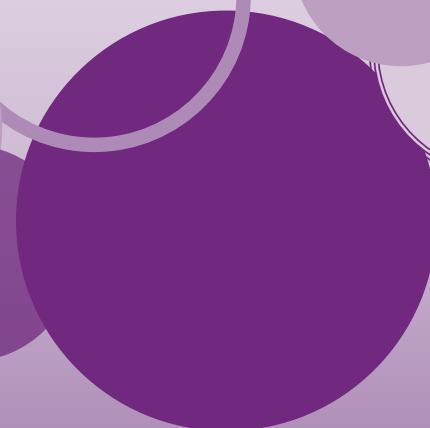
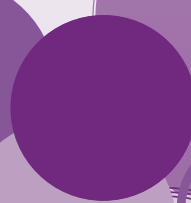
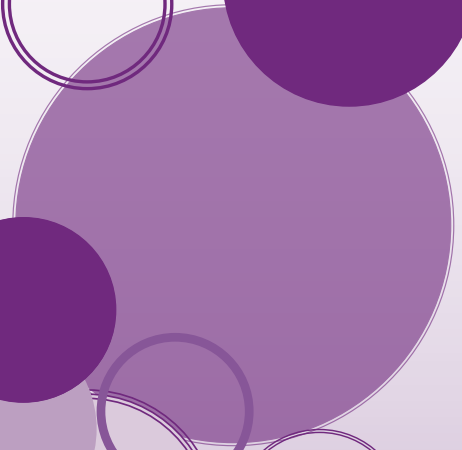
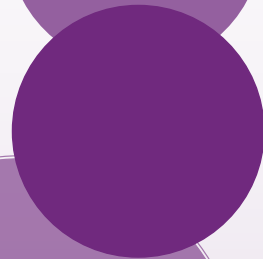
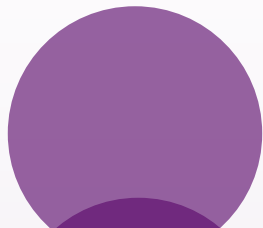
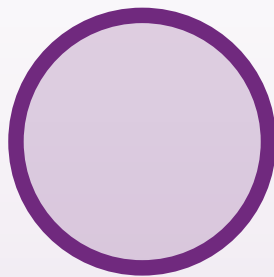
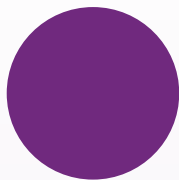
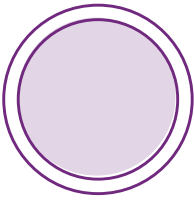


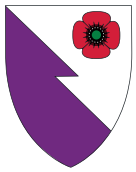
The Royal College of  
Emergency Medicine



# Promoting Excellence in Emergency Medicine Training

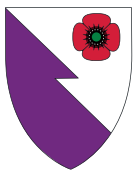
July 2020





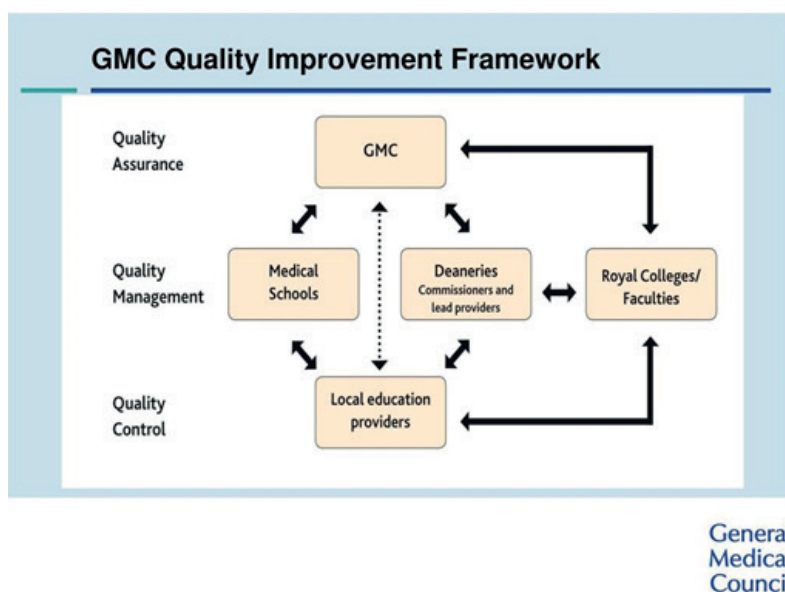
## Contents

Background	3
Standards for Medical Education and Training	5
Quality Control and Delivery of Postgraduate Training Programmes and Clinical Placements	7
Quality Management of Postgraduate Training Programmes and Clinical Placements	18
Quality Assurance of Postgraduate Training Programmes and Clinical Placements	24
Glossary of terms	26
References	27
Appendix A	28
Appendix B	29



The recommendations below outline the Royal College of Emergency Medicine (RCEM) approach to improving its standards for medical education and training. As outlined in the General Medical Council (GMC) Quality Improvement Framework, 2010, the GMC quality assures all medical education and training. To enable the delivery of the highest quality training in Emergency Medicine RCEM has an ongoing role and responsibility to set standards, monitor and feedback.

## Background

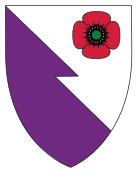


In recent times, service pressure and demand on Emergency Departments have escalated, compounded by an older population presenting with increasingly complex co-morbidities. In an already challenging and high-pressure Emergency Medicine (EM) environment, this has had an impact on the workforce.

Both EM trainees and their consultant trainers score highly on markers of burnout and dissatisfaction, which in turn has led to increasing attrition from EM training programmes.

The RCEM Training Standards Committee (TSC) recognises that this pressure has had an impact on the quality of EM training nationally. There is also considerable variation in quality across the United Kingdom. This has been highlighted by the Emergency Medicine Trainees Association (EMTA) surveys, the GMC national training survey and TSC Census data on training provision nationally. There is concern about an erosion of educational opportunities in training and the variation in working conditions for trainees across the UK.

The remit of the RCEM TSC is to assure, provide feedback and to improve the quality of training in EM in the UK. Current TSC Guidance, Educational Recognition of Specialty Training Posts and



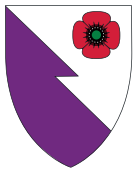
Programmes in Emergency Medicine, 2011, is outdated. Written before both the GMC's Promoting Excellence: standards for medical education and training, 2015, and HEE Quality Strategy 2016-20, it is not detailed enough to set quality standards that continue to both improve training and level the training field for all EM trainees nationally.

This current guidance supersedes the previous TSC document and aims to make excellence in Emergency Medicine training in the UK explicit, as defined by the RCEM Training Standards Committee.

