Welcome to Stage 1 training at the East of England School of Anaesthesia!

If you have not already done so, please register with the Royal College of Anaesthetists - the form is available on this link

https://rcoa.ac.uk/training-careers/training-anaesthesia

Your national training number will be given out by edit.eoe@hee.nhs.uk however for new starters these are not required by the college.

You can then start to use the Life Long Learning platform from the RCOA - There are links to YouTube videos on the RCOA website if you need help to get started.

The anaesthetic college tutor at your trust will let you know who your educational supervisor is - the college tutors have your contact details.

Stage 1 training contacts:

School of Anaesthesia administrator: c.beynon2@nhs.net

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North hospitals: Norfolk and Norwich, West Suffolk, Peterborough, James Paget, Kings Lynn, Luton, Bedford, Addenbrookes.

South Hospitals: Ipswich, Colchester, Chelmsford, Basildon, Southend, Harlow, Watford, Lister.

Core trainee representatives:

eoeanaesthesiareps@nhs.net

The HEEoE website is a useful source of information about study leave, training days, contact details for college tutors etc.

https://heeoe.hee.nhs.uk/anaesthesia

Study Leave

The study leave process is detailed on the link below:

https://heeoe.hee.nhs.uk/faculty-educators/study-leave-homepage

The anaesthesia school study leave policy can be found at

https://heeoe.hee.nhs.uk/anaesthesia/trainee-resources/study-leave-guideeoe-trainee-anaesthetists

Educational Development Time for Generic Professional Capabilities:

The 2021 CCT curriculum in anaesthesia includes reference to the General Medical Council's nine domains of Generic Professional Capabilities. The RCoA published guidance in November 2021 for Educational Development Time for Anaesthetists in Training (https://www.rcoa.ac.uk/training- careers/training-hub/2021-curriculum/guidance-educational-development-time
).

Please note that this guidance replaces the School's previous *"Study leave for non-clinical units of training (Generic Professional Capabilities)".* No specific funding is available for this activity. Your local Trust will coordinate this with you – please discuss with your local educational supervisor / college tutor. Please note that in contrast to previous arrangements within the School, this time no longer forms part of your study leave allowance.

The Anaesthesia 2021 Curriculum

The 2021 Curriculum learning syllabus: stage 1 is available on the RCOA website: https://www.rcoa.ac.uk/documents/2021-curriculum-learning-syllabus-stage1/introduction

The 2021 Curriculum is available on the RCOA website (https://www.rcoa.ac.uk/training-careers/training-anaesthesia/trainingnews/2021-curriculum-cct-anaesthetics)

We have included excerpts from the website below:

An Overview of Training:

Training in anaesthetics will be divided into three distinct stages each of which has a specific critical progression point to move to the next stage or be recommended for the CCT.

The GPCs and the specialty specific learning outcomes required will be identical throughout the duration of the training programme.

Stage 1 (indicative three years – CT1-CT3): anaesthetists in training will be exposed to a comprehensive introduction to elective and emergency anaesthetic practice and perioperative care in areas that reflect 'generalist' anaesthetic practice. The initial novice period will be directly supervised until the Initial Assessment of Competence progression point has been attained. Time is spent gaining clinical experience primarily in a low to moderate risk patient population although there will be some supervised exposure to more complex cases. Time will also be spent developing relevant skills in ICM. Anaesthetists in training will complete the Primary FRCA examination during this stage of training.

Domains of learning

The anaesthetics curriculum contains 14 domains that describe the standard that anaesthetists must demonstrate as they progress through training and ultimately attain a CCT. Anaesthetists in training are required to demonstrate achievement of both the generic professional and specialty- specific domains throughout their training period.

Each domain has a **High-level Learning Outcome (HLO)** that sets the scene for what constitutes an anaesthetist.

Below that is a **stage learning outcome** that provides a description of attainment to be achieved at the end of that stage in order to progress to the next.

Next follows a set of **key capabilities** that are mandatory capabilities that must be evidenced by anaesthetists in training to meet the stage learning outcome. These are also therefore mapped to the GPC framework.

