Sub-specialty Training in Pre-hospital Emergency Medicine

Good Medical Practice
- Working in Emergency Medical Systems
- Providing pre-hospital Emergency Medical Care
- Supporting emergency preparedness and response
- Supporting rescue and extrication
- Supporting safe patient transfer
- Using pre-hospital equipment

A guide for trainees, trainers, local education providers, employers and deaneries

Intercollegiate Board for Training in Pre-hospital Emergency Medicine
Pre-hospital Emergency Medicine involves providing immediate medical care in what is often a resource limited and physically challenging setting. Add to this the combination of time pressure, a medical emergency and an unfamiliar multi-disciplinary team and one wonders why any healthcare professional would seek to immerse themselves in this area of clinical practice. Yet over many years, a surprising number of doctors have, largely on a voluntary and altruistic basis, chosen to do so. Many of them regard the opportunity to support their local ambulance services and provide medical care in some of the most dangerous, distressing and challenging circumstances as both a privilege and, perhaps more importantly, a truly professional endeavour. In their desire to improve the quality and safety of their care, they have pioneered programmes of education and training, developed highly sophisticated operational services and championed the creation of postgraduate diplomas and professional bodies. Their drive and spirit is encapsulated in the introduction to the Pre-hospital Trauma Life Support Course:

“Our patients did not choose us. We chose them. We could have chosen another profession, but we did not. We have accepted responsibility for patient care in some of the worst situations: when we are tired or cold; when it is rainy and dark; when we cannot predict what conditions we will encounter. We must either embrace this responsibility or surrender it. We must give to our patients the very best care that we can - not while we are daydreaming, not with unchecked equipment, not with incomplete supplies and not with yesterday’s knowledge.”

In 1994, one of those doctors, now a Professor of Emergency Medicine, challenged our thinking in this area of clinical practice. He wrote: “It needs to progress from a group of enthusiasts of varying qualifications and standards to a fully fledged specialty.” It has perhaps taken longer than anticipated but we are pleased to report that the fully fledged specialty (or sub-specialty) has now arrived. What we hope will follow is a new generation of doctors who will benefit from even better access to structured and organised training and a career framework for clinical practice. In turn, our patients will continue to be assured of the highest possible standards of care.

We thank all of those who have contributed to this achievement and dedicate this first edition of the Guide and Curriculum to Professor Myles Gibson, who laid the foundations of Pre-hospital Emergency Medicine as a medical sub-specialty through the creation of the Faculty of Pre-hospital Care.

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1 Pre-hospital Trauma Life Support Committee of the National Association of Emergency Medical Technicians in co-operation with the Committee on Trauma of the American College of Surgeons. PHTLS: Pre-hospital Trauma Life Support (Seventh Edition). Mosby JEMS Elsevier, St Louis, 2011.
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Associated documents

Curriculum Framework and Assessment Blueprint for Pre-hospital Emergency Medicine
SECTION 1.
INTRODUCTION TO PRE-HOSPITAL EMERGENCY MEDICINE
1.1 INTRODUCTION

1.1.1 This Guide describes the curriculum, training and assessment processes for Pre-hospital Emergency Medicine (PHEM) sub-specialty training. It reflects the General Medical Council (GMC) standards and the UK wide regulations for specialty training (the Gold Guide). Where there are differences between the four UK national agencies, the parts of the Gold Guide applicable to these agencies should be regarded as the definitive guidance.

1.1.2 PHEM was approved by the GMC as a medical sub-specialty of the existing specialties of Emergency Medicine and Anaesthetics on 20 July 2011. The processes described in this Guide apply to PHEM training programmes and trainees entering PHEM sub-specialty training from 1 August 2012.

1.1.3 The PHEM sub-specialty approval process involved a wide range of services, providers and professional bodies. This Guide represents consensus from NHS, independent sector, defence medical services and third sector pre-hospital education and provider organisations across the UK and condenses many years of educational and operational experience. It reflects the real world challenges of training doctors to deliver high quality and safe emergency medicine in the hazardous, environmentally challenging and safety critical pre-hospital environment. It has evolved from the following documents, all of which are available from the Intercollegiate Board for Training in Pre-hospital Emergency Medicine:

- Pre-hospital and Retrieval Medicine: A new medical sub-specialty (16 June 2008).
- Application for approval in principle for the introduction of the new sub-specialty of Pre-hospital Emergency Medicine: GMC Step 1 Application (18 October 2010).
- Sub-specialty Training in Pre-hospital Emergency Medicine: Supplementary guidance following consultation (7 February 2011).

1.2 THE INTERCOLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

1.2.1 PHEM training is supervised by the Intercollegiate Board for Training in Pre-hospital Emergency Medicine (IBTPHEM) on behalf of:

- The Royal College of Surgeons of Edinburgh (Faculty of Pre-Hospital Care)
- The College of Emergency Medicine
- The Royal College of Anaesthetists
- The Royal College of General Practitioners

1.2.2 The IBTPHEM is responsible for determining the duration, content and assessment of training and, in collaboration with the Deaneries and Colleges, managing the quality of training. This guide reflects the current recommendations of the IBTPHEM and is intended to assist trainees, trainers, local education providers, employers, Colleges and Deaneries in managing sub-specialty training. The terms of reference of the IBTPHEM and its committees are provided at Annex A.

1.2.3 The IBTPHEM website (www.ibtphem.org.uk) provides useful additional information for trainees, trainers and the public. The most up-to-date versions of this Guide, the curriculum framework, the assessment system and the associated workplace based assessments are available from the website.

1.2.4 The IBTPHEM encourage feedback regarding this guide, the associated curriculum framework and any aspect of PHEM sub-specialty training.

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1.3 WHAT IS PRE-HOSPITAL EMERGENCY MEDICINE?

1.3.1 The term ‘pre-hospital care’ covers a wide range of medical conditions, medical interventions, clinical providers and physical locations. Medical conditions range from minor illness and injury to life threatening emergencies. Pre-hospital interventions therefore also range from simple first aid to advanced emergency care and pre-hospital emergency anaesthesia. Care providers may be lay first responders, ambulance professionals, nurses or physicians of varying backgrounds.

1.3.2 All of this activity can take place in urban, rural or remote settings and is generally mixed with wider out-of-hospital and unscheduled care. The complexity of unscheduled and urgent care provision is illustrated in figure 1.1. Another useful way to conceptualise this breadth of clinical providers is to use the levels of practice described in the Skills for Health Career Framework for Health (figure 1.2).

1.3.3 Sub-specialist PHEM practice relates to the Primary Scene Transfer and Secondary Emergency Transfer functions highlighted in figure 1.1 at the level of the Consultant (level 8) practitioner illustrated in figure 1.2. PHEM relates to that area of medical care required for seriously ill or injured patients before they reach hospital (on-scene) or during emergency transfer to or between hospitals (in-transit). It represents a unique area of medical practice which requires the focused application of a defined range of knowledge and skills to a level not normally available outside hospital.

1.3.4 There is a long established tradition of provision of voluntary and charitable emergency pre-hospital care by physicians in the UK. Building on the success of these individuals and services, the aspiration of the IBTPHEM is that each NHS Ambulance Service should have consistent immediate access to deployable sub-specialist PHEM services 24 hours a day. Other key drivers for the development of PHEM as a medical sub-specialty are:

(a) to meet existing demand for on-scene and in-transit medical support (sometimes referred to as pre-hospital ‘enhanced care’),

(b) to improve the quality and standards of pre-hospital critical care,

(c) to improve equity of access to on-scene and in-transit medical support,

(d) to improve governance of pre-hospital care and inter-hospital transfer services,

(e) to support the Care Quality Commission essential standards for quality and safety in pre-hospital care,

(f) to improve professional training and development of pre-hospital personnel,

(g) to provide a robust medical incident response (MERIT) capability and,

(h) to provide medical leadership for pre-hospital care services and providers.

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1 Direction of Travel for Urgent Care: a discussion document. Department of Health, October 2006
4 See http://www.skillsforhealth.org.uk/page/career-frameworks
13 As defined within the Medical Leadership Competency Framework available at www.institute.nhs.uk
Figure 1.1. Conceptual model of effective urgent care. Adapted from: Direction of Travel for Urgent Care: a discussion document. Department of Health, October 2006.

More senior level (e.g. clinical director)
Consultant practitioner level
Advanced practitioner level
Senior / Specialist practitioner level
Registered practitioner level
Associate / Assistant practitioner level
Senior healthcare assistant / Technician level
Support worker level
Initial entry level

Figure 1.2. Skills for Health Career Framework
1.3.5 The IBTPHEM estimates that ten full-time equivalent (FTE) sub-specialist consultants would be required per region to achieve the aspirations of the sub-specialty. However, many regions encompass large populations and/or geographical areas and distinct PHEM services may be justified in several parts of the UK (perhaps more closely aligned to Major Trauma Centre outreach and retrieval services or Air Ambulance Services than to regional NHS Ambulance Services). Workforce estimates are therefore based on 200 to 250 FTE consultants in PHEM across the UK. Given that all will have at least a 50% commitment to their base specialty, this FTE would relate to a head count of 600 to 750 sub-specialty trained doctors nationally.

1.3.6 The development of this cadre of sub-specialty trained doctors should not be regarded as diminishing or de-emphasising the importance of individuals (including non-specialist medical practitioners and allied health professionals such as paramedics and nurses) continuing to provide clinical service at different levels of the Skills For Health framework. Instead, the sub-specialty is a mechanism by which this area of medical activity can be aligned with other areas of specialist medical practice and existing practitioners can be better supported. The IBTPHEM also believes that, by addressing the key drivers in paragraph 1.3.4, the sub-specialty will result in strong medical leadership within all areas of pre-hospital clinical practice and help to substantially develop services and standards across all levels of pre-hospital care.

1.3.7 The NHS Ambulance Services in the UK deploy state registered paramedics. The College of Paramedics, together with the Health Professions Council, is developing the concept of specialist paramedics with a defined range of pre-hospital critical care knowledge and skills (referred to as Critical Care Paramedics). Multi-professional teams already work in many areas of specialist clinical and critical care and the combination of doctors and paramedics working closely together in pre-hospital care has been associated with effective operational services and good outcomes. The IBTPHEM supports the further development of sub-specialist paramedic practitioners to enhance and support the delivery of PHEM.

1.4 WHAT IS THE ROLE OF A SPECIALIST IN PRE-HOSPITAL EMERGENCY MEDICINE?

1.4.1 PHEM encompasses the underpinning knowledge, technical skills and non-technical (behavioural) skills required to provide safe pre-hospital critical care and safe transfer.