Following publication there will need to be a review of the current training placements and rotations in each region. Most will have areas for enhancement or development, as this guidance aims for excellence in EM training. The expectation of the TSC is that these new standards will be normal practice across the UK by September 2023.

If quality assurance and feedback mechanisms agree that training standards remain high then timelines for improvement should be at the discretion of the Head of School and regional postgraduate teams.

If quality assurance mechanisms highlight concern and training standards fall short of this guidance then it is anticipated that these standards will support the regional postgraduate team to set clear goals and timelines for improvement. In England, as per HEE Quality Framework, training concerns should be risk categorised, with monitoring and management as outlined in HEE's Intensive Support Framework. The devolved nations should refer to local processes.



## Standards for Medical Education and Training

In developing this guidance reference has been made to the best evidence available to ensure that EM training is of the highest quality. The RCEM Training Standards Committee has used both the GMC Promoting Excellence and HEE Quality Framework to form the basis of our standards for training sites, training programmes and postgraduate schools. The guidance and standards are based on current RCEM and other national guidance, EMTA feedback, GMC training survey data and other quality assurance processes.

Whilst aspiring for excellence in EM training in the UK, the standards are considered reasonable and realistic by the Training Standards Committee. They should form part of the quality assurance and management of EM training, with the clear expectation that this should be standard practice within 3 years across the UK.

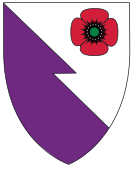
**Patient safety** is inseparable from a good learning environment and a culture that values and supports learners and educators. The Royal College of Emergency Medicine accept this is fundamental and aims to ensure education and training in Emergency Medicine takes place where patients are safe, the care and experience of patients is good and where education and training is valued.

**The GMC** sets out the professional values, knowledge, skills and behaviours required of all doctors working in the UK in Good Medical Practice. The learner's ability to develop the appropriate professional values, knowledge and behaviours is influenced by the learning environment and the culture in which they are educated and trained. Patient safety is at the core of the GMC standards for managing medical education and training: Promoting Excellence. Good doctors make the care of their patients their primary concern and so must the organisations that educate and train medical students and doctors.

**In England, HEE** is responsible for ensuring there are high quality learning environments for all healthcare learners in England. They have a statutory duty to secure continuous improvements in the quality of education and training and promote the skills and behaviours that uphold the NHS Constitution. Their Quality Strategy 2016-20 outlines the quality framework and standards to manage this.

**In the devolved nations**, NHS Education for Scotland (NES), Health Education and Improvement Wales and Northern Ireland Medical and Dental Training Agency are responsible for implementing medical training and each have local processes they adhere to.

**The Gold Guide** is a reference guide for postgraduate specialty training in the UK and sets out a framework with clear principles for the operational management of postgraduate specialty training to support consistent decision making by Postgraduate Deans and their support structures and is applicable to all trainees within GMC approved programmes. It states that Colleges have a roles in ensuring curricular are delivered at a local level, to support the local postgraduate structure in quality management of training delivered within training providers, and by externality in the quality management of the ARCP process.



**High quality supervision** is vital to the development of doctors as it directly relates to the patients safety and the safety of doctors and training as well as recruitment and retention. This is highlighted in a recent publication from HEE 'Enhancing the supervision of postgraduate doctors in training'.

It states that 'good supervision has 3 main functions:

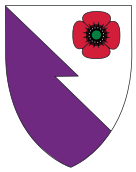
**Normative:** ensuring that the supervisee can provide high quality patient care.

**Formative:** learning in the workplace occurs through good supervision. High quality timely feedback to the supervisee from a senior professional is fundamental to this learning.

**Restorative:** good supervision enhances the wellbeing of the supervisee'.

The stated purpose of supervision is:

1. 'Enabling the progression of healthcare professionals along a training and/or professional development pathway with respect to acquisition of knowledge, clinical skills and competencies
2. Enhancement of general (clinical) and professional skills and attitudes
3. Ensuring both good patient experience and safety'

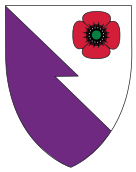


## Quality Control and Delivery of Postgraduate Training Programmes and Clinical Placements

### Section A:

#### **Workload and staffing of the Emergency Department – should be enough for a safe learning experience but not excessive**

- i. Emergency Departments (ED) must have the capacity, resources and facilities to deliver safe and relevant learning opportunities, clinical supervision and practical experiences for learners required by the curriculum and to provide educational supervision and support.
- ii. All emergency departments seeing children should have at least one Paediatric Emergency Medicine (PEM) trained consultant with dedicated session time allocated to paediatrics. This should be more in bigger ED's. They should have two registered children's nurses on each shift. Staffing facilities should comply with Facing the Future: Standards for Children in the Emergency Care Setting, RCPCH 2018
- iii. A general ED that treats at least 16,000 children per year and in which there is a substantive PEM consultant trainer is an acceptable alternative to a paediatric ED for the period of training with an emphasis on Paediatrics in the CT3/ST3 year of run-through training, as long as supervision meets the expectations in Section H.
- iv. For a Paediatric ED to be recognised for Paediatric EM sub-specialty training there must be a consultant in Paediatric EM who is a recognised trainer and a minimum of one whole time equivalent consultant working in the Paediatric ED. The recommended workload is at least 18,000 children per year.
- v. There must be enough staff members who are suitably qualified for learners to have appropriate supervision, working patterns and workload, for patients to receive care that is safe and of a good standard, whilst creating learning opportunities. Medical staffing should be working towards RCEM Workforce recommendations 2018: Consultant Staffing in Emergency Departments in the UK
- vi. There must be a balance between providing services and accessing educational and training opportunities. Services will focus on patient needs, but the work undertaken by doctors in training should support learning opportunities. Education and training should not be compromised by the demands of regularly carrying out routine tasks or out-of-hours cover that do not support learning and have little educational or training value.
- vii. ED's must ensure that learners have appropriate levels of supervision at all times by an experienced and competent supervisor, who can advise or attend as needed. The level of supervision must fit the individual learner's competence, confidence and experience.
- viii. The support and clinical supervision must be clearly outlined to the learner and supervisor including out of hours. See Section I.