> *We recommend that when you link evidence, you label which key capability you are linking to with a brief description of your evidence. This is because evidence needs to be provided for every key capability and it is easier to see which key capabilities have been evidenced if they are clearly labelled. A HALO cannot be approved if there is no evidence linked to a cluster or individual key capability. All clusters or individual key capabilities should have some form of evidence linked.*

Every HLO at each stage of training includes a selection of **examples of evidence** that give the range of clinical contexts that anaesthetists in training may use to support their achievement of the key capabilities, as well as suggested assessment methods. These are intended to provide a prompt to the anaesthetist in training and their trainers as to how the overall outcomes may be achieved. They are not intended to be exhaustive and there are many more examples that would provide equally valid evidence of performance. In addition, excellent anaesthetists in training may produce a broader portfolio of evidence that demonstrates deeper learning. It is not expected that anaesthetists in training provide a set quota of evidence; the aim of assessment is to provide adequate, robust evidence against every key capability to demonstrate acquisition of the HLOs at each stage.

Satisfactory achievement for each stage of training requires demonstration that, for each of the HLOs, the anaesthetist in training's performance meets or exceeds the minimum requirements as described. This will require educational supervisors to make a global judgement indicating whether satisfactory progress for the defined stage of training has been made. More detail is provided in the programme of assessment section of the curriculum.

Critical Progression Points

There are four critical progression points during anaesthetic training, two of which are in stage 1.

Stage 1:

Critical progression point 1: Initial Assessment of Competence (IAC)

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

Critical progression point 2: End of Stage 1 (CT3)

To complete Stage 1 training successfully, the anaesthetist in training must pass the Primary FRCA in its entirety, as well as attaining all of the generic and specialty learning outcomes required for that stage of training. In signing the *Stage One Training Certificate,* trainers must be satisfied that the anaesthetist in training has obtained the required level of achievement in all of the learning outcomes for stage 1. If this is not the case, then the anaesthetist in training requires additional training time, as detailed in the Gold Guide. Satisfactory

completion of Stage 1 is a prerequisite for eligibility for recruitment, and entry, to stage 2 of the anaesthetic training programme.

Additionally, The *Initial Assessment of Competence in Obstetric Anaesthesia (IACOA)* must be obtained by all anaesthetists in training during stage 1, before being considered safe to work in an obstetric unit without direct supervision. It is recommended that this is attained after a block of obstetric anaesthetic training, usually commenced after one year in programme. Achieving the IACOA does not signal meeting the obstetric anaesthetic capabilities of Stage 1 training.

Assessments:

The assessments used by the RCoA fall into two categories:

1. Fellowship of Royal College of Anaesthetists (FRCA) examinations 2. Assessments in the workplace

The assessments in the workplace can be further divided into:

1. Formative assessments: Structured Learning Events (SLEs), Multi Source Feedback (MSF), Multiple Trainer Reports (MTRs)
2. Summative assessments: Initial Assessment of Competence (IAC), Initial Assessment of Competence for Obstetric Anaesthesia (IACOA), Holistic Assessment of Learning Outcomes (HALO), Multiple Trainer Reports (MTRs).

At all stages of training the Educational Supervisor's Structured Report (ESSR) will make a recommendation to the ARCP panel as to whether the trainee has met the required level of achievement in each of the domains for each stage of training and where relevant, the critical progression points. The ARCP panel will make the final decision on whether the anaesthetist can be signed off to progress to the next year

Summative assessment

- Fellowship of the Royal College of Anaesthetists (FRCA) examinations: Primary and Final

- Initial Assessment of Competence (IAC)

- Initial Assessment of Competence in Obstetric Anaesthesia (IACOA)

- Holistic Assessment of Learning (HALO) form

- Multiple Trainer Reports (MTR)

- Educational supervisors structured report (ESSR)

- Entrustable Professional Activities (EPAs).

The Primary FRCA

The Primary FRCA is to be completed by the end of CT3 and the final FRCA by the end of ST5, notwithstanding any remedial time allocated. The FRCA examination is a two-part 'high-stakes' national assessment. Its major focus is on the knowledge required for practice but the structured oral examination [SOE] and objectively structured clinical examination [OSCE] test decisionmaking, understanding of procedure and practical elements (including the use of simulation).

The Primary examination is divided into two parts: the MCQ and the OSCE/SOE. Further details on the examinations are available on the *Examinations* pages on the RCoA website.

Formative assessment

Formative assessment is *assessment for learning.* The goal of formative assessment is to monitor progress in order to offer ongoing constructive feedback with the aim of improving performance. In formative assessment there is no grade or mark, no pass or fail. Formative assessment must provide good quality feedback; without this the process loses its purpose. The main formative assessments used in the curriculum are the Structured Learning Events (SLEs).