1.4.2 ‘Pre-hospital’ refers to all environments outside an emergency department resuscitation room or a place specifically designed for resuscitation and/or critical care in a healthcare setting. It usually relates to an incident scene but it includes the ambulance environment or a remote medical facility. Implicit in this term is the universal need, for this specific group of patients, for transfer to hospital. Although a component of urgent and unscheduled care (figure 1.1), PHEM practice relates to a level of illness or injury that is usually not amenable to management in the community setting and is focused on critical care in the out-of-hospital environment.

1.4.3 ‘Critical care’ refers to the provision of organ and/or system support in the management of severely ill or injured patients. It is a clinical process rather than a physical place and it requires the application of significant underpinning knowledge and technical skills to a level that is not ordinarily available outside hospital. Hospital based critical care is typically divided into three levels: Level three (intensive care areas providing multiple organ and system support), level two (high dependency medical or surgical care areas providing single organ or system support) and level one (acute care areas such as coronary care and medical admission units). In the context of PHEM, all three levels of critical care may be required depending on the needs of the patient. In practical terms, the critical care interventions undertaken outside hospital more closely resemble those provided by hospital emergency departments, intensive care outreach services and inter-hospital transport teams.

14 www.collegeofparamedics.co.uk
1.4.4 ‘Transfer’ refers to the process of transporting a patient whilst maintaining in-transit clinical care. A distinction between retrieval and transport (or transfer) is sometimes made on the basis of the location of the patient (e.g. scene or hospital) and the composition or origins of the retrieval or transfer team. Successful pre-hospital emergency medical services in Europe, Australasia and North America have recognised that many of the competences required to primarily transport critically ill or injured patients from the incident scene to hospital are the same as those required for secondary intra-hospital or inter-hospital transport. In this guide, and the associated PHEM curriculum, the term ‘transfer’ means the process of physically transporting a patient whilst maintaining in-transit clinical care.

1.4.5 The IBTPHEM has consulted a wide range of individuals and organisations regarding the scope of practice of sub-specialist practitioners. Consensus has been reached: The sub-specialist in PHEM must be capable of providing at-scene and in-transit clinical care to a level commensurate with independent consultant practice at level 8 on the Skills for Health framework. To achieve this, they must have fulfilled the requirements for specialist registration (i.e. CCT or CESR) in a relevant acute specialty (in the first instance, and for the purposes of this guide, Emergency Medicine or Anaesthetics) and have developed and demonstrated additional competence across the spectrum of activities that constitute the clinical practice of PHEM. These additional competences are described in detail in section 2. They include:

(a) Good Medical Practice
(b) Working in emergency medical systems
(c) Providing pre-hospital emergency medical care
(d) Using pre-hospital equipment
(e) Supporting rescue and extrication
(f) Supporting safe patient transfer
(g) Supporting emergency preparedness and response
(h) Operational practice
(i) Team Resource Management
(j) Clinical Governance

1.4.6 A sub-specialist in PHEM, as defined above, should be capable of fulfilling a number of career or employment roles which include, for illustrative purposes, provision of on-scene, in-transit and/or on-line (telephone or radio) medical care in support of PHEM service providers such as:

(a) NHS Acute Hospitals (particularly regional specialist hospitals with an outreach and transfer capability);
(b) NHS Ambulance Trusts (e.g. as part of regional Medical Emergency Response Incident Teams (MERIT) or their equivalent);
(c) The Defence Medical Services;
(d) Non-NHS independent sector organisations such as immediate care schemes, air ambulance charities, event medicine providers and commercial ambulance and retrieval services.

1.4.7 The PHEM sub-specialist practitioner role is uniquely challenging. The tempo of decision making, the hazards faced at incident scenes, the relatively unsupported and isolated working conditions, the environmental challenges, the resource limitations and the case mix all make this a very different activity compared to in-hospital Emergency Medicine and Anaesthetic practice. The remainder of this guide describes the training structure, curriculum framework and assessment system to ensure that that individuals undertaking this role are properly equipped to face the challenges.
1.5 EXPANSION OF PRE-HOSPITAL EMERGENCY MEDICINE SUB-SPECIALIST PRACTICE

1.5.1 PHEM is currently a sub-specialty of Emergency Medicine and Anaesthesia. The curriculum framework and assessment system have therefore been designed to complement and enhance core specialty training in Emergency Medicine and Anaesthesia. This guide should therefore be considered in the context of the current approved curricula and training management infrastructure for Emergency Medicine and Anaesthesia.\textsuperscript{15,16}

1.5.2 The IBTPHEM has always aimed to expand the range of specialties in which a certificate of completion of sub-specialty training in PHEM can be awarded. The Curriculum Committee is currently working with the GMC to develop applications for PHEM to be a sub-specialty of the CCT specialties of Intensive Care Medicine, Acute Internal Medicine, Paediatrics and some relevant surgical specialties. It is anticipated that these applications will be completed in time to allow entry into sub-specialty training in August 2013.

1.5.3 A parallel process is underway with respect to individuals within the CCT specialty of General Practice (GP). The existing regulatory framework and the current proposed changes in GP training make this a complex process. GPs in training should contact the Curriculum Committee or access the IBTPHEM website to obtain further information.

1.5.4 There is currently no regulatory mechanism for the award of a Certificate of Equivalence of Specialist Registration (CESR) for a sub-specialty. The Faculty of Pre-hospital Care is therefore, in collaboration with the GMC and the IBTPHEM, developing a process by which CCT or CESR holders in any specialty, including General Practice, may apply for recognition of their experience and Faculty Accreditation as a Consultant (level 8) Practitioner in PHEM. Existing practitioners should contact the Faculty or access the IBTPHEM website for further information on this process.

\textsuperscript{15} Curriculum and Assessment Systems For Core Specialty Training ACCS CT1-3 & Higher Specialty Training ST4-6. College of Emergency Medicine, May 2010.

\textsuperscript{16} Curriculum for a CCT in Anaesthetics, Edition 2, Version 1.1. The Royal College of Anaesthetists, August 2010
SECTION 2.
THE PRE-HOSPITAL EMERGENCY MEDICINE CURRICULUM
2.1 PURPOSE OF CURRICULUM

2.1.1 The curriculum defines the objectives, content, outcomes and process of training and the competences needed in order to be recommended for a certificate of completion of PHEM sub-specialty training.

2.1.2 As a sub-specialty of Emergency Medicine and Anaesthetics, the PHEM curriculum has been closely mapped to the current curricula for these core CCT specialties. This ensures that it is complementary and covers the additional discrete areas of underpinning knowledge and technical skill required of the PHEM specialist.

2.1.3 The trainee in PHEM will enter sub-specialty training with a relatively high level of medical expertise in Emergency Medicine and Anaesthetics (see section 3) but with potentially little or no experience of how to apply that expertise in the pre-hospital environment. The challenge of curriculum development has been how to balance the knowledge and skills of the in-hospital Emergency Physician or Anaesthetist with the needs of the critically ill patient in the pre-hospital environment.

2.2 CURRICULUM DEVELOPMENT

2.2.1 The curriculum presented in this guide was developed over a considerable time period using consensus development processes with trainees, other healthcare professionals and PHEM practitioners. The development process is described in detail in Annex B. The derived curriculum relates to what should be expected of a newly ‘qualified’ consultant in PHEM across the four nations of the UK.

2.2.2 The Curriculum framework is illustrated schematically in figure 2.1. It comprises six sub-specialty specific and four cross-cutting themes. ‘Themes’ are over-arching areas of PHEM professional practice. The framework diagram illustrates the central importance of Good Medical Practice and the relationship between the cross-cutting generic themes of Operational Practice, Team Resource Management and Clinical Governance to the six specialty specific themes. The diagram also emphasises the inter-relationship of all themes – none stands alone.

2.3 CURRICULUM CONTENT

2.3.1 Within each theme are a number of discrete work roles or activities which are referred to as ‘units’. Each unit contains grouped or related ‘elements’ of underpinning knowledge, technical skill and behavioural attribute or non-technical skill – otherwise referred to as ‘competences’. These elements are described in detail within the full version of the Curriculum Framework and Assessment Blueprint for Pre-hospital Emergency Medicine (the Curriculum). The ten themes and their composite units are described below.

2.3.2 Cross-cutting theme - Good Medical Practice (GMP)

Good Medical Practice (GMP) is the term given to the core ethical guidance provided to doctors by the GMC. GMP sets out the principles and values on which good practice is founded; these principles together describe medical professionalism in action. The seven sections of GMP have, together with other GMC guidance on confidentiality, management and research, been distilled into four domains and 12 attributes – all of which are central to the clinical practice of PHEM. The units or attributes within the four GMP domains are listed below. The standards associated with these attributes are derived from GMC guidance documents and are listed in further detail in the Curriculum. In all subsequent themes within the Curriculum Framework, relevant GMP domains are assigned to each group of elements. This assignment ensures that the assessment tools used for those particular groups of elements incorporate the relevant aspect of GMP (see section 4).
1. Knowledge skills and performance
   1.1 Maintain your professional performance
   1.2 Apply knowledge and experience to practice
   1.3 Keep clear, accurate and legible records

2. Safety and quality
   2.1 Put into effect systems to protect patients and improve care
   2.2 Respond to risks to safety
   2.3 Protect patients and colleagues from any risk posed by your health

3. Communication, partnership and teamwork
   3.1 Communicate effectively
   3.2 Work constructively with colleagues and delegate effectively
   3.3 Establish and maintain partnerships with patients

4. Maintaining Trust
   4.1 Show respect for patients
   4.2 Treat patients and colleagues fairly and without discrimination
   4.3 Act with honesty and integrity

Figure 2.1. Schematic representation of the PHEM Curriculum Framework.