- ix. Organisations must design rotas to:
  - a. Make sure doctors in training have appropriate supervision
  - b. Support doctors in training to develop professional values, knowledge, skills and behaviours of all doctors working in the UK
  - c. Provide learning opportunities that allow doctors in training to meet the requirements of their curriculum and training programme
  - d. Give doctors in training access to educational supervisors
  - e. Minimise effects of fatigue and workload. EM-POWER: A practical guide to flexible working and good EM rota design, 2019 is a useful resource.
- x. Trainees' duty hours should comply with the Junior Doctor Contract. They should have work schedules and access to a Guardian of Safe Working and Hours and should comply with other regional recommendations.
- xi. ED's should support trainees to work safely. RCEM support the provision of appropriate sleep and rest facilities **#RestEM**

#### **Section B:**

#### **The Emergency Department should provide a suitable environment with adequate equipment to give service of a high standard**

- i. There should be a dedicated and fully equipped resuscitation area.
- ii. There should be areas of adequate size and equipment for safe care of patients with less serious conditions.
- iii. Where children are cared for, facilities should comply with Facing the Future: Standards for Children in the Emergency Care Setting, RCPCH 2018
- iv. Where mental health is to be assessed and managed; facilities, processes and staffing should comply with recommendations in Mental Health in Emergency Departments toolkit for improving care, RCEM 2017.
- v. There should be a room for bereaved relatives.
- vi. Practical systems should be in place for the operation of rapidly available appropriately experienced support in cases of major trauma, paediatric and cardiac emergencies.

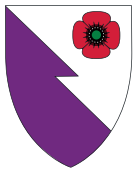
#### **Section C:**

#### **Experienced doctors working in the following main supporting specialities should be available in hospitals with Emergency Departments.**

It would be expected that the following specialties should be onsite:

- Anaesthetics
- Intensive Care
- Acute General Medicine





Coronary Care

Acute General Surgery, with consultant led operating theatre available 24 hrs

Orthopaedic Trauma

Paediatrics (if acutely ill or injured children are to be received)

24-hour radiology

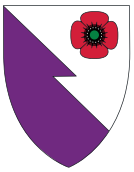
Haematology, Chemical Pathology and access to Blood Transfusion products

- i. Where any of these services are not on site, trainees may be exposed to increased clinical risk. There must be demonstrable and reliable systems in place to ensure proper clinical support is available. Robust, adequately staffed and equipped transfer systems will be required. The more of these supporting specialities that are not on site, the more difficult it will be to ensure that the clinical risk exposure of trainees is kept to an acceptable level.
- ii. If the case mix of patients attending the department is altered by local protocols for ambulance diversion, restricting the training opportunities in the unit, it may be necessary to restrict the time spent at such units. Training recognition may be precluded.
- iii. The training opportunities available throughout the region should be utilised and the contribution that individual units offer to balanced training rotations be considered. See Section M.
- iv. All services and support not on site should be readily accessible with clear protocols in place for how to utilise them.

**Section D:**

**Emergency Departments must demonstrate a safety culture.**

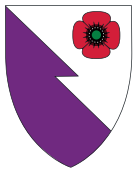
- i. Which allows learners and educators to raise concerns about patient safety, the standard of care and or of education and training, openly and safely without fear of adverse consequences
- ii. Concerns affecting the safety of patients or learners must be addressed immediately and effectively.
- iii. They must demonstrate a culture that investigates and learns from mistakes and reflects on incidents and near misses with effective reporting, feedback and local clinical governance activities.
- iv. They must demonstrate a learning environment that supports their duty of candour and helps them develop communication skills with tact, sensitivity and empathy.
- v. They should seek and respond to feedback from learners and educators.
- vi. They should be staffed appropriately and with adequate learner supervision to ensure quality of patient care.
- vii. Doctors may only take consent for procedures appropriate to their level of competence and act with GMC practice on consent.



**Section E:**

**Formal induction, handover and feedback arrangements should be in place. Multi-disciplinary team working within the department and the wider hospital should be encouraged.**

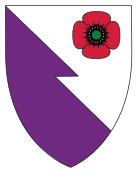
- i. Training sites must ensure learners have an induction in preparation for their placement which ensures
  - a. Their duties and supervision arrangements.
  - b. Their role in the team.
  - c. How to gain support from senior colleagues at all times with workplace and named clinical and educational supervisors.
  - d. The clinical or medical guidelines and workplace policies they must follow and ensure they are available electronically.
  - e. How to access clinical and learning resources.
  - f. Who is who in the ED team- 'my name is'.
  - g. They know how to raise concerns regarding themselves, others or patients.
- ii. Handover of care must be organised and scheduled to provide continuity of care for patients and maximise learning opportunities for doctors in training in clinical practice.
- iii. Work undertaken by doctors in training should provide opportunities for learning and feedback on performance, and give an appropriate breadth of clinical experience. There should be systems in place to learn from positive as well as adverse event reporting.
- iv. Organisations should support the learners to be an effective part of the multidisciplinary team by promoting a culture of learning and collaboration between specialty and professions.
- v. There must be support from relevant specialities within the hospital and they must also be supported with in the ED in return.
- vi. There must be support for training from hospital management, with an indication that the educational needs of trainees are accepted and adequate allocation of SPA in trainer job plans of 0.25 PA per trainee.



## Section F:

### **Doctors in training must have protected time for learning while they are doing clinical or medical work, or during academic training, and for attending organised educational sessions, training days and other learning opportunities to meet the requirement of their curriculum**

- i. Specialty trainees should be released to attend formal regional teaching. The quality and access to this should be overseen by the school and will include access to Simulation, Leadership, Quality Improvement, Ultrasound, Procedural Sedation and FRCM Examination support.
- ii. Departments must make sure that assessment is valued and that learners and educators are given adequate time and resources to complete the assessments required by the curriculum. Trainers responsible for assessments are expected to facilitate this.
- iii. ST3-6 trainees must have allocated office space with access to a computer and telephone. Access to Wi-Fi, the internet and on-line search services should be available within department, with library and IT services available in hospital.
- iv. Trainees should have the opportunity to develop their clinical, medical and practical skills and generic professional capabilities through technology enhanced learning opportunities, with the support of trainers, before using skills in a clinical situation.
- v. Appropriate opportunities for learning in the multi-professional team must be available including a departmental teaching programme.
- vi. Trainees should have access to funding and reasonable Study Leave as suggested by regional policy and their individual learning objectives. Currently funding is accessed through postgraduate centre after prospective agreement with trainee supervisor and formal application process.
- vii. Trainees must be allowed SPA time within their work schedules to complete curriculum related activities within and outwith (see point xi) the Emergency Department. RCEM TSC advice is available here and recommends that at a minimum:
  - a. ST3s should be allocated one day alternate months (ie four hours a month) or WTE
  - b. HST trainees should be allocated one half a day (ie a four-hour session) per week or WTE
  - c. This allocation should be in addition to regional training and includes time to prepare for their ARCP.
- viii. Trainees who are instructors on national life support courses, managerial or national roles e.g. working with RCEM/NICE should manage this within their study leave allocation. Further professional leave will be at the discretion of departments with support and discussion with the Head of School in accordance with RCEM advice.
- ix. From ST3, brief periods of training outside the ED may be required to ensure full curriculum coverage. For example:

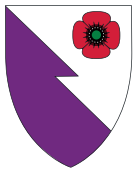


- a. CT3/ST3 as part of paediatric focussed training.
  - b. ST4 - ST6 short periods of time gaining additional competences agreed by the educational supervisor in SPA time.
- x. Periods of time outside the training programme gaining additional competencies, experiences or a career break must be formally agreed with the educational supervisor and the EM School/Postgraduate Dean as per the Gold Guide.