SLEs are *only one* source of evidence towards the attainment of a learning outcome. Their purpose is to demonstrate engagement of trainers and anaesthetists in training in professional educational conversations alongside the logbook and consultant feedback. Further examples of how anaesthetists in training might provide evidence of achievement of key capabilities and higher learning outcomes will be included in the examples of evidence section that accompanies each learning outcome. These will include activities such as teaching, course attendance and quality improvement projects.

The anaesthetic curriculum is outcomes-based. Key capabilities (knowledge or skills) relating to each learning outcome in the curriculum are listed in annexes at the end of this document. The key capabilities may be assessed by SLEs and these, along with other evidence, may be used to demonstrate their

attainment and therefore achievement of the learning outcomes at each stage of training.

Integral to the SLEs are reflection on the learning event by the anaesthetist in training and feedback from the assessor.

Reflection and feedback should be an integral component to all structured learning events. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently – and as soon as possible after any event to maximise benefit for the anaesthetist in training. Feedback should be of high quality and should include an action plan for future development for the anaesthetist in training. Both anaesthetists in training and trainers should recognise and respect cultural differences when giving and receiving feedback.

The purpose of feedback is to inform the learner about their work in relation to what is expected and direct them on how to improve. As part of this feedback the assessor can indicate what level of supervision the anaesthetist in training requires for that task or case and how they can improve in order to reach the level of supervision required. To facilitate this, levels of supervision have been developed and a supervision/entrustment scale is included on some of the SLEs.

A supervision scale will be used in a formative way to demonstrate progress by the trainee. It will be used to inform summative assessments such as the IAC and IACOA.

The levels of supervision

1	Direct supervisor involvement, physically present in theatre throughout
2A	Supervisor in theatre suite, available to guide aspects of activity through monitoring at regular intervals
2B	Supervisor within hospital for queries, able to provide prompt direction/assistance
3	Supervisor on call from home for queries able to provide directions via phone or non- immediate attendance
4	Should be able to manage independently with no supervisor involvement (although should inform consultant supervisor as appropriate to local protocols

The educational supervisor should review the SLE with the anaesthetist in training to see how they are progressing and to ensure that they are acting on feedback received.

The main formative assessments used in the curriculum are the SLEs:

- Anaesthetic Clinical Evaluation Exercise [A-CEX]

- Anaesthetic List/Clinic/Ward Management Assessment Tool [ALMAT]
- Direct Observation of Procedural Skills [DOPS]
- Case Based Discussion [CBD]
- Logbook
- Multi-Source Feedback [MSF]
- Anaesthetic Quality Improvement Project Assessment Tool [A-QIPAT]
- Multiple Consultant Report (MCR)

SLEs

There are no requirements for minimum numbers of SLEs. The SLEs should be used in a formative way to demonstrate reflection on learning and progress by the trainee. The SLEs allow the trainer to indicate what level of supervision is required for the trainee. For the IAC and IACOA trainers need to be satisfied that the anaesthetist is able to perform with the required a certain level of supervision in order to complete these training requirements.

The Faculty of ICM has set the number of assessments for ICM, which are listed in the ICM Curriculum, and some assessments achieved in the anaesthesia curriculum may be cross counted to satisfy ICM competences and vice-versa.

Who can assess?

Consultants, specialty anaesthetists, and senior anaesthetists in training can assess SLEs. In accordance with GMC standards, assessors must possess expertise in the area to be assessed and be familiar with the assessment process. Senior anaesthetists in training and non-medical staff may assess SLEs if they have completed appropriate training, and if the educational supervisor (ES) considers it appropriate. The ES may need to enter the assessment in the Lifelong Learning platform (LLp). **Anaesthetists in training must not perform assessments for the IAC and the IACOA.**

The structured learning event process:

- feedback is the most important element of a SLE

- anaesthetists in training should undertake SLEs relevant to their current practice

- areas for learning should be identified prior to starting a list, clinic, wardround, etc., and the anaesthetist in training should ask the trainer in advance to perform a SLE

- requesting SLEs retrospectively is considered poor practice and is not acceptable, except in Case-Based Discussions

- the anaesthetist in training should reflect on the learning event in the SLE

- the trainer should observe the performance of the anaesthetist in training, and give immediate verbal feedback as well as suggestions for future development, further reading etc.; they will indicate what level of supervision the anaesthetist requires for that activity

- trainers should comment on clinical and non-clinical aspects of performance, such as professionalism and team-working

- if facilities exist and it is safe to do so, the assessment can be documented on the LLp at this time

- if the online form cannot be completed at this time, the anaesthetist in training will send a request for a SLE to the trainer electronically

- verbal feedback should always take place at the time of the SLE

- the trainer should complete the online form as soon as possible

- the anaesthetist in training should link the form to the relevant learning outcome so that the SLE can be used as evidence for the HALO

- linking a SLE to more than one unit of training may be appropriate, if it demonstrates relevant progress.