2.3.3 Cross-cutting theme A. Operational Practice
Maintaining safe and effective operational practice is a generic or cross-cutting theme of professional practice within PHEM. This theme concerns the knowledge, skills and non-technical skills required to maintain safe and effective operational practice within a pre-hospital emergency medicine service provider. The units within this theme are:

A.1 Apply the curriculum framework to local operations
A.2 Respond to incidents by road
A.3 Respond to incidents by air
A.4 Utilise telecommunications and voice procedure
A.5 Apply principles of dynamic risk assessment at incident scenes
A.6 Provide scene management
A.7 Maintain records
A.8 Apply infection prevention and control principles and procedures
A.9 Apply moving and handling principles and procedures
A.10 Apply principles of Equality and Diversity
2.3.4 Cross-cutting theme B. Team Resource Management

Contributing to effective Team Resource Management is a generic or cross-cutting area of professional practice within PHEM. This theme concerns the knowledge, skills and non-technical skills required to work as part of a multi-disciplinary team in the high hazard, resource limited, environmentally challenging and time pressured pre-hospital environment. The units within this theme are:

- B.1 Understand human factors and their role in patient and team safety
- B.2 Maintain situational awareness
- B.3 Understand and apply principles of decision making
- B.4 Communicate effectively
- B.5 Employ effective team working
- B.6 Demonstrate leadership and followership
- B.7 Manage stress and fatigue
- B.8 Understand and apply principles of error investigation and management

2.3.5 Cross-cutting theme C. Clinical Governance

Application of clinical governance principles and techniques is a generic or cross-cutting area of professional practice within PHEM. This theme concerns the knowledge, skills and non-technical skills required to ensure that clinical governance principles and mechanisms are applied to clinical practice. The units within this theme are:

- C.1 Understand and apply principles of clinical governance as applied to pre-hospital practice
- C.2 Manage and support continuous professional development
- C.3 Utilise clinical evidence to support clinical practice
- C.4 Utilise and prepare documents that guide practice
- C.5 Support and apply clinical audit
- C.6 Understand and apply organisational risk management processes
- C.7 Support training and development
- C.8 Understand and apply quality management processes

2.3.6 Specialty theme 1. Working in emergency medical systems

Specialist practitioners in PHEM operate within wider Emergency Medical Services (EMS) Systems. These systems have a number of inter-dependent components. Having an understanding of these components, the way in which they interact and the wider regulatory framework surrounding them is essential to effective professional medical practice in this field. The units within this theme are:

- 1.1 Understand Emergency Medical Services (EMS) Systems models and components
- 1.2 Understand pre-hospital operational environments
- 1.3 Understand the training and regulation of pre-hospital healthcare personnel
- 1.4 Understand the process of ambulance emergency call handling, prioritisation, dispatch categorisation and resource management
- 1.5 Understand the role of pre-hospital emergency medical services within EMS
- 1.6 Understand the law relevant to Pre-hospital Emergency Medicine practice
- 1.7 Work effectively with emergency services
- 1.8 Work effectively with acute hospital services
- 1.9 Provide EMS clinical advice, support and co-ordination
- 1.10 Understand the pre-hospital and acute sector management structures within the wider healthcare system
2.3.7 Specialty theme 2. Providing Pre-hospital Emergency Medical Care

Sub-specialist training in PHEM currently commences after completion of ST4 in Emergency Medicine or Anaesthesia (see section 3). Trainees therefore have experience of emergency clinical care in the hospital environment. The established principles and techniques used in those settings often need to be modified for effective pre-hospital emergency use. In addition, the provision of emergency medical care in a relatively unsupported environment requires a greater in-depth knowledge of resuscitation in all age groups. The units within this theme reinforce resuscitation concepts learned during higher specialist training and relate them to the pre-hospital operational environment. The units within this theme are:

2.1 Assess patients in the pre-hospital phase
2.2 Provide immediate pre-hospital clinical care
2.3 Provide cardiopulmonary resuscitation in the pre-hospital environment
2.4 Manage acute medical emergencies in the pre-hospital environment
2.5 Manage injury in the pre-hospital environment
2.6 Provide analgesia, procedural sedation and anaesthesia in the pre-hospital environment
2.7 Manage obstetric emergencies in the pre-hospital environment
2.8 Manage the newborn in the pre-hospital environment
2.9 Manage injured or ill children in the pre-hospital environment
2.10 Manage the bariatric patient in the pre-hospital environment
2.11 Manage elderly patients in the pre-hospital environment
2.12 Manage acute behavioural disturbance in the pre-hospital environment
2.13 Manage chemical, biological and radiological emergencies
2.14 Provide end-of-life care and immediate management of bereavement

2.3.8 Specialty theme 3. Using Pre-hospital Equipment

Pre-hospital and in-transit emergency care requires use of a wide range of medicines, devices and portable equipment. Practitioners must be competent in both the application and operation of specific equipment items and the principles underlying their function and design. The units within this theme are:

3.1 Apply equipment governance principles and practice
3.2 Understand and use personal protective equipment
3.3 Operate all types of commonly used pre-hospital emergency medical device
3.4 Operate common non-medical pre-hospital equipment
3.5 Manage and administer medicines

2.3.9 Specialty theme 4. Supporting Rescue and Extrication

Pre-hospital emergency medical services are frequently targeted at patients who, because of physical entrapment, physical geography or functional geographic constraints, cannot just be taken to the nearest appropriate hospital. This competence theme focuses on the underpinning knowledge, technical skills and non-technical skills required to manage a trapped patient and effectively interact with professional rescue service personnel at common pre-hospital rescue situations. The units within this theme are:

4.1 Work within the rescue environment
4.2 Understand entrapment
4.3 Support extrication
4.4 Clinically manage the trapped patient
2.3.10 Specialty theme 5. Supporting Safe Patient Transfer
This theme covers the competences required to make destination hospital triage decisions, select the most appropriate transport platform, provide safe, effective and focused in-transit critical care and ensure that the patients’ condition and immediate needs are communicated to receiving hospital clinical staff. As with other competence themes, many of the elements are common across all clinical services. The constituent units within this theme are:

5.1 Understand the concepts underpinning transfer medicine
5.2 Understand the applied physiology of patient transfer
5.3 Co-ordinate and plan patient transfer
5.4 Prepare patients for transport
5.5 Utilise a range of patient transport modalities
5.6 Clinically manage patients during transport

2.3.11 Specialty theme 6. Supporting Emergency Preparedness and Response
This theme encompasses the competences required to ensure that practitioners are appropriately prepared and equipped for larger scale emergency incidents in terms of their understanding of emergency planning and the principles of major incident management. The units within this theme are:

6.1 Understand principles of emergency preparedness, response and recovery
6.2 Respond to emergencies at operational (bronze) level
6.3 Respond to emergencies at tactical (silver) level
6.4 Understand the psychosocial and mental health aspects of multiple casualty incidents

2.3.12 The full curriculum framework, detailing the elements of underpinning knowledge, technical skill and non-technical skill is provided in the Curriculum, available as a separate document.

2.4. LEARNING METHODS
2.4.1 The curriculum framework tables presented in the Curriculum define each element of knowledge, technical skill and non-technical skill and relate these to:
   (a) The relevant GMP domain – to ensure that the assessment tools used for those particular groups of elements incorporate the relevant aspect of GMP
   (b) The phase of training (see section 3)
   (c) Recommended assessment methods (see section 4)
   (d) Recommended learning methods

2.4.2 The recommended learning methods have been adapted from established learning methods within the specialties of Anaesthetics and Emergency Medicine. They are described in table 2.1. These were applied during prototype Faculty of Pre-hospital Care PHEM Training Fellowships. They were then further adapted according to the feedback provided by trainees, trainers and local education providers.18

2.4.3 Trainees in PHEM will be experienced adult learners with differing learning styles. The list of recommended learning methods should therefore be tailored to the individual. The list is not exhaustive but is to serve as a guide for trainers and trainees.

2.4.4 The IBTPHEM provides, through its Training Committee, training and guidance for trainers in relation to supporting these learning methods (see section 5).

18 Sub-specialty Training in Pre-hospital Emergency Medicine. Supplementary guidance following consultation. 7 February 2011
### 2.5 IMPLEMENTATION AND MANAGEMENT OF CURRICULUM

#### 2.5.1 The curriculum framework and associated guidance is available from the IBTPHEM and its constituent Colleges. Postgraduate Deaneries who wish to implement the curriculum should consult the IBTPHEM to ensure that lessons identified from prototype training programmes can be shared.

#### 2.5.2 The IBTPHEM is responsible for curriculum review via its Curriculum Committee. The curriculum will be monitored and formally reviewed after one year of implementation (i.e. by 31 July 2013) and thereafter on a two yearly cycle. The curriculum will indicate the date of formal review and document version.

#### 2.5.3 The IBTPHEM encourages all involved in implementing and using the curriculum to provide active feedback to inform the review process. It will aim to take into account new clinical and service developments, reports from sources such as trainees, educational supervisors, programme directors, Deaneries, local education providers (LEPs), and patients.

#### 2.5.4 The GMC must approve any significant changes to the curriculum before they are implemented.

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**Table 2.1. Recommended learning methods**

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directed Reading (DR)</td>
<td>Reading recommended texts, journal articles and monographs (whether available online or offline)</td>
</tr>
<tr>
<td>Lectures and Tutorials (LT)</td>
<td>Use of lectures, small group teaching and tutorials (including practical skills sessions) where the learning is moderated by the teacher</td>
</tr>
<tr>
<td>Deliberate Practice (DP)</td>
<td>The repeated execution of a skill or task (without having to have a mentor present)</td>
</tr>
<tr>
<td>Simulation Learning (SL)</td>
<td>The simulation (at any level of fidelity and reality) of a situation in order to attain pre-determined learning objectives (e.g. simulated patients, simulated incident scenes, use of models, tabletop exercises)</td>
</tr>
<tr>
<td>Reflective Practice (RP)</td>
<td>Reflection upon past events to critique performance and so guide further development</td>
</tr>
<tr>
<td>Role Modeling (RM)</td>
<td>Role modeling is a process that allows trainees to learn new behaviours without the trial and error of doing things for themselves</td>
</tr>
<tr>
<td>Collaborative Learning (CL)</td>
<td>Learning from peers through discussion of situations, cases or concepts</td>
</tr>
<tr>
<td>Experiential Learning (EL)</td>
<td>Observation of or participation in events experienced by the learner</td>
</tr>
</tbody>
</table>

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SECTION 3.
TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE


3.1 TRAINING OVERVIEW

3.1.1 Sub-specialty training in PHEM takes place in the context of UK wide specialty training in Emergency Medicine and Anaesthetics. The relationship between LEPs, Postgraduate Deaneries, the IBTPHEM and the specialties of Emergency Medicine and Anaesthetics is illustrated in figure 3.1.  

3.1.2 It is recommended that trainees who might be interested in PHEM but who have had little previous exposure to the sub-specialty consult their nearest Postgraduate Deanery PHEM Training Programme Director or LEP for details of opportunities to observe PHEM services or otherwise gain some experience of the operational environment and clinical practice. Details of the Deaneries and LEPs that offer sub-specialty training programmes in PHEM can be obtained from the IBTPHEM.  

3.1.3 The PHEM trainee is required to undertake a minimum of 12 months whole time equivalent sub-specialist training in PHEM (in approved PHEM training posts) and successfully complete the required formative and summative assessments in order to be recommended for a certificate of completion of PHEM sub-specialty training.  