### **Section G:**

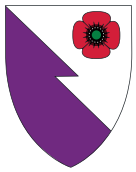
#### **The Emergency Department is expected to provide training opportunities in Teaching, Procedural Sedation, Ultrasound, Management, Quality Improvement, Leadership and Research**

- i. Trainees should have the opportunity to gain experience in teaching and supervision of more junior trainees and medical students. In ST6 undertaking formal Educational Supervisor development is encouraged.
- ii. Trainees should be confident with airway management and a range of procedural sedation skills to fit the appropriate setting. Trainers and trainees must ensure the safety and standards of these procedures before competence is agreed for adults and for children.
- iii. Ultrasound is a required in day to day EM practice and trainees must gain skills need for Level 1 Competence as part of the curriculum. All training departments should have at least one Level 1 trainer available as local lead. An appropriate standard of US equipment must be available for daily use, with the capacity for storage and downloading of images needed for sign off. When equipment is not available this is a risk for both patient care and training, and should be escalated to EM School.
- iv. Trainees at ST3-6 must be given opportunities to gain supervised experience in aspects of management to allow completion of the RCEM management portfolio.
- v. All specialty trainees should be actively involved in the ongoing departmental quality improvement and audit programme, supervising more junior staff if appropriate and have an opportunity to lead their own quality improvement project at least once during higher training with appropriate supervision and advice. Focussed support for Quality Improvement (QI) should be overseen regionally by the EM school, and include access to a local QI lead in addition to the trainee's educational supervisor.
- vi. Leadership training should be supported throughout EM training ST1-6. Trainers and trainees should be familiar with the EMLeaders framework and able to facilitate leadership conversations on the shop floor and in formal teaching sessions.
- vii. Advice and support for research projects must be available within region.



## Section H: Educational capacity

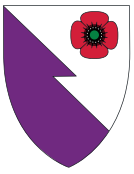
- i. Training capacity is defined by the ability to provide workplace, clinical and educational supervision for specialty trainees. Trainers should have 0.25 PA per trainee in their job plans to ensure they can deliver high quality training.
- ii. In general Emergency Departments there must be at least 2 substantive FRCM consultants on the specialty register for EM training posts to be recognised.
- iii. For higher specialty trainees in ST4 or above, the training capacity is linked to consultant staffing. There should be at least one consultant per trainee and one FRCM Educational Supervisor for every two trainees at ST4 level or above.
- iv. RCEM recommends a minimum of 50% of shifts to have direct clinical supervision by an EM consultant for all trainees working in the Emergency Department.
- v. In PEM Sub-specialty training posts, there should be at least one PEM trainer and at least 50% shifts should have direct supervision by PEM consultants.
- vi. RCEM recognises that there is also a significant training workload and need for quality standards when supporting the wider EM multi-disciplinary team. In particular:
  - Advanced Clinical Practitioner (ACP) trainees. There should be at least one consultant per trainee and one RCEM trainer who has completed ACP credentialing training for every two trainees, with 0.25PA allocated in the job plan per trainee. Please refer to current RCEM ACP curriculum for ES/ACP credentialing trainer requirements.
  - CESR trainees. There should be at least one consultant per trainee and an accredited consultant trainer with 0.25 PA allocated in their job plan per trainee
- vii. When trainers are required to supervise higher numbers of educational supervisees this must be reviewed as it may indicate insufficient training capacity. In this situation trainees may be exposed to increased clinical risk and less individual supervision especially in the consultant to learner ratios on the shop floor. The EM School will be expected to monitor this as per HEE Quality Framework or other local processes.



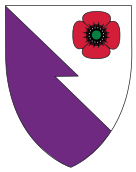
## Section I: Supervision of Emergency Medicine Trainee in training sites

- i. Every EM trainee will be allocated an approved Educational Supervisor (ES) and a Named Clinical Supervisor (NCS). These may be the same person. Their roles and responsibilities are outlined in HEE's Enhancing the supervision of postgraduate doctors in training, 2019.
- ii. Educational Supervisors are recommended to have 0.25 PA in their job plans per trainee they supervise. At present there is no time recommendation for NCS, nor how time is allocated when both are present. The roles vary considerably between and within regions. Ideally both trainers should have time in their job plans proportionate to the role and time they spend with the trainee.
- iii. The ES or NCS should fulfil the eligibility requirements as recommended by the RCEM TSC here:
  - a. Be a fully trained medical practitioner with a GMC license to practice
  - b. More than 1 year in a substantive Emergency Medicine post as consultant
  - c. Recognised by the GMC as having received appropriate training in Educational Supervision.
  - d. Undergoes annual appraisal of educational role as per deanery and NHS processes.
  - e. Shows evidence of being up to date with RCEM training curriculum and examination regulations by attending regular updates and ARCPs
  - f. Has an interest in education and supported in Educational Supervisory role by the deanery and NHS services
  - g. Be CPD-maintained (name on CPD roll), if eligible.
  - h. Be approved jointly by the deanery and NHS services.
  - i. Be trained in equality and diversity.

RCEM recognise that there are a cohort of senior SAS doctors who have a proven track record in of excellence in educational supervision. We are supportive that, on an individual basis, subject to discussion with the Head of School they may provide Educational supervision for appropriate RCEM trainees.
- iv. They should have access to a Specialty Tutor and local Quality Improvement and Ultrasound leads within each training department capable of supporting their development in these areas.
- v. Departments with EM trainees should have a departmental (local) faculty group (LFG) who meet regularly to discuss the training environment, local issues and concerns. Departmental faculty groups should have trainee representation during discussions, except when this involves individual trainee feedback.
- vi. They should discuss trainees on a regular basis (every 2-3 months) to allow the faculty to provide all trainees regular feedback on their progress in the form of faculty educational governance statements (FEGS). A quorate meeting would have a minimum of three consultants who are trained Educational Supervisors, more in a larger site.



