User Guide to Implementation of the 2021 ACCS Curriculum

Guidance for training programme directors, supervisors, and doctors in training

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2 Introduction

This guide is intended to support ACCS training programme directors (TPDs), supervisors, doctors in training, and others in understanding, implementing, and working with the new ACCS curriculum. It has been put together by members of the Intercollegiate Committee for ACCS Training (ICACCST) with additional help from external stakeholders including doctors in training.

This guide is intended to supplement the main curriculum. The curriculum, ARCP decision aid and this guide are available on the ACCS and parent specialty websites.

3 What is different about the 2021 ACCS curriculum?

3.1 Background

There have been two major drivers to the need for change:

1. A move away from the 'tick-box' approach associated with the current competency-based curriculum to a more holistic assessment of high-level outcomes. The new curriculum has a relatively small number of ACCS Learning Outcomes (LOs) which are based on the concept of entrustable professional activities (EPAs).
2. The GMC mandate that all postgraduate curricula must incorporate the essential generic capabilities required by all doctors as defined in the *Generic Professional Capabilities (GPC) framework*.

3.2 Summary of what has stayed the same

- ***Principle of training junior doctors in acute care***: the purpose of ACCS is still to equip doctors with the skills and competencies required to recognise and initially manage the acutely unwell patient.
- ***Curriculum content***: this is largely unchanged – it is the 'packaging' and the approach to assessment that has changed to become more focussed on outcomes.
- ***ACCS placements***: doctors in training still rotate through the four core specialties of ACCS; Emergency Medicine, Internal Medicine, Anaesthesia and Intensive Care Medicine.
- ***Supervision***: doctors in training are still supervised by a Clinical Supervisor (CS) in each placement and an overall Educational Supervisor (ES) throughout their rotation.
- ***Evidence*:** doctors in training still collect evidence to support their learning, however the quantity and nature is more flexible and doctor in training-driven.
- ***E-portfolio***: doctors in training still use their **parent specialty e-portfolio** – the e-portfolios are being adapted to accommodate the new curriculum.
- ***Reports and ARCP***: end of placement reports from the CS and an end of year report from the ES are still required to inform the ARCP panel.

3.3 Summary of what has changed

- ***Ethos***: move towards outcome-based training underpinned by GPCs.
- ***Terminology:*** some new terminology has been introduced.
- ***Assessment process***:
    - move away from a 'tick box' approach, to promote self-regulated learners
    - greater emphasis on formative assessment
    - introduction of intermittent, panel-based, individualised judgements that regulate the progression of the doctors in training
    - move to entrustment-type decisions for each of the LOs to determine the doctors in training's degree of independence and whether they have met the required level to progress.
- ***Rotation***:

- the ACCS curriculum now exclusively covers the generic 2-year rotation prior to joining the parent specialty
- the ACCS rotation is now 4 x 6 month blocks (FTE); it is no longer possible to make up the anaesthetic/ICM year with anything other than 6 months (FTE) in each placement
- Anaesthetic ACCS doctors in training are appointed to a 4-year programme; following the 2 years of ACCS they progress to complete the final 2 years of Anaesthetic stage 1 training
- IM ACCS doctors in training are appointed to a 4-year programme; following the 2 years of ACCS they progress to complete the final 2 years of stage 1 IMT training
- EM ACCS doctors in training are appointed to a 6-year run-through programme; following the 2 years of ACCS they progress to ST3 EM intermediate training

4 The ACCS Curriculum

4.1 Generic Professional Capabilities

These are the fundamental principles that underpin all medical practice and are common to all specialties. There are 9 domains to which all curricula learning outcomes are mapped.

4.2 ACCS Learning Outcomes

There are 11 ACCS Learning Outcomes (LOs); 8 **clinical** and 3 **generic**, that describe the professional tasks within the scope of the ACCS specialities. These are to be covered during the 2 years of ACCS and form the 'backbone' for training.

Some of the clinical LOs are specific to one ACCS placement but most are addressed over a number of the placements. The generic LOs relate to all four ACCS placements. All LOs are mapped to the GPCs.