3.1.4 Training in PHEM may be undertaken before or after completion of the core CCT programme in Emergency Medicine or Anaesthetics. For trainees who are pre-CCT, PHEM training is undertaken after the fourth year of specialty training (ST4). For post-CCT trainees, PHEM training may be undertaken at any stage.

![Figure 3.1 Quality framework for PHEM training and relationships between LEPs, the IBTPHEM, the Colleges, the Postgraduate Deaneries and the GMC.](image)

3.2 STRUCTURE OF TRAINING

3.2.1 For pre-CCT trainees, Deaneries and LEPs are able to design training programmes that integrate the recommended minimum 12 months whole time equivalent PHEM training into core specialty training. Although there are many possible ways of integrating PHEM sub-specialty training with core CCT training, the IBTPHEM recommend one of three options.

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19 Quality framework for specialty including GP training. General Medical Council, April 2010
(a) a 24 month period of PHEM training blended with core CCT training (Scheme A) – figure 3.2
(b) a 24 month period of alternating 6 month blocks of sub-specialty PHEM and core CCT training (Scheme B) – figure 3.2
(c) a 12 month period of PHEM training inserted into core CCT training (Scheme C) – figure 3.3

3.2.2 Scheme A comprises four six month posts which each provide a blended mixture of PHEM and core specialty training that in total gives 12 months of PHEM training and 12 months of core specialty training over 24 months. This blending is achieved by proportionally splitting the PHEM and core CCT training in a way that is complimentary. Figure 3.2 illustrates the proportional split that has been found to be most successful. Experience has also shown that two ‘paired’ trainees are required for LEPs to effectively deliver Scheme A. Trainees must commence scheme A with the majority of time allocated to PHEM training.

3.2.3 Scheme B comprises alternating six month posts within PHEM and the core CCT specialty of the trainee. Scheme B may fit more conveniently with core CCT training placement rotations but the gap between phases 1 and 2 may compromise PHEM training and, in contrast to Scheme A training, this model of training has not been piloted. Nonetheless, Scheme B illustrates another way of achieving 12 months whole time equivalent PHEM training.

3.2.4 Scheme C comprises two full-time six month posts undertaken outside of core specialty training. Scheme C is the preferred model for post-CCT trainees. Scheme C is illustrated in figure 3.3.
3.2.5 All PHEM training programmes will take place after ST4 and should be expected to extend core specialty training by one year (figure 3.4). Experience gained through prototype Training Fellowships has suggested that a blended model of training delivery (Scheme A) is the preferred model for pre-CCT trainees with little or no previous PHEM experience as it allows more time for PHEM competences to develop and embed whilst retaining core specialty training experience. It also more closely reflects the future sub-specialist working pattern of a consultant in PHEM.

3.2.6 Those with a CCT in either Emergency Medicine or Anaesthetics who meet the person specification will be able to apply competitively for a training grade post in PHEM. Trainees on this pathway are likely to undertake 12 months full-time training (scheme C).

3.3 PHASES OF TRAINING

3.3.1 All training programmes, regardless of which scheme is followed, will comprise three distinct phases of whole time equivalent (WTE) training:

(a) Phase 1(a) – Initial training
(b) Phase 1(b) – Development training
(c) Phase 2 – Consolidation training
 SECTION 3. TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

3.3.2 In a 12 month WTE programme, phase 1(a) would typically last 1 month, phase 1(b) would typically last 5 months and phase 2 would typically last 6 months. For those in a Scheme A training programme, the phases last slightly longer in proportion to the amount of PHEM being undertaken: for example, an 80% PHEM programme, phase 1(a) would last 4 to 6 weeks. Progression from one phase to the next relies upon successful assessment (see section 4).

3.3.3 Phase 1(a) involves dedicated training to allow the trainee to operate under supervision with a LEP in phase 1(b). Throughout phase 1(a), trainees will be taught the phase 1(a) clinical knowledge and skills (as defined in the Curriculum, receive an induction with the LEP and be taught the LEP specific knowledge and skills. Much of this training will be using patient simulators with an experienced faculty, and may be provided at a regional or supra-regional level. Section 4 describes the mandatory formative assessment at the end of phase 1(a) that allows progression to phase 1(b) of training.

Figure 3.4. Comparison of PHEM training schemes and their relationship to core CCT training pathways in Emergency Medicine and Anaesthetics (ACCS route). PHEM sub-specialty training should be expected to extend core specialty training by one year. Note that non-ACCS Anaesthetic trainees are required to undertake an additional 6 months of Emergency Medicine training prior to entry to sub-specialty training (not illustrated).
3.3.4 Phase 1(b) involves directly supervised operational practice and demonstration of the phase 1(a) and 1(b) competences under close supervision. Trainees are expected to progressively become more autonomous in their practice during this phase, whilst retaining a high level of supervision. Section 4 describes the mandatory national summative assessment at the end of phase 1 that allows progression to phase 2 of training.

3.3.5 The trainee in phase 2 is expected to develop a greater depth of knowledge and improved clinical performance whilst retaining, at a more remote level, appropriate supervision. This phase may be undertaken with a different LEP to phase 1 to allow for exposure to a different case-mix or pre-hospital environment. Section 4 describes the mandatory summative assessment at the end of phase 2 that will provide information for the final Structured Training Report (STR), core CCT Annual Review of Competence Progression (ARCP) and recommendation via the IBTPHEM to the GMC regarding completion of sub-specialty training.

3.4 MANAGEMENT OF TRAINING

3.4.1 The IBTPHEM is responsible for determining the duration, content and assessment of training in PHEM. Postgraduate Deaneries who provide PHEM training programmes must comply with the GMC generic standards for training and the IBTPHEM requirements for LEPs in section 5.

3.4.2 Trainee and training programme management structures should reflect those in place for the core CCT specialties of Emergency Medicine and Anaesthetics. The Deanery must have a PHEM Regional Training Committee and a Training Programme Director who will be the trainee’s point of contact.

3.4.3 All elements of work in training posts must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure and case mix undertaken. A minimum of 20% direct supervision of trainees is expected throughout PHEM training. As training progresses the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

3.4.4 Trainees will at all times have a named Educational Supervisor and Clinical Supervisor, responsible for overseeing their education. Depending on local arrangements these roles may be combined into a single role of Educational Supervisor. The responsibilities of supervisors are as defined by the GMC and are reproduced in section 5.

3.5 ENTRY TO TRAINING

3.5.1 Recruitment to PHEM sub-specialty training will be managed nationally through a national recruitment scheme. The scheme recognises that not all regions will be able to deliver sub-specialty training and aims to:

(a) provide equity of access to approved training programmes
(b) foster fair, criterion-referenced and competitive entry to programmes
(c) support quality management of training programmes
(d) guide workforce development and planning

3.5.2 The IBTPHEM has asked the Lead Deanery (the East of England Multi-professional Deanery) to act as the co-ordinating body for national recruitment to PHEM sub-specialty training until such time as an independent specialty and sub-specialty National Recruitment Office is formed. The co-ordinating body will undertake all aspects of the recruitment process including advertising, application handling, assessment and matching of successful candidates to places.
SECTION 3. TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

3.5.3 The principle of national recruitment is that any PHEM service provider which meets, either alone or in partnership, the criteria and standards for LEPs, may become an LEP within a Deanery training programme. Any approved LEP can then offer training posts to the Deanery programme for inclusion in the national PHEM recruitment scheme. In the initial phases of sub-specialty development, LEPs may have national recruitment posts and locally organised recruitment posts within an approved programme. In the fullness of time however, it is expected that all approved training posts will be accessed via the national recruitment scheme. It is anticipated that, pending GMC approval of training programmes, this will be achieved by 2015.

3.5.4 National recruitment will be on an annual basis according to the timetable outlined in table 3.1. A detailed description of all declared national scheme posts within approved training programmes will be available to all applicants. Postgraduate Deans, Heads of Schools of Emergency Medicine and Anaesthetics, and PHEM Training Programme Directors will be provided with copies of any adverts and post/programme descriptions so that all will be fully aware of the commencement of recruitment.

<table>
<thead>
<tr>
<th>Month</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>December/January</td>
<td>PHEM Training Programme Directors and Deaneries declare the number of posts they have available for appointment in the next recruiting cycle.</td>
</tr>
<tr>
<td>January/February</td>
<td>Standard adverts will be published on the NHS jobs and IBTPHEM websites. Deaneries may also advertise on their websites.</td>
</tr>
<tr>
<td>February/March</td>
<td>Long-listing and Short-listing</td>
</tr>
<tr>
<td>March/April</td>
<td>Selection and matching process</td>
</tr>
<tr>
<td>August</td>
<td>Successful applicants commence training</td>
</tr>
</tbody>
</table>

Table 3.1. Outline timetable for national recruitment process

3.5.5 Applications will be made online using software already widely used in postgraduate training and a standardised application form based upon the national specialty registrar template. Applicants will be asked to rank all training programmes and posts they are willing to be considered for in order of preference. It is possible that on completion of the recruitment process, a successful candidate’s preferences cannot be accommodated due to them already being filled by higher ranking candidates. Applicants should be aware that they will not be offered a programme they have not expressed a preference for in their original application.

3.5.6 Long-listing will be undertaken by the co-ordinating body and will be based on the person specification and confirmation of eligibility to commence sub-specialty training. The PHEM person specification at Annex C describes the eligibility requirements. In summary:
(a) The earliest application for pre-CCT training is at ST3
(b) The earliest commencement of PHEM sub-specialty training is at the end of ST4
(c) Applicants must have been awarded core specialty NTN for Emergency Medicine or Anaesthetics
(d) Applicants must have MCEM or primary FRCA or equivalent
(e) Entry is conditional on successful ST4 ARCP

3.5.7 Short-listing, if required, will be undertaken using established processes and a short-listing panel which will include IBTPHEM and LEP representatives. All successfully shortlisted candidates will then be invited to a selection centre. The selection process will be confirmed in detail by the co-ordinating body but will typically include three ten minute stations (General interview station, Patient scenario station and Communication / team resource management station).
3.5.8 The selection centre will operate in keeping with standard national recruitment processes. Candidates will be scored using a standard framework. Appointable candidates will be ranked in order of merit. Once the final ranking has been confirmed, co-ordinating body staff will complete the matching process using the candidate’s previously declared preferences. For all appointable candidates, offers will be based on firstly where the candidate is ranked and then the candidates preference (i.e. the top ranked individual is matched to their first choice programme, the second ranked candidate if possible will receive their first choice, unless it has already been filled and so on).