- vii. Departments training trainees at ST4 level should have at least one FRCEM Examiner.
- viii. The NCS and ES, in addition to fulfilling requirements for ES in iii, should have an enthusiasm and commitment to training, been identified as being able to provide excellent clinical support and direction / supervision for each trainee.
- ix. An NCS is expected to have meetings with their supervisees, at a minimum of every three months, to help plan training, review progress and achieve agreed learning outcomes. They are responsible for the educational agreement, and for bringing together all relevant evidence to form a summative judgement about progression at the end of the placement or a series of placements.
- x. The NCS is the first point of contact for wellbeing issues and should be able to sign post resources such as EM-POWER: A Wellness Compendium for EM (April 2019), sources of advice or support and when to involve the school, director of medical education or professional support services.
- xi. Every ES/ NCS should demonstrate at their educational appraisal that they are up to date in regards to the RCEM training curriculum, leadership framework and examination regulations by attending RCEM and School updates as appropriate. They should be aware of The Academy of Medical Educators publication, A Framework for the professional development of postgraduate medical supervisor, 2010 which outlines both the expectations of supervisors and what makes it excellent. They should attend ARCP panels a minimum of once every revalidation cycle.
- xii. Workplace Supervision:
  - a. A trainee at ST1-3 level must be able to contact a trainee or trainer of ST4 level or above to attend immediately should the clinical situation require.
  - b. A trainee at ST4 level or above (i.e. a more senior trainee taking on additional managerial and clinical responsibility) must be able to contact their appropriately qualified clinical supervisor, usually a consultant in EM (or PEM), for advice or to attend at all times.
  - c. Where an EM ST4 or equivalent is not on site, or when more than one site is being covered trainees may be exposed to increased clinical risk. There must be demonstrable and reliable systems in place to ensure proper clinical support is available and the EM School should monitor this.
- xiii. ST3 trainees are allowed to 'act up' as an ST4 onto the middle grade rota in the final 2 months of ST3 as long as they meet the following criteria:
  - a. Passed full MRCEM or Primary and Intermediate FRCEM examinations
  - b. In date certification in ATLS, APLS and ALS (or equivalent)
  - c. Be within 2 months of completion of all six attachments within the Core EM programme and have a completed structured training report for each section



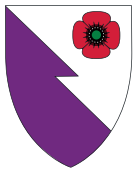
- d. Be on track for an ARCP Outcome 1 or 6 for ACCS (EM) CT/ST3 year as agreed with the TPD and HOS evidenced by nomination by ES and Specialty Tutor to confirm that 'acting up', and the period of time, is appropriate for the trainee and that it is supported by the Local Faculty Group.
- e. The Director of Medical Education and the Medical Director of the Trust to conform that they accept the clinical risk and other governance implications of a trainee 'acting up' as an ST4 in the context of these criteria.
- f. The CT/ST3 doctor must have shadowed night-time cover in this role with an in house more senior doctor in advance of 'acting up'.
- g. Confirmation that for the duration of each shift undertaken, clear clinical supervision arrangements are in place and that supervisors are appropriately qualified
- h. Clearly defined educational objectives are set with the trainees ES/named CS indicating expected outcomes from the 'acting up' experience
- i. The ES/named CS must ensure that the trainee completes a reflective practice diary within their e-portfolio for each shift that they undertake at ST4.

## Section J:

### **Training sites are responsible for ensuring that trainees meet their learner responsibilities**

- i. Doctors in training are responsible for their own development as adult learners as outlined in 'Enhancing supervision of postgraduate doctors in training' HEE, 2019 and in the Gold Guide.
- ii. Trainees are expected to keep an up to date record of their educational progress on the RCEM e-portfolio, participate in workplace-based assessment and appraisal as defined in the RCEM curriculum and assessment system. Trainees are expected to be responsible for this as agreed in their educational contract.
- iii. Education and Clinical Supervisors will support the trainee but not take over the trainees responsibilities to engage with the available elements of specialty training.
- iv. The trainee must familiarise themselves with the relevant ACCS or RCEM curriculum, assessment requirements and documentation at the beginning of their programme and at each new placement or rotation.

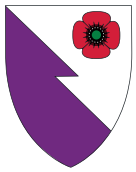




## Section K:

### **Training sites are responsible for their organisational culture and the quality of education and training in their organisations.**

- i. They must have effective, transparent and clearly understood educational governance systems and processes to manage or control quality of medical education and training.
- ii. An executive must be accountable for educational governance, and those in educational leadership roles must have demonstrable educational credibility and capability.
- iii. They will consider impact on learners and take account of learners and educators, collect and act on feedback collated from within organisation or by other means.
- iv. They must allow monitoring, share and report information about quality management and control of education and training with other bodies that have educational responsibilities, in order to identify risk, improve quality locally and more widely, and to identify good practice.
- v. Emergency Departments are responsible for ensuring that their training meets GMC requirements, RCEM curricular and assessment frameworks, HEE (or equivalent) placement standards and work to improve the quality of education and training. This should be led by the specialty tutor and supported by the LFG and training faculty.
- vi. There must be systems in place to manage learner's progress, with input from a range of people, to inform progression. An example of this is with the faculty governance statement.
- vii. They must have a process for sharing information between all relevant organisations whenever they identify safety, wellbeing or fitness to practice concerns about a learner. Trainers are expected to escalate concerns early regarding learners to the postgraduate school or local Director of Medical Education (DME), to ensure that appropriate support can be given to trainee and/or supervisor.
- viii. In Emergency Medicine, the specialty tutor is responsible for monitoring placement standards; they must investigate and respond when concerns are raised to the DME, EM School and Postgraduate teams.

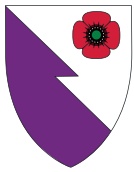


## Quality Management of Postgraduate Training Programmes and Clinical Placements

### Section L:

**Postgraduate schools in EM will ensure that their EM specialty training programme fulfils the following training standards and curriculum requirements. This does not apply to Foundation trainees in EM.**