Further guidance on SLEs is available here: https://www.rcoa.ac.uk/sles-mtrsadditional-guidance-new-curriculum

Supervision levels are ***'the supervision level the anaesthetist in training would require if they were to repeat that same activity right here, right now.'***

Holistic Assessment of Learning Outcomes (HALOs)

A satisfactorily completed HALO form provides evidence that an anaesthetist in training has achieved the key capabilities required to demonstrate attainment of a stage learning outcome, in order to progress to the next. Supervisors should draw upon a range of evidence including the logbook of cases completed, SLEs, illustrations set out in the curriculum document, and consultant feedback to inform their decision as to whether the stage learning outcome has been achieved. The logbook review should consider the mix of cases, level of supervision and balance of elective and emergency cases, if relevant, for the stage learning outcome. Evidence for achievement of key capabilities and learning outcomes will be uploaded to the LLp and will be linked by the anaesthetist in training to the relevant stage learning outcome. The supervisor will be able to review this evidence at the end of a stage of training to complete the HALO but it is expected that the evidence will be collected and

linked throughout the stage of training period so that educational supervisors and ARCP panels are able to review progress.

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

- *Towards the end of the stage of training if the anaesthetist in training does not have an SLE which demonstrates the required supervision level, the HALO can still be completed if the assessment faculty agree that the trainee is performing safely at the required level. This should be supported by the Multiple Trainer Report feedback. Equally, for the IAC and IACOA there should be a selection of SLEs, some of which should demonstrate the required supervision level. This is then taken into account with the other evidence by the assessment faculty.*
- *A HALO cannot be approved if there is no evidence linked to a cluster or individual key capability. All clusters or individual key capabilities should have some form of evidence linked.*
- *Successful completion of all 14 HALOs is required to complete each stage of training. Most HALOs will be approved **towards the end** of a stage of training. Some HALOs may be approved earlier in the stage, for example ICM, after completion of the relevant clinical attachments.*

Anaesthesia Clinical Evaluation Exercise (A-CEX)

The A-CEX is used during clinical sessions, and the assessments are based on the observed performance of the anaesthetist in training's skills, attitudes and behaviours, and knowledge. It looks at the anaesthetist in training's performance in a case rather than focusing on a specific procedure, for example the anaesthetic management of a patient with renal failure.

Anaesthesia List Management Tool (ALMAT)

Similar to the A-CEX, the ALMAT is designed to assess and facilitate feedback on an anaesthetist in training's performance during their practice. When undertaking an ALMAT, an anaesthetist in training is given responsibility for the running of a surgical list according to their level of competence. This tool is particularly appropriate for more senior anaesthetists in training and allows assessment of both clinical and non-clinical skills. Anaesthetists in training should request this assessment before the start of the list, and they may be

assessed either by the trainer with direct responsibility for that list, or it may be possible for an anaesthetist in training working with indirect supervision to be assessed by the nominated supervising consultant for that area.

Directly Observed Procedural Skills (DOPS)

The DOPS tool is used for assessing performance in procedures, such as arterial cannulation or epidural insertion. This tool is therefore more suited to Stage 1 training rather than Stage 2 or 3, except for new areas of anaesthetic practice, which should focus on higher level skills. They are useful for assessing anaesthetists in training who are learning a new skill e.g. nerve block.

Case-Based Discussion (CBD)

The CBD is usually used away from the clinical environment – it allows the assessor to question the anaesthetist in training about a clinical episode in order to assess their knowledge and rationale for their actions, or what they would do if presented with the clinical scenario. When undertaking a CBD, the anaesthetist in training should bring the case notes and/or anaesthetic chart of a case that they wish to discuss in retrospect. The conduct and management of the case as well as the standards of documentation and follow up should be discussed. CBDs offer an opportunity to discuss a case in depth and to explore thinking, judgement and knowledge. They also provide a useful forum for reflecting on practice, especially in cases of critical incidents.