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 including sedation	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

4.3 Key Capabilities

Each ACCS LO is presented with a set of **key capabilities** which provide clear guidance of what is expected of the doctor in training for completion of that LO. The key capabilities are prefixed by 'at the end of ACCS….', making them easy to use for entrustment decisions.

4.4 Descriptors

Beneath the key capabilities sit a set of **descriptors** which are intended to help trainers and doctors in training recognise the minimum level of knowledge, skills and attitudes required to meet these capabilities. They are not a comprehensive list but are there to provide guidance.

4.5 Evidence

For each LO, a list of suggested types of evidence is provided.

During their ACCS training, the doctor in training collects evidence to support their learning. This should be linked to the relevant LOs. This evidence is then used at the end of each placement to support an entrustment decision on each of the relevant LOs for that placement. The entrustment decision is a holistic judgement of the doctors in training's capability made by the clinical supervisor, based on the evidence provided, including feedback from the panel-based judgements (see section 4).

4.6 What are the Clinical Presentations and Conditions?

The table of 'Presentations and Conditions' (section 3.3 of the curriculum document) represents a list of the principal conditions with which the ACCS doctor in training should become familiar, either because they are common or serious. Doctors in training will need to become familiar with the knowledge, skills and attitudes around managing patients with these conditions and presentations.

The table of systems/specialties, presentations and conditions of ACCS is to be interpreted with common sense. It is not felt necessary to document the specific attributes of each presentation and condition with which doctors in training need to be familiar as this will vary. Doctors in training will, however, need to be familiar with such aspects as aetiology, epidemiology, clinical features, investigation, management, potential complications and prognosis.

The ACCS approach is to provide general guidance and not exhaustive detail, which would inevitably become out of date.

5 Assessment

5.1 Overview

The assessment of doctors in training is broadly composed of 2 elements:

1. **Work Place Based Assessments** (WPBAs) plus other evidence collected by the doctor in training to reflect their learning and evidence their progress
2. **Panel-Based Judgements** made by a group of senior clinicians who have worked closely with the doctor in training.

5.2 Work Place Based Assessments

There has been an explicit move away from providing minimum requirements, that can promote a tick-box mentality, to one where the doctor in training chooses how to use WPBAs to guide their development and to evidence their progress against the ACCS LOs. The WPBAs are largely formative and the doctor in training builds up a body of evidence to reflect their learning.

The wide range of WPBAs which can be used are outlined in the assessment blueprint (see section 4.5). Full explanations of their use are available in the curriculum.

WPBAs are termed Supervised Learning Events (SLEs) in the Anaesthetic curriculum and LLp.

5.3 Panel Based Judgements

These are regular, information-rich judgements which are made by a group of senior clinicians who have worked closely with the doctor in training.

5.3.1 EM Placement: Faculty Educational Governance Statements (FEGS)

The group of senior clinicians who have worked closely with the doctor in training form a faculty who meet regularly to collate information about the doctor in training's performance in the workplace and assess their progress. Together they provide **summative** recommendations about whether the doctor in training is progressing adequately and has met the required standard in the ACCS LOs for that placement. These form the basis for the entrustment level decisions at the end of the EM placement.

The purpose is not only to make an assessment of a doctor in training but to plan on-going training. It is recommended as an optimal way of providing information about doctors in training's progress. The FEGS should be documented and communicated to the doctor in training via their CS. The CS will initiate the FEGS meetings.

5.3.2 Anaesthetic Placement: Multiple Trainer Report (MTR)

The MTR is the equivalent of the FEG but carried out during the Anaesthetic placement. It can be performed, like the FEGS, as a collective discussion, or as independent feedback from a selected group of trainers who have worked with the doctor in training. The MTR captures the views of senior clinical staff, based on observation of a trainee's performance in practice, providing similar valuable insight into how well the trainee is performing, highlighting areas of excellence and areas where support is required.

Like the FEGS, it is used to make entrustment decisions.