- i. Specialty training in Emergency Medicine includes both core training and higher training posts in Emergency Departments. The timings are indicative, as training is competence - based.
- ii. The periods of training given in this document are those normally required to gain the requirements delineated in the College curriculum.
- iii. There must be flexibility to allow trainers to optimise the use of all the training opportunities available locally, to ensure the curriculum requirements are met.
- iv. CT1/ST1 or CT2/ST2 The acute care common stem (ACCS) rotation that makes up these 2 years will include 6 months EM, 6 months Acute Medicine, 6 months Anaesthetics and 6 months Intensive Care Medicine.
- v. CT3/ST3 Emergency Medicine, Intermediate training, is a total of 12 months covering 6 months of paediatrics and 6 months general EM competencies to prepare trainees for HST responsibilities. At least 3 months should be spent in a department which meets the requirements outlined in section A iii . Some of this training can be delivered in an acute paediatric inpatient setting.
- vi. Defined Route of Entry in Emergency Medicine (DRE-EM) is an alternative route of application into the Emergency Medicine Training Scheme if applicants have experience of ACCS specialties outside an Emergency Medicine training programme. Full details of entry requirements can be found on the RCEM website.
- vii. Progression. In order to progress from ST3 to ST4 trainees will have been successful in the Primary and intermediate components of the FRCM examination and have an Outcome 1 for ACCS ST3 or equivalent evidence.
- viii. Higher Specialist Training in Emergency Medicine (HST) ST4 - ST6 the last 36 months of training are based in EM.
- ix. Sub-specialty training and dual accreditation
  - a. Sub-specialty training in paediatric EM involves an additional year usually comprised of 6 months in a Paediatric Emergency Department recognised for sub-specialty training and 6 months in in-patient Paediatric specialties. This latter training must include care of critically ill children (usually at least 3 months working in a Paediatric ICU) and at least



3 months in acute inpatient Paediatrics. Appointment is by competitive application, advertised nationally in the first two weeks of March and September each year and regional appointment using RCEM standards. Applicants are expected to have ARCP Outcome 1 for ST4 at time of starting PEM training.

b. Sub-specialty training in Pre-Hospital EM (PHEM) involves an additional year which can either be completed as a single year or part of a two year EM/PHEM blended programme. Posts are recognised by the ICBPHEM and quality standards and progression monitored by them. Appointment is by competitive application, advertised nationally in August each year with national interview and appointment. Applicants are expected to have ARCP Outcome 1 for ST4 at time of starting PHEM training.

c. Intermediate & Advanced Level Accreditation in Intensive Care Medicine is also available for EM trainees who compete for training posts as regulated by the Intercollegiate Board for ICM. This usually extends specialty training time by around 12 to 18 months and leads to dual accreditation.

- x. Fellowship and other additional training opportunities exist within regional training programmes but are appointed and overseen within the regional postgraduate offices.
- xi. HEE Schools of Emergency Medicine (or equivalent in nations with devolved arrangements for healthcare administration) will co-ordinate the rotation of trainees through relevant posts in a training programme.

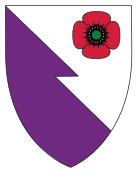
#### Section M:

**It is the responsibility of EM Schools in conjunction with Postgraduate Quality Management processes to ensure that, over the course of Specialty Training Programmes, each trainee is exposed to the full range of Emergency Medicine practice in a balanced rotation which allows them to meet all their curricular competencies.**

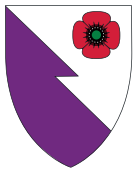
- i. The case mix of an Emergency department will have an impact on the training opportunities available at any one training site. The case mix will depend on the:
  - a. locality and population
  - b. distribution of patients throughout emergency care facilities locally
  - c. supporting specialities present within the hospital
  - d. presence of any ambulance bypass arrangements, for example to a major trauma centre

Where training recognition is granted, it may be necessary to limit the time spent in departments with restricted case mix, as part of a rotation. If training is significantly restricted or persistently then postgraduate schools must follow quality management processes to protect trainees.

- ii. Where supporting specialities are not on site, it will also be more difficult to ensure that the clinical risk exposure of trainees is kept to an acceptable level.



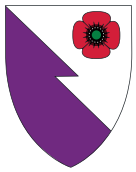
- iii. Rotations must ensure that trainees gain adequate training in the care of children. During the training in Emergency Medicine in years ST4 to ST6, at least 24 months should be spent in departments that treat children as well as adults. The 6-month EM post focusing on children in CT3/ST3 or sub-speciality training in paediatric EM does not alter this requirement.
- iv. Rotations must ensure that all curricular elements are gained and retained during training including in minors and paediatrics. Service pressures are driving clinicians to spend disproportionate time covering 'major' cases in EM; all aspects of the curriculum are required for CCT/CESR-CP. If these cannot be gained during placement then the ES and trainee should make plans for solutions to address them – for example paediatric or minors “ring-fenced” shifts, time in paediatric assessment unit or specialist clinics.
- v. Rotations must ensure that trainees get adequate exposure in the management of trauma to meet the curriculum. During the EM training years St4-6 at least 6 months should be spent in the Major Trauma centre (MTC) or an accredited trauma unit with “ring-fenced” trauma experience within each region. In rotations where this is not possible the EM School must ensure that the Trauma Unit experience meets all curriculum needs and at least a short placement in an MTC would be expected.
- vi. All training rotations must allow experience in at least one teaching centre (or large department seeing at least 100,000 new patients a year) and one district general hospital Emergency Department. Rotation should be through a minimum of 2 departments.
- vii. All placements must be long enough to allow trainees to become members of the multidisciplinary team, and to allow team members to make reliable judgements about their abilities, performance and progress. A minimum of 6 months in each training site is required ideal as recommended in Enhancing Junior Doctor Lives 2018. Only in exceptional circumstances or in order to gain focussed curricular elements would shorter placements be appropriate.
- viii. Trainees at any level should not be placed in training sites in isolation, at least 2 ACCS and/or 2 ST3-7 trainees should be any one site to provide peer support.
- ix. Rotation planning should comply with Code of Practice guidance.
- x. When organising rotations schools will give thought to trainee wellbeing and involve them as much as possible in rotation planning. EMTA has found clear evidence that both length of commute and working in a department you haven't wanted to be placed in are risks to trainee wellbeing.
- xi. Periods of time outside of the training programme (OOP) gaining additional competencies, experiences or a career break must be formally agreed with the educational supervisor and the EM School/Postgraduate Dean as per guidance from the Gold Guide. Prospective approval for OOPT is required from RCEM and the GMC. Additional time will be reviewed by EM School and competencies assessed and on occasion may need to be added on to CCT/CESR-CP training time.



**Section N:**

**Postgraduate training programme will ensure that 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 the curriculum**

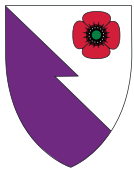
- i. Learners must have access to resources to support their health and wellbeing, and to educational and pastoral support including
  - a. Confidentially counselling services
  - b. Careers advice and support
  - c. Occupational health services
- ii. Learners must be encouraged to look after their own health and wellbeing
- iii. Learners must not be subjected to, or subject others to, behaviour that undermines their professional confidence, performance or self-esteem.
- iv. Reasonable adjustment should be made for disabled learners in accordance to the Equality Act 2010, with information and named contacts
- v. Learners must receive timely and accurate information on curriculum, assessment and clinical placements as per the Junior Doctor Contract.
- vi. Doctors in training must have access and information about academic opportunities, less than full-time training and SuppoRTT return to training after a break.
- vii. Doctors in training should be able to take study leave appropriate to the curriculum, to the maximum time permitted in their terms and conditions of service.
- viii. Learners must receive regular constructive and meaningful feedback on their performance, development and progress and be encouraged to act on it.
- ix. Learners whose progress, performance or conduct gives rise to concern must be supported where reasonable to overcome concerns and, if needed, give alternative career options.
- x. Learners must not progress if they fail to meet the required specialty learning outcomes.