Logbook

The LLp integrated logbook allows the anaesthetist in training's development as assessed by certain SLEs to be placed in context. It is not a formal assessment in its own right, but anaesthetists in training are required to keep a log of all anaesthetic, pain and ICM procedures they have undertaken including the level of supervision required on each occasion. The logbook demonstrates breadth of experience and a logbook review should consider the mix of cases, level of supervision and balance of elective and emergency cases, if relevant, for the learning outcome.

Multi-Source Feedback (MSF)

The MSF, unlike the other SLEs, provides specific feedback on generic skills such as communication, leadership, team working, reliability, etc., across the domains of Good Medical Practice from a wide range of individuals who have worked with the anaesthetist in training in the current training year. Other SLEs are a snapshot in time covering a clinical episode, where the MSF is used to measure an anaesthetist in training's performance across a broader period of time and informs the assessment of achievement of learning outcomes.

Anaesthetists in training are required to have **at least one MSF completed for each training year** and MSFs can be conducted in anaesthesia, pain medicine or ICM. The anaesthetist in training identifies a minimum of 12 people (who

should be from a mixture of disciplines) with whom they have worked, for example, consultants, theatre staff, recovery staff, ODPs, midwives and administrative staff, and sends a request through the LLp. An additional MSF for ICM is required.

Anaesthetic Quality Improvement Project Assessment Tool (A-QIPAT)

Quality improvement is a key element of professional practice. The A-QIPAT form is introduced in this curriculum to enhance assessment of this learning outcome. This assessment allows individuals who have worked with the anaesthetist in training to comment on their performance as part of a quality improvement project. This is a very useful way to provide the anaesthetist with feedback that is specific to their performance in quality improvement projects.

Multiple Trainer Reports (MTRs)

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

The MTRs differs from the MSF as it concerns an anaesthetist's training progress with key capabilities and learning outcomes. MSFs seek feedback from the multidisciplinary team, including consultants, on overall professional behaviour and attitude.

The current RCoA consultant feedback form has been developed to provide reports that give feedback across *all* the learning outcomes. Consultant feedback will be collated through the LLp and will form part of the Educational Supervisor's Structured Report (ESSR). **At least one MTR will be required per year of training, and for certain areas of training specific MTRs will be required. This includes paediatric, cardiac, neuro and obstetric anaesthesia. For CT1 an MTR is required for the IAC and a CT1 MTR is required in addition. For CT2 an MTR is required for the IACOA and a CT2 MTR is required in addition.**

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

Educational supervisors structured report (ESSR)

The LLp system allows for multiple ESSRs per year that can be completed at intervals reflective of individual training programmes, as agreed between an anaesthetist in training and an educational supervisor. These will all subsequently feed into an ARCP.

The ESSR will periodically (at least annually) record a longitudinal, global report of an anaesthetist in training's progress based on a range of assessment,

potentially including exams and observations in practice or reflection on behaviour by those who have appropriate expertise and experience. The ESSR can incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

Entrustable Professional Activities (EPAs)

The RCoA utilises supervision/entrustment scales for SLEs (DOPS, A-CEX, ALMAT, and CBDs) within the curriculum to provide formative assessment and meaningful feedback on the level of supervision that was required for anaesthetists in training undertaking clinical activities. Entrustable professional activities (EPAs) involve looking across a range of different skills and behaviours to make global decisions about an anaesthetist in training's suitability to take on particular responsibilities or tasks and help to establish an increase in autonomy and responsibility for the unsupervised practice of key activities. (ten Cate, 2013) Unlike conventional SLEs that assess previous activity, EPAs focus on an anaesthetist in training's ability to cope with future situations and challenges. (Peters, 201717)

This curriculum embeds EPAs at two critical progression points to make summative decisions on defined areas of practice confirming that the trainee is able to undertake specific responsibilities safely and independently. These summative assessments will be undertaken by 'training faculty members' who have observed an anaesthetist in training's performance on multiple occasions and who utilise all available sources of relevant information including; SLEs, clinical logbook, supervisor reports, MSF, and MTRs. Utilising all the relevant information available at each progression point for individual anaesthetists in training will ensure that the curriculum is underpinned by a programmatic approach to assessment. The EPAs are centred on an anaesthetist in training's ability to join the on-call rotas for general and obstetric anaesthesia and are widely recognised as priority areas in which entrustment decisions are required to ensure patient safety. *Initial Assessment of Competence*

https://www.rcoa.ac.uk/sites/default/files/documents/2021-06/EPA-1and2workbook.pdf

This comprises three arenas of professional activity:

- safe general anaesthesia with spontaneous respiration to ASA 1-2 patients for uncomplicated surgery in the supine position

- safe rapid sequence induction for ASA 1-2 patients aged 16 or older and failed intubation routine

- safe perioperative care to ASA 1E – 2E patients requiring uncomplicated emergency surgery.