5.3.3 ICM and IM Placements: Multiple Consultant Report (MCR)

The MCR is the equivalent of the MTR but carried out during the ICM and IM placements.

The number of FEGs, MTRs and MCRs considered necessary is 1 per placement but regular training faculty meetings throughout the placements are recommended.

The FEGS, MTR and MCRs are different from the MSF (see section 4.4.1) and should be performed in addition to it.

5.3.4 Holistic Assessment of Learning Outcome (HALO)

These are used within the Anaesthetics module and the ICM module, at the end of the placement, to assess LO7 Sedation and LO8 ICM. A satisfactorily completed HALO provides evidence that the doctor in training has achieved the required key capabilities for this LO. If the doctor in training is 'parent specialty Anaesthetics', these HALOs will count towards stage 1 Anaesthetics training and won't need to be repeated.

5.3.5 Initial Assessment of Competence (IAC) (EPAs 1 and 2)

LO7 requires successful completion of the IAC (EPAs 1 and 2) which is undertaken in the Anaesthetics module.

5.4 Other important evidence

All forms of educational experiences can be included by the doctor in training to evidence their learning eg teaching attended, articles read, projects undertaken.

5.4.1 Multi-Source Feedback (MSF)

The MSF provides feedback on the doctor in training that covers areas such as communication and team working. It closely aligns to the generic LOs. Feedback should be sought from a wide range of individuals with whom the doctor in training works including non-clinical staff. Feedback should be discussed with the doctor in training. Repeat MSFs can be undertaken where appropriate.

The ***minimum*** number of MSFs required is 1 per year.

5.4.2 Reflection

Undertaking regular reflection is an important part of doctor in training development towards becoming a self-directed professional learner. Through reflection a doctor in training should develop learning objectives related to the situation discussed which should be subsequently incorporated into their PDP. Reflections are also useful to develop 'self-knowledge' to help doctors in training deal with challenging situations.

It is important to reflect on situations that went well in addition to those that did not go so well. Doctors in training should be encouraged to reflect on their learning opportunities and not just clinical events.

5.5 Assessment Blueprint

The assessment blueprint below illustrates 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 also be included.

Learning Outcome	Mini-CEX	CbD	ACAT	DOPS	Logbook	Teaching/presentation feedback tool	QIPAT	Portfolio/self-directed learning	Entrustment decision/FEG Statement/MCR	MSF	HALO	IAC
1. Care for physiologically stable adult patients presenting to acute care across the full range complexity	X	X	X		X			X	X	X		
2. Make safe clinical decisions, appropriate to level of experience, knowing when and how to seek effective support	X	X	X		X				X	X		
3. Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	X	X	X	X	X				X	X		
4. Care for acutely injured patients across the full range of complexity	X	X	X	X	X				X	X		
5. Deliver key ACCS procedural skills				X	X				X	X		
6. Deal with complex and challenging situations in the workplace	X				X				X	X		
7. Deliver safe anaesthesia and sedation	X	X		X	X				X	X	X	X
8. Manage patients with organ dysfunction and failure	X	X		X	X				X	X	X	
Generic ACCS LOs												
9. Support, supervise and educate						X			X	X		
10. Participate in research and manage data appropriately						X		X	X	X		
11. Participate in and promote activity to improve the quality and safety of patient care						X	X	X	X	X		

5.6 Entrustment

The concept of entrustment underpins the assessment process and is the means by which trainers will assess whether a doctor in training has reached the appropriate level to cross thresholds and take on new responsibility with a higher degree of independence.

Decisions about a doctor in training's competence progression will be based on an assessment of how they are achieving their LOs. There will be an entrustment decision made about what level of supervision they require using the entrustment scale below:

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 doctors in training practice with a consultant taking overall clinical responsibility)

The entrustment matrix provides a structure for the level that must be reached for each LO by the end of each ACCS placement in order for a standard outcome to be achieved at the Annual Review of Competence Progression (ARCP). Some LOs relate specifically to one placement (eg LO7 for anaesthesia). Most, however, should be addressed during several of the ACCS placements, as demonstrated in the entrustment matrix below. These entrustment levels are designed to be achievable for each placement they relate to independently, so the order of the ACCS rotation doesn't matter.