**Section O:**

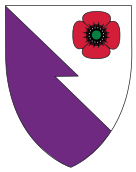
**The postgraduate programme will ensure quality of Educators; that named Clinical and Educational Supervisors are well trained, well supported and deliver high quality supervision for trainees**

- i. Educators must be selected against suitable criteria and receive an appropriate induction to their role, access to appropriately funded professional development and training for their role, and an appraisal against their educational responsibilities. This is set out in the GMC requirement for recognising and approving trainers.
- ii. Trainers must have enough time in their job plans to meet their educational responsibilities so that they can carry out their role in a way that promotes safe and effective care and a positive learning experience.
- iii. Educators must have appropriately funded resources to meet needs of the curriculum
- iv. Organisations must support educators by dealing effectively with concerns or difficulties they face as part of their educational responsibilities
- v. Educators should liaise with each other to make sure they have a consistent approach to education and training, both locally and across specialties and professions.
- vi. When trainers are required to supervise higher numbers of educational supervisees this must be reviewed as it may indicate insufficient training capacity. In this situation trainees may be exposed to increased clinical risk and less individual supervision especially in the consultant to learner ratios on the shop floor. The EM School will be expected to monitor this.
- vii. The programme will request externality from RCEM for 10% ARCPs and will be provided with a report from the external RCEM representative.
- viii. Schools are expected monitor local training;
  - a. Trainee feedback on individual supervisors,
  - b. Local trainee survey including feedback on training placements and training programme on a minimum of an annual basis.
  - c. ARCP feedback for educational supervisors
  - d. ARCP Outcomes
  - e. Examination results
  - f. Differential attainment data



## Section P: The Regional Postgraduate School

- i. Will provide support for trainees in difficulty.
- ii. Will facilitate training for the educational and clinical supervisors or be responsible for approval of other providers.
- iii. Will be responsible for the quality delivery of training placements and approval of training sites in line with these RCEM recommendations.
- iv. Will ensure EM schools participate in HEE quality framework processes.
- v. Will be responsible for ensuring that the Code of Practice for EM rotations will be applied to and trainees are informed about rotational changes within the appropriate time lines.
- vi. Will oversee equality, diversity and opportunity for all trainees.
- vii. Will oversee less than full time training opportunities. EM is a specialty that should lend itself to flexible working. Without accommodating doctors who have well founded reasons for wanting to work less than full time, we risk losing good trainees to General Practice and other specialties that are able to offer flexibility. Enhancing Junior Doctor Lives 2019. Flexible working should reflect the rota and case mix of full time trainees, including night and weekend shifts on an approximate pro- rata basis.
- viii. Will ensure access to training and appropriate supervision is in place for supported return to training trainees who may have had > 3 months away from clinical work for a variety of reasons e.g. Sick leave, Maternity Leave.



## Quality Assurance of Postgraduate Training Programmes and Clinical Placements

### Recruitment

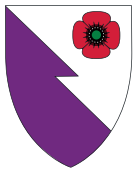
RCEM Training Standards Committee (TSC) will oversee national recruitment processes to core, ST3, DREEM and Higher Training Programmes in England and Wales. Deaneries recruit to ST4 in Scotland and Northern Ireland.

RCEM and Health Education England or relevant devolved national bodies will ensure that recruitment, selection and appointment of learners and educators is open, fair and transparent.

### Review and Evaluation

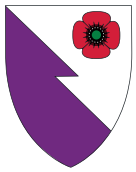
- i. Trainees should complete the GMC National Training Survey annually
- ii. Trainers should complete GMC survey biennially.
- iii. Heads of EM schools (or their equivalent), must produce an annual report for the RCEM and if required their postgraduate dean.
- iv. Heads of EM Schools will work with the RCEM TSC to enable the quality assurance of EM training.
- v. RCEM TSC will work to quality assure the ARCP process by providing externality, ARCP checklists and support for the decision making process.
- vi. Each EM school will reflect on its ARCP externality report and responses will be collated by the TSC Quality lead.
- vii. Heads of School will work with postgraduate school and local training sites to ensure quality in their region. If these standards are not met there should be a plan in place to achieve compliance with an anticipated completion date and evidence that progress is being monitored within the regional school structure and appropriate quality framework.
- vii. Schools of EM will comply with requests from the TSC for data sharing, for example annual census or progression data annually about trainees in order to support the workforce planning and quality improvement of EM training. This should also cover those who left training in the region prior to attaining their CCT in Emergency Medicine.
- viii. The TSC will work with the GMC in its quality assurance processes, on differential attainment and provide an Annual Specialty Report as requested.
- ix. RCEM publishes cumulative results from the FRCEM examination after each diet. The results are broken down regionally for comparison of outcomes and will be shared with the GMC in an annual report.





## Externality

- i. RCEM Externality can be requested for ARCPs and monitoring visits via the TSC.
- ii. Externality training is done formally by the RCEM TSC Quality lead, training lasts 5 years and should be maintained with either another face to face session or evidence to support reapproval submitted to TSC Quality Lead.
- iii. Each EM school will request externality from RCEM for at least 10% ARCPs
- iv. Each EM school will ensure that they have at least two EM trainers who are trained in externality who can represent RCEM at ARCPs in other regions.
- v. Externality reports must be sent to the Head of School, Postgraduate Dean and copied to TSC Training Manager and Quality Lead.
- vi. TSC Quality Lead will collate and feedback learning from externality returns.



## Glossary of terms

**Direct Clinical Supervision** – in this document this means supervision by a consultant on the specialist register working on the shop floor at the same time as trainee they are supervising

**Educational Supervisor (ES)** – a named consultant in Emergency Medicine designated to support, guide or monitor a trainee's progress over a specific time. They may support trainee through a number of clinical placements. Some ESs also act as named clinical supervisor for their trainees; others will be more of a career mentor.

**Named Clinical Supervisor (NCS)** – this is a named consultant working in the same department as the trainee during a placement, who oversees their clinical development over that placement. They will be responsible for writing the end of placement report for ARCP. They may not regularly work with the trainee directly so will gather information about the trainee performance from other members of the multi-disciplinary team (workplace supervisors) which can be used in the end of placement sign off.