3.5.9 Once offers are accepted, details of applicants will be passed on to the respective Deanery who will take over all correspondence. The co-ordinating body will provide further detailed guidance regarding the recruitment scheme (available through the IBTPHEM website).

3.5.10 The advantages of a national recruitment scheme is that it will allow trainees who wish to train in PHEM to apply in open competition for the programmes available nationally. If successful through shortlisting and selection, candidates are then matched to the programmes offered within the sub-specialty, based on the maximum appointments to be made and the candidates’ programme preferences in rank order. The scheme will therefore enable the sub-specialty to ensure that the appropriate numbers of trainees are being trained.

3.6 PROGRESSION THROUGH TRAINING

3.6.1 Progression through training is dependent upon successful completion of formative and summative assessments and evidence of satisfactory progression through the curriculum framework. On appointment to a training post in PHEM, all trainees are required to register with the IBTPHEM in order that training numbers and progression can be monitored. On enrolling with the IBTPHEM, trainees will be given access to the e-Portfolio for PHEM operated by the Faculty of Pre-hospital Care. This portfolio allows trainees and supervisors to record and view all aspects of training – duty hours, clinical cases, assessment tools etc. It will form an essential component of PHEM programme structured training reports (STRs) and the core specialty ARCP.

3.6.2 The trainee is responsible for ensuring that the e-Portfolio is kept up to date, arranging assessments and ensuring they are recorded, preparing drafts of appraisal forms, maintaining a personal development plan, recording their reflections on learning and recording their progress through the curriculum.

3.6.3 Educational supervisors and trainees should work together to provide this evidence of progression at regular meetings. The Educational Supervisor, when meeting with the trainee, should discuss issues of clinical governance, risk management and any clinical incidents involving the trainee. The Educational Supervisor should be part of the PHEM clinical specialty team. Thus if the LEP clinical directorate/clinical director has any concerns about the performance of the trainee, or where there are issues of doctor or patient safety, these can be discussed directly with the Educational Supervisor.

3.6.4 Opportunities for feedback to trainees about their performance will arise through the use of the workplace based assessments, regular appraisal meetings with supervisors, other meetings and discussions with supervisors and colleagues, and feedback from STRs and the ARCP.

3.6.5 A formal process of appraisal assists training and development, ensures adequate supervision during training, and provides feedback to trainees. All appraisals should be recorded in the PHEM e-Portfolio. The trainee and educational supervisor should have an appraisal meeting at the beginning of each post to review the trainee’s progress, agree learning objectives for the post ahead and identify the learning opportunities presented by the post using the curriculum framework. A mid-point review meeting should be conducted within each post to ensure trainees are progressing satisfactorily.
3.6.6 On completion of a placement, post or programme, trainees should review their progress with their Educational Supervisor using evidence from the PHEM e-portfolio related to their phase of training. 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 training programme director should be informed.

3.7 DURATION OF TRAINING

3.7.1 Trainees are expected to undertake a minimum of 12 months whole-time equivalent training in approved training posts. This may take place over a time period agreed with the Training Programme Director. Training time may have to be increased depending upon a trainee’s progress.

3.7.2 It is recognised that each training provider is likely to provide a slightly different clinical case mix or environment exposure. Services in large UK cities will, for example, offer different cases and challenges to services operating in a remote and rural area. For that reason, with the agreement of the Training Programme Directors and in the context of an approved programme, trainees may split their training between different LEPs.

3.8 LESS THAN FULL TIME TRAINING (LTFT)

3.8.1 Trainees are entitled to opt for less than full time training programmes in PHEM. This training shall meet the same requirements as full-time training and the Deanery shall ensure that the competences achieved and the quality of part-time training are not less than those of full-time trainees. These posts are not supernumerary and may fit easily into existing training programmes running Scheme A. Deaneries will be able to give advice on this.

3.8.2 In order to comply with GMC guidance, retain competence and acquire new knowledge and skills, LTFT trainees would still normally be expected to work a minimum of 50% of full time.

3.8.3 LTFT trainees should assume that their clinical training will be of pro-rata duration compared with the full time indicated/recommended, but this should be reviewed during annual appraisal by their Training Programme Director, Specialty Training Committee and Deanery.

3.9 COMPLETION OF TRAINING

3.9.1 Completion of training is achieved by successful completion of an approved training programme of appropriate duration combined with successful assessment as detailed in section 4 and a successful ARCP.

3.9.2 The IBTPHEM is responsible for making recommendations to the GMC regarding eligibility for inclusion of sub-specialty registration on the specialist register. The process for making such recommendations is not yet established but is likely to mirror core CCT processes.

3.10 RESEARCH

3.10.1 There is currently no specific provision for academic training within the sub-specialty program. Where appropriate, Deaneries may integrate PHEM training with the academic training program. After completion of Academic Clinical Fellow and PhD posts an ‘academic’ PHEM trainee would extend the Academic Clinical Lecturer Post from 3 years to 4 years, integrating PHEM sub-specialty training in exactly the same pattern as the sub-specialty program integrates with ST4-6 for trainees who are not in an academic training program.
SECTION 4. THE ASSESSMENT FRAMEWORK FOR PRE-HOSPITAL EMERGENCY MEDICINE
4.1 INTRODUCTION TO ASSESSMENT

4.1.1 The purpose of assessment is to:

- assist learning and development
- evaluate progress and support transition through training
- ensure achievement of necessary competence relevant to the work role
- ensure trainees possess the essential underlying knowledge, technical skills and behaviours
- assure the profession and public regarding the standards of performance
- inform trainees’ Structured Training Reports (STRs) and Annual Review of Competence Progression (ARCP), identifying any requirements for targeted or additional training where necessary and facilitating decisions regarding progression through the training programme

4.1.2 The integrated assessment system for PHEM mirrors, in many respects, the established assessment systems for Emergency Medicine and Anaesthetics. It measures progress of trainees against the curriculum for sub-specialist PHEM training and is composed of a mixture of workplace based assessments and summative phase assessments.

4.1.3 This section of the guide should be read alongside the Curriculum.

4.2 ASSESSMENT FRAMEWORK

4.2.1 The assessment framework utilises a combination of formative and summative assessment. Figure 4.1 illustrates the duration of each phase of PHEM training and the relationship between continuous workplace based assessments and end-of-phase summative assessments for both phase 1 and phase 2.

![Figure 4.1. The 2 phases of sub-specialist training in PHEM with assessment types and timings.](image)

4.2.2 Within PHEM sub-specialty training, the majority of assessment is formative and conducted within training programmes. There are however key stages in training where there is formal assessment of the knowledge, technical skills and non-technical skills assimilated at that point in training. Evidence of completion of formative and summative assessments is summarised in the trainee’s STR and will be required at ARCP. An overview of the formal assessment elements is provided in table 4.2.
4.3 FORMATIVE ASSESSMENTS

4.3.1 Formative assessments take place throughout PHEM training. Formative assessment is a supported, reflective process that aims to promote trainee learning and development. It is used to develop and support trainees as their understanding and experience increases. Trainers, peers, and other healthcare professionals can conduct formative assessments. They are, in a sense, a learning method and they relate closely to the Experiential Learning and Reflective Practice methods described in table 2.1.
4.3.2 The following assessment tools will be used throughout the entire PHEM training to support this process:

- Mini-Clinical Evaluation Exercise (CEX)
- Case-Based Discussions (CbD)
- Direct Observation of Procedural Skills (DOPS)
- Acute Care Assessment Tool (ACAT)
- Audit Assessment (AA)
- Teaching Observation (TO)
- Multi-Source Feedback (MSF)
- Full case Simulation (SIM)

4.3.3 Defining minimum numbers for formative assessments is challenging given that a number of tools can be used to assess the same elements and many elements can be assessed with one tool. The minimum number must also reflect the clinical exposure and number of duty periods working under direct supervision – some assessment tools are most effectively applied during, or soon after, provision of clinical care whilst others can be utilised at a later stage. Nonetheless, the IBTPEHM recognise the need to set a minimum number of assessments to guide trainees, trainers and Deaneries.

4.3.4 Table 4.1 shows the minimum recommended number of each assessment tool to be used over 12 month PHEM training period. The IBTPEHM believes that these minimum numbers of assessments are achievable, will adequately sample from the curriculum and will reflect the importance of direct consultant supervision and training in this discipline:

<table>
<thead>
<tr>
<th>Minimum recommended number of assessment tools used over 12 month PHEM training</th>
<th>Assessment tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEX</td>
<td>CbD</td>
</tr>
<tr>
<td>15</td>
<td>30</td>
</tr>
</tbody>
</table>

*Table 4.1 Count of formative assessments.*

4.3.5 As shown in the Assessment Blueprint, the bulk of formative assessment takes place in phase 1(b). This assessment burden is achievable because this is a phase of close supervision and the assessment tools can sample across many elements of the curriculum framework.

4.3.6 In addition to workplace based formative assessments throughout training, trainees will undergo a locally organised structured formative assessment at the end of phase 1(a). This assessment, typically 4 to 6 weeks after commencing training, is analogous to the Anaesthetic Initial Assessment of Competence at 3 months. It is intended to support the trainee in progressing to phase 1(b) and satisfy the needs of the LEP in relation to evidence of assimilation of:

- (a) phase 1(a) elements of the curriculum framework
- (b) LEP safety policies and procedures
- (c) LEP clinical policies and procedures

4.4. SUMMATIVE ASSESSMENTS

4.4.1 Summative assessment refers to the assessment of learning at a particular time. It is used to assess progression through training, support transition through training phases and confirm achievement of competences. Summative assessments are made against clear descriptors and only conducted by formally trained assessors.
4.4.2 There are three components to summative assessment within the overall assessment system:

- Ten summative workplace based assessments (WPBA) of technical and/or non-technical skills during phase 1 (DoPS).
- Two National Summative Assessments (NSA): the phase 1 NSA at the end of phase 1 and the phase 2 NSA at the end of phase 2 (1 month before the end of each phase at the earliest).
- Two Structured Training Reports which draw on the results of both formative and summative processes and are used to inform the ARCP process and determine progression through, or completion of, training.

4.4.3 The ten summative WPBA should follow the structure of the DoPS assessment tool and relate to supervised clinical encounters after the phase 1(a) formative assessment. The topics may sample from the phase 1(a) and phase 1(b) elements of the Curriculum.

4.4.4 The phase 1 NSA is a test of underpinning knowledge. It assures that sub-specialty trainees have assimilated (and can demonstrate) the relevant underpinning knowledge expected at that level of specialist training. For the phase 1 NSA, the candidate is expected to be able to apply the underpinning knowledge across all phase 1(a) and phase 1(b) elements in the Curriculum. This is equivalent to medical practice expected in later specialty training years (ST5/6). A person is eligible for the phase 1 NSA after completion of a minimum of 5 months WTE training in PHEM.