Initial Assessment of Obstetric Competence

https://www.rcoa.ac.uk/sites/default/files/documents/2021-06/EPA-3and4workbook.pdf

This comprises four arenas of professional activity:

- safe administration of epidural/CSE for pain relief in labour

- safe administration of epidural top-up for an emergency caesarean section

- safe administration of spinal/CSE for elective or emergency caesarean section

- safe administration of general anaesthesia for elective or emergency caesarean section.

Appraisal

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

Induction appraisal

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

Monthly meetings

Monthly meetings between anaesthetist in training and Educational Supervisor are not mandatory but are strongly encouraged. These are particularly important if either the anaesthetist in training or educational or clinical supervisor has training concerns, or the anaesthetist in training has been set specific targeted training objectives at their ARCP. At these meeting anaesthetists in training should review their PDP with their supervisor using

evidence from the LLp. SLEs and progress through the curriculum can be reviewed to ensure anaesthetists in training are progressing satisfactorily, and attendance at educational events should also be reviewed.

End of attachment appraisal

Anaesthetists in training should review the PDP and curriculum progress with their Educational Supervisor using evidence from the LLp. Specific concerns may be highlighted from this appraisal. The end of attachment appraisal should record the areas where further work is required to overcome any shortcomings. Further evidence of competence in certain areas may be needed, such as planned workplace-based assessments, and this should be recorded. If there are significant concerns following the end of attachment appraisal, then the TPD should be informed. Information gathered from this meeting should be incorporated into the Educational Supervisor's Structured Report.

Recording progress on the Lifelong Learning platform (LLp)

On enrolling with the RCoA anaesthetists in training will be given access to the LLp. The platform allows evidence to be built up to inform decisions on an anaesthetist in training's progress and provides tools to support their education and development.

The anaesthetist in training's main responsibilities are to ensure their LLp record is kept up to date, arrange SLEs and ensure they are recorded, prepare drafts of appraisal forms, maintain their PDP, record their reflections on learning and record their progress through the curriculum.

The supervisor's main responsibilities are to use the LLp evidence such as outcomes of SLEs, reflections and PDPs to inform appraisal meetings. They are also expected to update the anaesthetist in training's record of progress through the curriculum, write end-of-attachment appraisals and supervisor's reports.

Deaneries, TPDs, College Tutors and ARCP panels will use the LLp to monitor the progress of anaesthetists in training for whom they are responsible. The RCoA will use summarised, anonymous LLp data to support its work in quality assurance.

All appraisal meetings, personal development plans and SLEs (including MSF) should be recorded in the LLp. Anaesthetists in training are encouraged to reflect on their learning experiences and to record these in the LLp. Reflections can be kept private or shared with supervisors.

Reflections, SLEs and other LLp content should be used to provide evidence towards acquisition of curriculum requirements.

Decisions on progress

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

Throughout training, anaesthetists should engage with the learning process by using the LLp to demonstrate that they are meeting the requirements of the curriculum.

The evidence collected on the LLp includes:

- placements in programme
- examination outcomes
- milestones such as training certificates
- personal development plans
- logbook data
- evidence of supervisory meetings
- structured learning events and other evidence for HALOs
- MSFs
- MTRs
- evidence of reflection.

This evidence should form the basis of the ESSR that is reviewed at the ARCP and considered when awarding an ARCP outcome.

Keeping up with your LLP as you go along will prevent any last minute rushes. Remember your MSF should be completed in good time before your ARCP. If your educational supervisor returns the ESSR for example due to the lack of a QIP, the ESSR will have to be deleted to allow a QIP to be linked (as after ESSR closure date). The new ESSR can be returned to the ES/CT who will have to re-type their comments.

Please ensure that your ESSR has been reviewed and approved by your Educational Supervisor and College tutor so that it is uploaded and ready TWO WEEKS prior to your ARCP date. ESSRs not uploaded in a timely manner may result in an outcome 5 (Incomplete evidence presented – additional training time may be required) at your ARCP.