Entrustment matrix

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

The table below sets out the minimum competency level expected for each of the ACCS LO5 practical procedures at the end of ACCS.

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

Lumbar puncture	2b

6 What is required from doctors in training and trainers?

6.1 Doctor in training

The doctor in training, while progressing through each placement, needs to collect evidence of their learning. 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, using a range of learning methods, enable the achievement of the learning outcomes. The doctor in training must try to capture evidence for these in their e-portfolio. This will include, for example, undertaking WPBAs, maintaining a logbook, monitoring teaching attended, self-directed learning, and receiving feedback in their MSF and from local faculty groups.

There is no set number of WPBAs to complete, but the evidence collected must be sufficient to enable entrustment decisions to be made on each LO. The WPBAs are not pass/fail summative assessments but should be seen by both doctor in training and trainer as learning opportunities for a doctor in training to have one to one teaching and receive helpful and supportive feedback from an experienced senior doctor. Doctors in training should therefore be seeking to complete WPBAs as often as practical. They must continue to attend and document their teaching sessions and must reflect (and record that reflection) on teaching sessions, clinical incidents and any other situations that would aid their professional development.

Each doctor in training must ensure that they have acquired multi-source feedback (MSF) on their performance each year and that this feedback has been discussed with their CS for that placement, (or their ES where appropriate) and prompted appropriate reflection. Feedback will also be collected from the local faculty groups in each placement. These take the form of a FEGS in EM, MTR in Anaesthetics and MCRs in ICM and IM.

As the end of a placement approaches, the doctors in training should meet with their CS to facilitate preparation of their end-of-placement report. In this report, entrustment decisions must be made for each relevant LO.

At the end of the year, as the ARCP approaches, the doctors in training should meet with their ES to discuss the two end-of-placement reports for that year, which will enable the ES to produce an end of year educational supervisor's report (ESR) for the ARCP panel.

Regular interaction between doctors in training and their trainers is critical to the doctor in training's development and progress through the programme.

6.2 Educational Supervisor (ES)

Each doctor in training should be allocated an ES at the start of the ACCS programme, who should be from the doctor in training's parent specialty. The ES will oversee the doctor in training's educational development throughout their two-year generic ACCS programme.

At the end of each year, the ES will review the two end-of-placement reports for that year and using these together with all other educational evidence available from the doctor in training, will produce the annual ESR to inform the ARCP. It is essential that this document contains the entrustment decisions for each of the ACCS LOs.

The ES and doctor in training should meet at the start of each training year and maintain regular contact throughout the 2 years.

6.2.1 ES induction meeting

The induction meeting between the ES and the doctor in training is pivotal to the success of the training year and should include the following:

- previous ESR, ARCP, etc. reports or transfers of information on the doctor in training if available
- how to meet the training requirements of the programme, addressing each LO separately
- the resources available to help with the programme
- developing a Personal Development Plan (PDP) for the training year
- the teaching programme, relevant courses, a plan for using study leave,
- use of the various assessment/development tools
- pastoral support.

The induction meeting should be recorded formally in the doctor in training's e-Portfolio.

6.3 Clinical Supervisor (CS)

The doctor in training should be allocated a CS for each of the training placements. The CS will be from the specialty that the doctor in training is doing at the time. They will be responsible for the training of the ACCS doctor in training during their 6-month placement. They should meet with the doctor in training at the start of the placement and regularly throughout the 6 months.

6.3.1 CS induction meeting

Like the ES induction meeting, the induction meeting between the CS and the doctor in training is pivotal to the success of the placement and thus needs both preparation and time.

The induction meeting should be recorded formally in the doctor in training's e-Portfolio.

The following areas should be covered:

- establish a clear plan for how the module will be supervised including setting a date for the next meeting
- review the LO matrix with the doctor in training and ensure the doctor in training understands the learning objectives for the placement, including the generic LOs
- record the learning objectives in the PDP
- consider the initiations of local faculty groups for FEGS/MTRs/MCRs
- consider arrangements for MSF
- review the teaching opportunities, courses, and use of study leave
- pastoral support.