4.4.5 The phase 2 NSA consists of three individual parts named A, B and C:

- Part A: Knowledge Test
- Part B: Objective Structured Practical Examination (oSPE)
- Part C: Full case Simulation (SIM)

4.4.6 The phase 2 NSA assures that all elements of the PHEM sub-specialty curriculum framework have been assimilated and demonstrated at the level of the newly qualified independent (level 8) consultant practitioner. The candidate is therefore expected to perform to the standard expected of a newly qualified sub-specialist consultant (level 8) practitioner in PHEM. This is equivalent to independent clinical practice with high levels of underpinning knowledge, technical expertise and clinical experience across all elements of the Curriculum. A person is eligible for the phase 2 NSA after completion of a minimum of 11 months WTE training in PHEM and successful completion of the phase 1 NSA.

4.4.7 The phase 1 NSA and part A of the phase 2 NSA comprise 20 questions in the extended matched question (EMQ) format and 40 questions in the single best answer (SBA) format over two and a half hours. This will be conducted via a web-based interface at a designated assessment centre. The pass mark for the Knowledge Test will be determined in advance following a standard-setting exercise conducted by the Assessment Committee. This exercise determines the relative weighting of each question and the threshold for passing the assessment. This threshold is further modified by subtracting one Standard Error of the mean (SEM) from each sitting of the assessment. The resultant threshold is calculated as a percentage score rounded to one decimal place. Candidates’ scores will be calculated to one decimal place, with scores being rounded up.

4.4.8 Part B of the phase 2 NSA involves a 14 station Objective Structured Practical Examination (oSPE) over two and a half hours. Each station lasts 8 minutes and the assessment covers the technical skills in the Curriculum pertinent to the NSA. Note that 25% of the stations will relate to neonates, infants or children. Each station is marked out of 20 marks with the pass mark for each station being determined by the Assessment Committee prior to the assessment. The pass mark for each of the 14 stations are summed to obtain the pass mark for the whole assessment. Up to two additional stations may be included in an examination to test new questions. Neither the candidates nor the examiners will know which stations these are and the marks will not contribute to the final result.
4.4.9 Part C of the phase 2 NSA involves two full immersion high fidelity human simulations lasting 30 minutes and involving a critically injured or ill adult or child in a simulated pre-hospital setting. The simulation will be selected in advance from a range of pre-selected scenarios with standardised physiological start states and anatomical injury patterns. Equipment will also be standardised and publicised in advance. The expected clinical course will be determined by the Assessment Committee prior to the assessment and be related to specified elements of the Curriculum. Each simulation will be marked independently by two assessors using a marking sheet with specific components for underpinning knowledge, technical skills and non-technical skills relevant to the simulation and the expected clinical course. The marking sheets will indicate whether the relevant elements were demonstrated in a manner which reflected pre-determined criteria for acceptable practice, questionable practice or unsafe practice. Critical pass/fail practice will be determined in advance. Details of the marking scheme will also be published in advance.

4.4.10 Detailed regulations and guidance pertaining to summative assessment will be made available from the IBTPHEM in mid 2012. They will include:

(a) The assessment calendar.
(b) The processes and procedures for summative assessment.
(c) The fees schedule.

4.5 ASSESSMENT BLUEPRINT

4.5.1 The Assessment Blueprint is available within the separate Curriculum Framework and Assessment Blueprint document. The blueprint describes the integrated set of assessments for sub-specialty training in PHEM.

4.5.2 The assessment blueprint displays all elements of competence from the PHEM curriculum framework and describes which assessment tools can appropriately be used to assess attainment of competence in each element. Although it is expected that all competencies will be assessed, it is not expected that every recommended assessment method will be used.

4.6 ASSESSMENT TOOLS

4.6.1 Every element in the Curriculum must be assessed in one form or another. The Assessment Blueprint details the range of assessment tools recommended for each element. Appropriate assessment tools have been selected from the range already in use by the core CCT specialties of Anaesthetics and Emergency Medicine (Table 4.3).

4.6.2 A Knowledge test (KT) is a summative written assessment of underpinning knowledge using a combination of extended matched and single best answer questions (EMQ and SBA). Knowledge tests combined with selected DoPS, simulation and case based discussion, are used to support transition between phases. They are only used for summative assessment.

4.6.3 The Mini-Clinical Evaluation Exercise (CEX) evaluates a clinical encounter with a patient to provide an indication of competence in skills essential for good clinical care such as history taking, examination and clinical reasoning. The trainee receives immediate feedback to aid learning. The CEX can be used at any time and in any setting when there is a trainee and patient interaction and an assessor is available. Trainees should aim to complete a minimum of 15 CEXs during their training.

4.6.4 The Case-Based Discussion (CbD) assesses the performance of a trainee in their management of a patient or situation to provide an indication of competence in areas such as clinical reasoning, decision-making and application of knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by trainees. The CbD should focus on a written record such as written case notes. CbD is also used for assessing the more generic, and less clinical, knowledge and skills needed for effective practice. e.g. evidence based practice, maintaining safety, teamwork, clinical research methodologies etc. Trainees should aim to complete a minimum of 30 formative CbDs during their training.
4.6.5 A Direct Observation of Procedural Skills (DOPS) is an assessment tool designed to evaluate the performance of a trainee in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development. DOPS may be used for formative assessments and is used for the phase 1 workplace based summative assessments. Trainees are required to complete 10 summative DOPS in phase 1 and should aim to complete a minimum of 30 formative DOPS during their training.

4.6.6 The PHEM curriculum requires that trainees develop skills and behaviours that allow them to manage rare and critically important events. Simulated situations allow trainees skills to be tested before practicing in live situations and also for trainees to be exposed to a range of situations that would not be met in one year of training. They can be repeated as guided by the learner’s needs and performance.

4.6.7 As well as technical skills, full case simulation (SIM) is appropriate for assessment of non-technical skills such as task management, team working, situational awareness and decision-making. Simulation does not require complex technology; high fidelity situations can be achieved with low or intermediate fidelity technology. Models or manikins can be used for invasive procedures; actors can be used to assess communication and teamwork in simulated situations. PHEM simulations should be carefully structured with key learning points derived from audit and review of real life cases (‘lessons identified’). PHEM simulations should be delivered, wherever possible, within appropriate contexts, e.g. in an ambulance, in a car wreck or in the ‘hostile’ conditions frequently encountered in pre-hospital work. By using simulators for formative assessments regularly during PHEM training, trainees will become familiar with the modality and allow its successful use in summative assessments. Trainees should aim to complete 10 formative simulation assessments during their training.

4.6.8 The Acute Care Assessment Tool (ACAT) is designed to assess and facilitate feedback on a doctor’s performance across a number of domains. The ACAT is designed for use during their practice on a pre-hospital emergency medicine duty period. Any doctor who has been responsible for the supervision of the duty period
can be the assessor for an ACAT. This tool should only be used formatively. It should cover as many domains as possible. For each case, the case notes and management plan should be reviewed by the clinical supervisor/assessor before it is signed off on the ACAT form. If the assessor raises concern about the performance of a particular case, this case should be further assessed using a CEX or CbD. ACAT may only be used as a means of formative assessment. Trainees should aim to complete 25 ACAT formative assessments during their training.

4.6.9 The Teaching Observation (TO) tool is designed to provide structured, formative feedback to trainees on their competence at teaching. The Teaching Observation can be based on any instance of formalised teaching by the trainee, which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors). Teaching Observation is an acceptable form of formative assessment for complex knowledge and skills given the need for the teacher to demonstrate competence (and often mastery). Trainees should aim to complete 5 formative teaching observations during their training.

4.6.10 The Multi-Source Feedback (MSF) is a method of assessing generic skills such as communication, leadership, team working, reliability etc, across the domains of Good Medical Practice. This provides objective systematic collection and feedback of performance data on a trainee, derived from a number of colleagues. ‘Raters’ are individuals with whom the trainee works, and includes doctors, administration staff, and other allied professionals. The trainee will not see the individual responses by raters and formative feedback is given to the trainee by the Educational Supervisor. A MSF is required in each phase of PHEM training.

4.6.11 The e-Portfolio or Logbook (LOG) provides information to support the ARCP in relation to clinical case mix, operational experience and achievement of competences across the spectrum of the curriculum framework. The logbook informs the STR process and should record all educational activity, including formative and summative assessments.

4.6.12 The Patient survey (PS) addresses issues, including behaviour of the doctor and effectiveness of the consultation, which are important to patients. It is intended to assess the trainee’s performance in areas such as interpersonal skills, communication skills and professionalism by concentrating solely on their performance during one consultation. Patient surveys may be conducted by LEPs and used to inform the STR and ARCP process.

4.6.13 The Audit Assessment (AA) Tool is designed to assess a trainee’s competence in completing an audit. The Audit Assessment can be based on review of audit documentation or on a presentation of the audit at a meeting. If possible the trainee should be assessed on the same audit by more than one assessor. Audit assessments are used to inform the STR and ARCP process.

4.7 USE OF ASSESSMENT TOOLS

4.7.1 Annex E contains examples of each assessment tool. The following example illustrates how assessment tools can be used across several elements of the curriculum framework.

Case Scenario

Guy, a year 5 emergency medicine trainee, is spending a year in pre-hospital emergency medicine sub-specialty training. He has successfully completed his phase 1 training and summative assessment and is now managing patients with supervision during his phase 2 training.

It is 21:00 on a wet winter’s night and the pre-hospital team are tasked to a road traffic incident involving a car that has driven head on into a tree at 60 mph. Guy, his supervising consultant and their paramedic colleague attend the scene, treat the patient and transfer the patient to hospital.

On arriving back from the incident, Guy and his supervising consultant take the opportunity to discuss the incident and their management, and complete a CEX and a DOPS form.
### Clinical scenario observed

24 year old male, unrestrained driver of car, high speed head on collision with tree. Police, fire and ambulance services on scene. Massive deformation to vehicle, patient physically trapped due to dashboard intrusion. Severe head and facial injuries with airway compromise, shocked due to blood loss from scalp and bilateral femoral fractures. Reduced conscious level, became combative.

The patient required basic airway manoeuvres, oxygen and in line manual immobilisation of C-spine whilst in the vehicle. He is fully monitored and, to enable extrication, he receives procedural sedation and analgesia intravenously. Once extricated has a pre-hospital emergency anaesthetic, intubation and continuation of anaesthetic. His limbs are splinted. He is transferred directly to a specialist neurosurgical centre by the team, who provide neuro-protection en route.