**Clinical Supervisor** – has overall responsibility for patients on a shift – every trainee must at all times on a shift (day-time and out of hours), be responsible to a specific consultant. This will usually be the Lead consultant who holds clinical responsibility for the patients. They should be clearly known to each trainee and how to contact them.

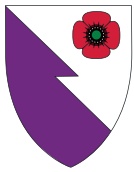
The consultant providing clinical supervision must be available to advise and assist the trainee as appropriate – whether this means attending or giving advice over the phone. If a consultant providing clinical supervision isn't immediately contactable, they must nominate a deputy or the team who is.

**Workplace supervisor – multiprofessional team member who supervises specific tasks** – every doctor in training needs access to some degree of supervision whilst they are at work in the clinical environment. The less experienced trainee the more supervision they will need. A workplace supervisor can be anyone within the multiprofessional team who is competent to carry out the task in question.

For example

- An Emergency Nurse Practitioner can supervise a trainee doctor suturing a patient's wound
- A senior nurse can supervise a trainee doctor managing a patient's catheter
- A registrar can supervise a more junior trainee doctors assessing and managing an acutely unwell patient.

Workplace supervisors have delegated authority from the clinical supervisor with overall patient's responsibility (usually on call consultant for the shift).



## References

[Academy of Medical Educators \(November 2010\) A Framework for the professional development of postgraduate medical supervisor](#)

[Conference of Postgraduate Medical Deans of the United Kingdom \(November 2017\) The Gold Guide A Reference Guide for Postgraduate Specialty Training in the UK Seventh Edition Version:GG7.JANUARY2018](#)

[EM Power](#)

[General Medical Council \(2019\) Good Medical Practice](#)

[General Medical Council \(July 2015\) Promoting Excellence: standards for medical education and training](#)

[Health Education England \(HEE\) \(2018\) Code of practice for medical recruitment](#)

[Health Education England \(HEE\) \(2018\) Enhancing Junior Doctors working Lives](#)

[Health Education England \(HEE\) \(2019\) Enhancing supervision for postgraduate doctors in training](#)

[Health Education England \(HEE\) \(2018\) Enhancing Training and support for learners](#)

[Health Education England \(HEE\) \(2015\) HEE Quality Strategy](#)

London School of Emergency Medicine, 2015 Acting up Guidance at ST3 Core level for ACCS Emergency Medicine Trainees,

[Junior Doctors Contract](#)

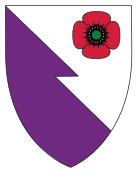
[Royal College Emergency Medicine \(2011\) Educational Recognition of Specialty Training Posts and Programmes in Emergency Medicine](#)

Royal College Emergency Medicine (May 2018) Eligibility requirements to be a Named Educational Supervisor for Emergency Medicine Trainees

[Royal College Emergency Medicine \(2017\) Mental Health in Emergency Departments. A toolkit for improving care.](#)

[Royal College of Paediatrics and Child Health \(2018\) Facing the Future: Standards for Children in the Emergency](#)

[#RestEM](#)



## Appendix A

### Quality Indicators for Clinical Placements 2020-23

- i. 0.25 PA per trainee in ES/NCS job plans
- ii. ES meet required specifications
- iii. Number PEM consultants
- iv. Access to specialty tutor
- v. Local QI lead
- vi. Local US lead
- vii. FRCEM examiner
- viii. SIM training opportunity
- ix. Representation at regional ARCPs
- x. Local feedback mechanism
- xi. Comply with SPA recommendations for trainees
- xii. 50% shifts have direct consultant supervision
- xiii. 2 substantive consultants on specialty register
- xiv. 1 consultant per HST and ACP trainee
- xv. Local training programme

### Quality Indicators for EM Schools 2020-23

- i. All ES formally trained and approved
- ii. FRCEM examiners in all training sites
- iii. Regional US lead
- iv. Regional QI lead
- v. Regional feedback at least annually
- vi. Feedback for ES from ARCPs
- vii. Feedback for ES from Trainees
- viii. Regional training Programme
- ix. Regional exam courses
- x. Regional SIM lead
- xi. Shares data with TSC
- xii. Provides annual school report to TSC
- xii. Has at least two regional external assessors

## Appendix B

This guidance has been written by RCEM Training Standards Committee (as at September 2019)

<b>Dr Maya Naravi</b>	Chair
<b>Dr Jo Hartley</b>	Lead for Quality and Wessex Head of School (Lead author)
<b>Dr Katherine Henderson</b>	RCEM President
<b>Miss Sarah Kaufmann</b>	Lead Dean for Emergency Medicine
<b>Dr Jason Long</b>	Dean of the College
<b>Mrs Emily Beet</b>	Deputy Chief Executive
<b>Dr Amar Mashru</b>	EMTA Chair
<b>Mr Will Townend</b>	Chair, Curriculum Sub-Committee
<b>Dr Jane Brenchley</b>	Lead for HST and Regional Head of School, Thames Valley
<b>Dr Mal Jones</b>	Lead for ACCS and Regional Head of School, Northern
<b>Dr Alison Smith</b>	Lead for Paediatric EM
<b>Dr Nam Tong</b>	Lead for DRE-EM and Regional Head of School, East of England
<b>Dr Amanda Farrow</b>	Regional Head of School, Wales
<b>Dr Tamsin Dunn</b>	Regional Head of School, North West
<b>Dr Ellen Jones</b>	Regional Head of School, West Midlands
<b>Dr Chris Lacy</b>	Regional Head of School, London
<b>Dr Asif Malik</b>	Regional Head of School, East Midlands
<b>Dr Kevin Maguire</b>	Regional Head of School, Northern Ireland
<b>Dr Nandita Parmar</b>	Regional Head of School, Kent, Surrey & Sussex
<b>Dr Andrew Paterson</b>	Scotland Representative
<b>Dr Katherine Robinson</b>	Regional Head of School, SW Peninsula
<b>Dr Vicky Stacey</b>	Regional Head of School, Severn Institute
<b>Dr Jeremy Till</b>	Regional Head of School, Yorks and the Humber
<b>Lt Col Jon Walker</b>	Head of School, Defence Emergency Medicine
<b>Mr Paul Ransom</b>	Lead for CESR
<b>Dr Nanette Bothma</b>	FASSGEM Representative
<b>Dr Mark Winstanley</b>	EMTA Representatives with support from the
<b>Dr Kuldeep Kaur</b>	EMTA committee
<b>Dr Dhakshinamoorthy Vijayasankar</b>	Lead for International Sponsorship Scheme (MTI)
<b>Mr David Greening</b>	RCEM Training Manager
<b>Ms Oonah Newbury</b>	RCEM Training Supervisor