A satisfactory outcome at the ARCP is required in order to progress through the training programme.

Assessment of attainment of the learning outcomes involves looking across a range of different skills and behaviours to make global decisions about an anaesthetist in training's suitability to progress.

As a precursor to ARCPs, the RCoA strongly recommend that anaesthetists in training have an informal LLp review either with their educational supervisor or arranged by the local School of Anaesthesia. These provide opportunities for early detection of anaesthetists in training who are failing to gather the required evidence for ARCP.

In order to guide anaesthetists in training, supervisors and the ARCP panel, the RCoA has produced ARCP guidance which sets out the requirements for a satisfactory ARCP outcome at the end of each stage of training and critical progression point. The ARCP decision aid is available on the RCoA website.

Minimum annual requirements for satisfactory ARCP

CT1	IAC
	Satisfactory progression with key capabilities
CT2	IACOA
	Satisfactory progression with key capabilities
CT3	HALOs for Stage 1 learning outcomes for all domains
	Primary FRCA examination pass

As a school, we are recommending that the Sedation HALO is signed at the end of CT1.

The programme of assessment (** critical progression point)

	Stage 1			**Stage 2**		**Stage 3**	
	CT1	CT2	CT3 **	ST4	ST5 **	ST6	ST7 **
***Formative* Supervised Learning Events (SLEs)**							
A-CEX	There is no requirement for a minimum number of SLEs each year. The anaesthetist in training should use SLEs in a formative way to demonstrate reflection on learning and progress. Feedback on the learning event should help the learner improve their practice. The SLEs allow the trainer to indicate what level of supervision is required for the trainee for that case or procedure. Feedback should include guidance on how the learner develops their practice to reach the desired supervision level. Practical procedures should be assessed with a DOPS tool.						
ALMAT							
CBD							
DOPS							
A-QIPAT							
***Summative* Assessments**							

Initial Assessment of Competence (IAC) **	■ Completed in CT1 ■ Supervision level 2b ■ EPAs 1 and 2						
Initial Assessment of Competence in Obstetric Anaesthesia (IACOA)	■ Completed by end of CT2 ■ Supervision level 3 ■ EPAs 3 and 4						
MSF (one per year)	✓	✓	✓	✓	✓	✓	✓
Multiple Trainer Report	✓	✓	✓	✓	✓	✓	✓
HALO	Stage 1 domains of learning 1-14			Stage 2 domains of learning 1-14		Stage 3 domains of learning 1-14	
FRCA Examinations							
Primary FRCA	Essential						
Final FRCA				Essential			
Educational Supervisors Structured Report (ESSR)							
ESSR	✓	✓	✓	✓	✓	✓	✓

Please see the RCOA National Anaesthetic ARCP Checklist:

https://www.rcoa.ac.uk/sites/default/files/documents/2022-04/National%20Anaesthetic%20ARCP%20Checklist%202021%20curriculum%20v1.0.pdf

Overarching assessment blueprint

The overarching assessment blueprint shows how each of the assessments relates to the domains of learning. It is not necessary that every method will be used for each key capability and additional evidence may be used to make a global judgement on attainment.

https://www.rcoa.ac.uk/sites/default/files/documents/2021-05/Table%202%20%20The%20assessment%20blueprint.pdf

Independent self-directed learning

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

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

Formal postgraduate education sessions

The content of formal postgraduate education sessions and access to other more formal learning opportunities are determined by the local faculty of anaesthetic education and will be based on the curriculum. There are many opportunities throughout the year for formal teaching locally and at regional, national and international meetings. Many of these are organised by the RCoA.

Where appropriate formal teaching/meetings should include the multiprofessional team. Access should also be provided to key meetings within the service. Suggested activities include:

- a programme of formal ‘bleep-free’ regular teaching sessions to cohorts of anaesthetists in training
- attendance and presentation at mortality and morbidity meetings
- case presentations
- research, audit and quality improvement projects
- attendance and presentation at governance and risk meetings
- lectures and small group teaching
- clinical skills demonstrations and teaching
- critical appraisal and evidence-based medicine and journal clubs
- joint specialty and multi-professional meetings

- attendance at training programmes organised on a deanery or regional basis, which are designed to cover aspects of the training programme outlined in this curriculum.