7 Reports

7.1 End-of-placement report

The CS is responsible for completing an end-of-placement report at the end of the 6 months, using the evidence collected by the doctor in training and feedback provided from FEGS/MTR/MCR/MSF, etc. The report will include the entrustment decisions for the relevant LOs.

The suggested evidence to inform entrustment decisions is listed for each LO in the assessment blueprint. It is, however, critical that trainers appreciate that doctors in training do not need to present every piece of evidence listed, the list is not exhaustive and other evidence may be equally valid.

The end-of-placement report template can be found on the parent specialty e-portfolio.

7.2 Educational supervisor report (ESR)

The ESR should be written ahead of the ARCP and discussed between the ES and the doctor in training, with any aspects likely to result in a non-standard outcome at ARCP made clear. This conversation should be documented. The report is written using the 2 end-of-placement reports for that year and documents the entrustment decisions made by the supervisors for all the LOs set out in the curriculum. It will also incorporate evidence collected about all educational activities including study leave taken, courses attended, reflections, publications, presentations, teaching etc. The ESR will inform the ARCP.

The ESR template can be found on the parent specialty e-portfolio.

8 Annual Review of Competence Progression (ARCP)

The ARCP is a procedure for assessing competence annually in all medical doctors in training across the UK. The ARCP gives the final summative judgement about whether the doctor in training can progress into the next year of training. The panel will review the e-Portfolio (especially the ES Report) in conjunction with the decision aid for the appropriate year. The panel must assure itself that the ES has made the appropriate entrustment decisions for each LO and that they are evidence-based and defensible.

The change from the tick-box style competencies to the high-level learning outcomes will have a major impact on how doctors in training are assessed and how they will progress through their ARCPs. It is vital we avoid an increase in doctors in training failing to achieve a standard ARCP outcome by helping doctors in training and trainers to prepare for the ARCPs and by stressing to ARCP panels the basis of their assessment. ARCP panel members must ask the question: "Overall, on reviewing the e-portfolio, including the Educational Supervisor Report, the Multi-Source Feedback and (if necessary) other information such as end of placement reports, workplace-based assessments, reflections, etc., is there evidence to suggest that this doctor in training is safe and capable of progressing to the next stage of training?"

8.1 ARCP requirements by placement

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

8.2 ARCP Decision Aid for ACCS

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

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

9 Training resources

At the time of writing this guide, there are a number of resources being produced and as they are completed, they will be made available on the ACCS and parent specialty websites. These are intended to help you with understanding and implementing the 2021 curriculum.

They will include, amongst others; the full curriculum, recordings of introductory webinars, a library of short videos and podcasts, FAQs and a 'tool kit' for running local curriculum introduction events.

The curriculum resources can be found here: https://www.accs.ac.uk/accs/2021-curriculum/resources

10 Glossary of abbreviations

ACAT	Acute Care Assessment Tool
ACCS	Acute Care Common Stem
ALS	Advanced Life Support
ARCP	Annual Review of Competence Progression
CCT	Certificate of Completion of Training
CS	Clinical Supervisor
DOPS	Direct Observation of Procedural Skills
EPA	Entrustable Professional Activity
EPR	End of Placement Report
ES	Educational Supervisor
ESR	Educational Supervisor Report
FEGS	Faculty Educational Governance Statement
FTE	Full-Time Equivalent
GPC	Generic Professional Capabilities
GMC	General Medical Council
HALO	Holistic Assessment of Learning Outcome
HoS	Head of School
ICU	Intensive Care Unit
LFG	Local Faculty Groups
MDT	Multidisciplinary Team
MCR	Multiple Consultant Report
MTR	Multiple Trainer Report
Mini-CEX	Mini-Clinical Evaluation Exercise
MSF	Multi-Source Feedback
PDP	Professional Development Plan
PS	Placement Supervisor
SLE	Supervised Learning Event
WPBA	Workplace Based Assessment