### Curriculum elements covered

| 1.3.5 Demonstrate respect for individuals within the multi-professional workforce |
| 1.4.3 Formulate response decisions on the basis of ambulance service emergency call information |
| 2.1.9 Demonstrate ability to perform an organised, structured, relevant and focused assessment across the range of pre-hospital situations in infants, children and adults |
| 2.1.10 Demonstrate ability to accurately interpret clinical history and physical signs in the pre-hospital environment in infants, children and adults |
| 2.1.11 Demonstrate appropriate use and interpretation of pre-hospital monitoring in infants, children and adults |
| 2.1.13 Demonstrate ability to balance risk and benefits of actions prior to full patient assessment |
| 2.1.16 Demonstrates effective communication with patients and their family during clinical assessment |
| 2.2.7 Demonstrate the immediate clinical interventions for managing and supporting: |
| 2.2.9 Demonstrate ability to provide safe and effective immediate clinical care in the pre-hospital environment |
| 2.2.10 Display a calm and methodical approach to providing immediate clinical care |
| 2.5.8 Describe the immediate pre-hospital management of the following: (a) Injuries to the head, (b) Injuries to the face, (c) Injuries to the neck, (h) Injuries to the limbs |
| 2.6.13 Demonstrate appropriate risk/benefit analysis for pre-hospital: (a) Analgesia, (c) procedural sedation, (d) emergency anaesthesia |
| 2.6.14 Demonstrate safe pre-hospital: (a) Analgesia, (c) procedural sedation, (d) emergency anaesthesia |
| 3.1.4 Apply equipment governance procedures (b) during deployment and clinical care, (c) on completion of deployment |
| 3.2.5 Demonstrate the correct use of PPE |
| 3.2.6 Demonstrate the ability to operate whilst using PPE |
| 3.2.7 Demonstrate a professional approach to use of PPE |
| 3.3.3 Demonstrate confident and technically correct operation of: (a) Airway management devices, (b) Ventilatory support devices, (d) Devices for accessing the circulation, (f) Devices for administering medicine and blood products, (h) Devices for immobilizing joints, limbs and patients, (i) Devices for near patient testing, (j) Devices for temperature management, (k) Devices for non-invasive patient monitoring, (n) Devices for moving and handling patients |
| 3.5.10 Demonstrate preparation of medicines for parenteral use |
| 3.5.11 Demonstrate safe and effective administration of medicines by all routes |
### Clinical scenario observed | Curriculum elements covered
---|---
3.5.12 | Demonstrate compliance with legislation related to Controlled Drugs
3.5.16 | Demonstrate a professional approach to management and administration of medicines
4.1.10 | Demonstrate a dynamic risk assessment in practice at a rescue operation
4.3.6 | Demonstrate ability to make a rapid assessment of the extrication needs of a trapped patient
4.3.7 | Demonstrate ability to manage clinical equipment during the extrication process
4.3.8 | Demonstrate ability to facilitate extrication through medical intervention
4.3.11 | Display medical leadership in co-ordinating medical and rescue interventions
4.4.10 | Demonstrate ability to make a rapid assessment of the clinical needs of a trapped patient
4.4.11 | Demonstrate effective management of the trapped patient
4.4.13 | Display leadership in co-ordinating multi-professional medical care of trapped patients
4.4.14 | Demonstrate a compassionate patient-focussed approach throughout rescue and extrication
4.6.4 | Demonstrate correct preparation of patients for safe pre-hospital transfer
5.4.4 | Demonstrate the ability to maintain monitoring of vital signs throughout transfer
5.6.5 | Determine appropriate choices of sedation, muscle relaxation and analgesia to maintain the patient’s clinical status during transfer
5.6.6 | Demonstrate the safe pre-hospital transfer of ventilated patients
5.6.9 | Demonstrate the ability to maintain monitoring of vital signs throughout transfer
B 1.6 | Demonstrate a professional attitude to patient safety
B 2.4 | Demonstrate, in the context of PHEM practice, the ability to: (a) gather information, (b) interpret information, (c) anticipate likely events
B 4.5 | Demonstrate the ability to communicate in an accurate, brief and clear manner
B 4.8 | Demonstrate the ability to communicate effectively with different groups encountered in the pre-hospital environment
B 4.9 | Recognises the importance of effective communication to safe and efficient delivery of patient care in the pre-hospital environment
B 5.5 | Demonstrate the ability to work in multi-disciplinary and unfamiliar teams

<table>
<thead>
<tr>
<th>Please TICK to indicate the standard of the trainee’s performance in each area</th>
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<th>Demonstrates good practice</th>
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<td>Examination</td>
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<tr>
<td>Communication with patient, relatives, staff</td>
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<td>Overall plan</td>
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<tr>
<td>Adherence to Good Medical Practice</td>
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Areas of strength

Initial clinical approach - Obtained information from the pre-hospital personnel already on scene and utilised their skills to continue care.

History and information gathering - Performed an organised, structured, relevant and focused assessment of a trapped adult patient in cold, dark and wet conditions.

Examination - Demonstrated accurate interpretation of clinical history and physical signs in cold, wet and dark condition in a trapped critically injured adult patient.

Communication with patient, relatives, staff - Utilised the multi-disciplinary team well and allowed appropriate involvement of all members.

Adherence to Good Medical Practice - Demonstrated work with an unfamiliar team

Areas for improvement

Initial operational approach - A slower walk into the scene, obtaining an overview of the scene risks and current scene activity would benefit your ability to maintain situational awareness.

Clinical decision making and judgment - Risk to the patient from their injuries and situation have to be balanced against risks of medical interventions. Chaotic situations with unstable patients require imposed control in order to ensure safety of patient and the team. Control of the patient’s agitation could have been gained more quickly.

Overall plan - Incidents are dynamic environments and require decisions to be revised in the face of new information. The tempo of patient management should be consistent with the severity of injury. The flow of the extrication was affected by the patients change in agitation level.

Action plan

1. Concentrate on obtaining a scene overview before involving yourself in patient detail
2. Compare the various methods of achieving sedation to allow extrication in a head injured patient

<table>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alan Statham</td>
<td></td>
<td></td>
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<tr>
<td>Trainee Signature:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Guy Secretan</td>
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Inter-Collegiate Board for Training in Pre-Hospital Emergency Medicine
# DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS)

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<th>Guy Secratan</th>
<th>Training Phase:</th>
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<tr>
<td>Assessor name:</td>
<td>Alan Stathan</td>
<td>Registration no:</td>
<td>123456</td>
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<tr>
<td>Grade of assessor:</td>
<td>Consultant</td>
<td>Date</td>
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</table>

## Curriculum elements covered

1. **Pre-hospital emergency anaesthesia**

- 2.6.13 Demonstrate appropriate risk/benefit analysis for pre-hospital: (a) Analgesia, (c) procedural sedation, (d) emergency anaesthesia,
- 2.6.14 Demonstrate safe pre-hospital: (a) Analgesia, (c) procedural sedation, (d) emergency anaesthesia
- 3.3.3 Demonstrate confident and technically correct operation of: (a) Airway management devices, (b) Ventilatory support devices, (d) Devices for accessing the circulation, (f) Devices for administering medicine and blood products, (k) Devices for non-invasive patient monitoring,
- 3.5.10 Demonstrate preparation of medicines for parenteral use
- 3.5.11 Demonstrate safe and effective administration of medicines by all routes
- 3.5.12 Demonstrate compliance with legislation related to Controlled Drugs
- 3.5.16 Demonstrate a professional approach to management and administration of medicines
- B 1.6 Demonstrate a professional attitude to patient safety

## Formative? – Yes

## Summative? – No

<table>
<thead>
<tr>
<th>Please TICK to indicate the standard of the trainee’s performance in each area</th>
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<th>Further core learning needed</th>
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<td>Clinical indication</td>
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</tr>
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<td>Appropriately deals with issues related to consent</td>
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<td></td>
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<tr>
<td>Appropriate preparation</td>
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<td>Technical skills</td>
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<tr>
<td>Situational awareness and clinical judgement</td>
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<td>Safety, including prevention and management of complications</td>
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</table>

**Areas of strength**

- Clinical reasoning for appropriateness of intervention.
- Preparation of personnel, equipment and patient for procedure.
- Clear communication with multi-disciplinary team

**Areas for improvement**

- Intubation technique should use a lifting action, not a rotatory action. Sliding down the tongue prevents the blade entering the oesophagus.
- Delivery of the long acting muscle relaxant required prompting.

**Action plan**

1. Concentrate on obtaining a scene overview before involving yourself in patient detail
2. Compare the various methods of achieving sedation to allow extrication in a head injured patient

<table>
<thead>
<tr>
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4.8 DECISIONS ON PROGRESS (ARCP)

4.8.1 The Annual Review of Competence Progression (ARCP) is the formal method by which a trainee’s progression through her/his training programme is monitored and recorded. ARCP is not in itself an assessment – it is the review of evidence of training and assessment. The ARCP process is described in A Reference Guide for Postgraduate Specialty Training in the UK (the “Gold Guide” – available from www.mmc.nhs.uk). Deaneries are responsible for organising and conducting ARCPs. The evidence to be reviewed by ARCP panels should be collected in the trainee’s ePortfolio (or logbook). In the context of PHEM sub-specialty training, the core specialty ARCP process for the trainee will be informed by PHEM Structured Training Reports (STRs) for each phase of training - it is not necessary to conduct separate PHEM ARCP panels.

4.9 TRAINEES IN DIFFICULTY

4.9.1 When a trainee’s performance gives cause for concern, more assessments will be needed. It is the responsibility of the trainee to provide at their Educational Review meetings what they consider to be evidence of satisfactory performance and satisfactory progress. They will need evidence of performance in each unit of training or section of the curriculum they have undertaken. This may increase the number of assessments they need. It is the educational supervisor’s responsibility to help the trainee to understand what that evidence will be appropriate in their specific circumstances. The educational supervisor will then write a summary of the learner’s performance for the STR. The Trainee will work with their educational supervisor to develop evidence of satisfactory progression through their agreed learning. The educational supervisor will then present a summary of this evidence to the ARCP via the STR.

4.9.2 It is recognised that trainees learn at different paces, and will improve as they progress through the training programme. The formative assessments may be undertaken many times and are expected to improve whilst the summative phase assessments give trainees the opportunity to demonstrate their learning at that point in time. Where either progression or summative assessment falls below the expected standard, the trainee and supervisors must rapidly evaluate and form plans for future learning supported by the educational team.