The ilnk for the regional core anaesthesia teaching is

https://heeoe.hee.nhs.uk/anaesthesia/east-england-anaesthesia-calendarand-regional-training-days

For face to face days, you are welcome to attend the one closest to your home. Please contact the organiser to check there is space. The Blended Learning Platform contains a wealth of resources, please register for access.

For Novices to ICM, we have put a link from the blended learning platform signposting you to access the e-learning for Healthcare hub, which contains an e-learning package for novices to ICM mapped to the curriculum.

Other resources for ICM:

1) FICM e-learning modules via e-LFH

3) For Neurocritical care, NACCS have recently launched their e-learning, all endorsed by FICM on https://naccs.org.uk/resource/contents/

4) The Basic Assessment and Support in Intensive Care course is a relevant course for novices

Simulation training

The following simulation courses will be offered at *approximately* the following stages:

CT1 / ACCS2 An / ACCS2 EM & AM / DRE EM

- **Novice Introduction to Anaesthesia programme** - Twice per annum when new Novices start (Feb and August). Intro to School, three lecture days and simulation days.

CT1 / ACCS2 An

- **Anaesthetic Critical Incident Simulation**

CT2 / ACCS3 An

- **Basic Obstetric Anaesthetic Simulation**

CT2 / ACCS3 An

- **Transfer Training** (this is not routinely offered and will need to be applied for, but will be funded).

CT3/ACCS4 An
- **Paediatric Anaesthesia simulation**

Collecting Evidence for your Generic Professional Domains

HEE EoE has a number of useful resources!

Please have a look at the **Leadership Ladder**

https://heeoe.hee.nhs.uk/medical-training/leadership-hub/hee-eoe-leadershipladder

As a rough guide, our HEE EoE fellow has reviewed our generic professional domains and has helped to map these to the modules:

Professional behaviours and communication – the most useful module would probably be the one about reflection (Anticipated to be ready in August or September) but there are also aspects in the modules on leading handover (which features Civility Saves Lives), leading an arrest team (not released yet but in progress, covers helping your team deal with traumatic events and debriefing) and understanding state (which helps the trainee manage their own emotional state) which would be applicable.

Management and professional and regulatory requirements - we have a module on NHS structure already ("A Junior Doctor Guide to the NHS", created with Sean O'Kelly, the Regional Medical Director for the East of England. There will eventually be modules on inclusion and diversity and on unconscious bias (in progress).

Teamworking - the single most useful module will probably be "Developing Teams and Psychological Safety". Other useful modules would include Theories of Leadership, Strengths Based Leadership and Your Role within a Team.

Safety and Quality Improvement – the most useful would be our four Quality Improvement modules, though some elements of "Leading an Arrest Call" would also be relevant due to the element on debriefing.

Mentoring

EOE Mentoring Masterclasses are available free of charge:
https://heeoe.hee.nhs.uk/faculty-educators/mentoring

Buddying

We have set up a buddying scheme, and participation in this can be used as evidence

Educator Development

HEE EoE offers a tiered approach for educator development:

https://heeoe.hee.nhs.uk/faculty-educators/tiered-approach

Blended Learning Platform

Panopto and Bridge are software packages, which have allowed creation and storage of video lectures. These can be accessed via this platform.

https://heeoe.hee.nhs.uk/blended-learning-platform

Professional Support and Well-being Service

We really want you to enjoy your core training time with us, but life doesn't always go to plan! If there are personal circumstances which you are happy to share with your supervisor/college tutor or TPD, we would endeavour to put in place support systems for you if we are able to. We have a professional support and well-being service, and you can be referred by your clinical or educational supervisor, college tutor, or TPD. You can self refer as well. https://heeoe.hee.nhs.uk/psw/east-england-professional-support-and-wellbeing-service

Less than Full Time

As a part of HEE's work to Enhance Junior Doctors Working Lives several initiatives have been developed with partners to increase flexibility within Post Graduate Medical Education. Please contact us as early as possible if you would like to work less than full time.

Trainees may apply for LTFT under the following categories:

Category 1 (Responsibility for caring for children / Health related reasons / Direct carer for ill/disabled partner, relative or dependent)

Category 2 (Unique opportunity for Professional development / Short term extraordinary responsibility Religious commitment / Other)

Category 3 (Trainees who choose to train LTFT as a personal choice)

There is a 12-week notice. Therefore, the application must be approved 12 weeks before the start date. Please note it can take up to 28 working days to process your application, so please do not delay submitting your LTFT application form.

https://heeoe.hee.nhs.uk/faculty-educators/less-full-time-training