4.9.3 Persistent failure to progress indicates a trainee in difficulty and this should be managed through local Deanery systems to support the trainee. The Training Programme Director should be involved at the earliest opportunity.

4.9.4 Where the trainee is unsuccessful in a summative assessment, discussions with the Training Programme Director, Educational Supervisor and LEP will need to take place to identify the trainee’s learning needs. This may require examining possible opportunities for the extension of PHEM training or abandonment of PHEM training to focus on core specialty training.

4.10 COMPLAINTS AND APPEALS

4.10.1 All workplace based assessment methods incorporate direct feedback from the assessor to the trainee and the opportunity to discuss the outcome. If a trainee has a complaint about the outcome from a specific assessment this is their first opportunity to raise it. Further disagreement should follow local grievance procedures.

4.10.2 Appeals against decisions concerning summative phase assessments will be handled at IBTPHEM level and the IBTPHEM is responsible for setting up and reviewing suitable processes. If a formal complaint about assessment is to be pursued this should be referred in the first instance to the Training Programme Director who is accountable to the regional Deanery.
SECTION 5.
GUIDANCE FOR TRAINERS, LOCAL EDUCATION PROVIDERS, EMPLOYERS AND DEANERIES
5.1 INTRODUCTION

5.1.1 PHEM is a new medical sub-specialty and despite a long history of physician-based pre-hospital care in the UK, there is little experience of formal structured training programmes. As the sub-specialty matures, it is anticipated that this section of the guide will expand in content and better support trainers, local education providers, employers and deaneries in their role in managing the delivery of sub-specialty training.

5.2 TRAINERS

5.2.1 Clinical Supervisors (CS) and Educational Supervisors (ES) have important and distinct roles in PHEM training.

(a) An Educational Supervisor is a trainer who is selected and appropriately trained to be responsible for the overall supervision and management of a specified trainee's educational progress during a training placement or series of placements. The Educational Supervisor is responsible for the trainee's Educational Agreement and would ordinarily remain a trainee's ES throughout their programme.

(b) A Clinical Supervisor is a trainer who is selected and appropriately trained to be responsible for overseeing a specified trainee's clinical work and providing constructive feedback within a training placement. The roles of Clinical and Educational Supervisor may be merged for some placements or programmes.

5.2.2 Within Local Education Providers (LEPs), all trainers must:

(a) understand and demonstrate ability in the use of the recommended assessment tools and be clear as to what is deemed acceptable progress;

(b) ensure that all involved in training and assessment of their designated trainee understand the requirements of the programme;

(c) regularly review the trainee’s progress; adopt a constructive approach to giving feedback on performance; advise on career progression and understand the process for dealing with a trainee whose progress gives cause for concern;

(d) liaise as necessary with other trainers both within the organisation and Deanery School to ensure a consistent approach to education and training and the sharing of good practice across specialties and professions;

(e) have adequate time for training identified in their job plans;

(f) have knowledge of, and comply with, the GMC’s regulatory framework for medical training.

5.2.3 Trainers are required to comply with Deanery requirements regarding generic training. In addition, the IBTPHEM requires trainers to:

(a) be clinically active in PHEM at the level of consultant practice;

(b) have at least five years clinical and operational experience;

(c) have adequate time for training identified in their job plans;

(d) satisfactorily complete a IBTPHEM Trainer Workshop (and undertake refreshers as stipulated by the IBTPHEM).

(e) be able to demonstrate generic competencies for educators (described by the Academy of Medical Educators)\(^ {21}\) and specific skills for simulation-based training (described by the Association for Simulated Practice in Healthcare [previously the National Association of Medical Simulators]).\(^ {22}\)

\(^ {21}\) [www.medicaleducators.org](http://www.medicaleducators.org)

\(^ {22}\) [www.namsonline.com](http://www.namsonline.com)
5.3 LOCAL EDUCATION PROVIDERS

5.3.1 Local Education Providers (LEPs) are approved by a Postgraduate Deanery to support and provide sub-specialty training in PHEM following assessment that they meet the standards for LEPs and are able to maintain the provision of high quality training in PHEM.

5.3.2 Due to the nature of the current pre-hospital medical service provision, the LEP may be an NHS Trust (Acute or Ambulance), an independent healthcare provider, the Defence Medical Services or a third sector (charitable) organisation operating in partnership with the NHS.

5.3.3 Organisations seeking to become LEPs within a Deanery PHEM sub-specialty training programme must:
(a) be registered with the IBTPHEM
(b) either have a Learning Development Agreement (or equivalent) with the relevant Postgraduate Deanery or with the organisation that holds that agreement
(c) be compliant with the Care Quality Commission essential standards for quality and safety
(d) be compliant with the GMC standards for training

5.3.4 The LEP is subject to inspection, both initially and subsequently, within the local Deanery Quality Management framework. All LEPs must comply with the GMC standards for training (as must all Deaneries). Results of inspections will be reported to regional and national bodies as per GMC guidelines.

5.3.5 Sufficient practical experience must be available within the clinical services and LEPs associated with a Deanery programme to support acquisition of knowledge and skills set out in the Curriculum. The Deanery programme, and associated LEPs (either individually or in collaboration) must therefore:
(a) have an adequate case volume. It seems reasonable to suggest that the pre-hospital emergency anaesthetic rate is a useful surrogate marker of overall exposure. A programme should therefore demonstrate that it could achieve 8 to 10 pre-hospital emergency anaesthetics per trainee per 6 months.
(b) offer exposure to the full range of undifferentiated adult and paediatric PHEM case presentations as described in the Curriculum.
(c) include exposure to both primary and secondary transfer cases.

5.3.6 Compliance with 5.3.3 and 5.3.5 above will be a significant challenge for many current PHEM services. It is likely that regionalised services, perhaps mirroring the regionalisation of trauma care and development of trauma networks, will be required to support sub-specialty training.

5.3.7 A key challenge for LEPs relates to the role of simulation. Simulation is used widely throughout postgraduate medical training for both learning and assessment. Within the Emergency Medicine curriculum, it is recognised that some skills may only be acquired by simulation and simulator based training courses are strongly recommended. Within the Anaesthetic curriculum, it is recognised that effective use of simulation will support:

- Acquisition and application of knowledge.
- Training and ingraining new skills: learning routines and steps that together comprise a complex skill.
- Reinforcement of drills: teaching and testing learners responses to specific critical incidents
- Developing professional behaviour and the set of non-technical skills which support delivery of expert anaesthetic practice, especially in the context of working within multi-professional teams and a variety of clinical environments.

5.3.8 Within the PHEM curriculum, ‘Simulation Learning’ is a specified learning method. It is defined as the simulation (at any level of fidelity and reality) of a situation in order to attain predetermined learning objectives and it includes simulated patients, simulated incident scenes, use of models and tabletop exercises. Simulation is also recommend as an assessment tool for both formative and summative assessment.

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23 www.cqc.org.uk
24 Generic standards for specialty including GP training, General Medical Council, April 2010.
5.3.9 The PHEM environment is unique amongst healthcare environments and exposes trainees to challenges not encountered in other areas of clinical practice. Clinical care is often provided in a high pressure, time critical, resource limited environment where errors, equipment failures and poor team resource management can lead to catastrophic outcomes. PHEM practice is therefore comparable to high risk or high performance industries where the importance of training for catastrophic events with minimal opportunity to practice for real in a controlled environment is well recognised. Another similarity with these industries is that exposure to certain particular problems can be very limited. The experience of the Faculty Training Fellows (FTF) programme emphasises this. In order to effectively train FTFs, extensive and effective use was made of simulator-based training and assessment – a relatively low number of critically injured patients (approx. 8 per trainee per month) was supplemented by a much higher number (> 30) of simulated patients.

5.3.10 Simulation is an essential and central part of training and assessment in PHEM clinical practice. There has historically been debate regarding high vs. medium vs. low fidelity simulators and the merits of each. There is a tendency to feel it necessary to use the highest fidelity simulators available with these often being extremely expensive to purchase. Experience of simulation in PHEM so far has demonstrated that the overall fidelity of the scenario is more important than the fidelity of the simulator mannequin itself. Most PHEM simulations can be effectively achieved with low to medium fidelity human simulators and the correct environmental set.

5.3.11 The general principles of simulation teaching and training can be summarised using the BEME guidelines (table 5.1).25 The IBTPHEM will produce further detailed guidance on the use of simulation for formative and summative assessment.

5.3.12 Additional support for learning and training will be provided by the IBTPHEM in the form of a virtual learning environment (VLE), access to the Faculty of Pre-hospital Care e-Portfolio and access to resources for training trainers.

5.3.13 The Faculty Training Fellows (FTF) programme has supported the development of a VLE for PHEM. The VLE is a web accessible collection of tools to support self-directed learning, physical learning (face to face teaching) and curriculum management. The VLE provides, through a single, consistent, and intuitive interface, all the components required for a course of education or training such as:

- The syllabus and curriculum – a road map for education and training
- Administrative information such as the location of teaching sessions
- An e-notice board for up-to-date course information
- Participant tracking facilities
- Basic teaching materials (which may include the content of courses and e-learning resources)
- Self-assessment quizzes and formal assessment procedures
- A mechanism for remote support with electronic communication including e-mail and threaded discussions
- Differential access rights for trainers, trainees and other participants
- Production of documentation and statistics in the format required for administration and quality control
- A digital library / repository for additional resources, including reading materials, and links to other resources
- A mechanism for remote assessment
- A mechanism for sustaining Continuous Professional Development and stimulating self-learning

25 BEME Guide no 4: Features and uses of high-fidelity medical simulations that lead to effective learning. 2004, Dundee, UK: Association for Medical Education in Europe
5.3.14 The VLE used for the FTF programme is the commercially available Coursesites content management system provided by Blackboard. It is used widely in the UK to provide supporting VLEs for undergraduate and graduate students. It is the intention of the IBTPEM to develop a UK wide VLE to support PHEM sub-specialty training in the same way as the local VLE has supported the FTF programme.

5.3.15 The Faculty of Pre-hospital Care PHEM e-Portfolio and logbook was also developed to support the FTF programme. iMobileMedic (www.imobilemedic.com) have been commissioned to transfer the existing Microsoft Access based e-portfolio to a multi-platform web-based portfolio. This process is currently underway (http://phemportfolio.org/).

5.3.16 The e-Portfolio and logbook is intended to provide trainees, trainers and LEPs with an easy to use, accessible and effective tool to record work-place based assessments, clinical activity and educational experiences against the Curriculum. The e-Portfolio and Logbook has the following key attributes:

- Curriculum-linked portfolio able to log duty periods, incidents, interventions, training and learning needs
- Web-based and accessible from multiple-platforms
- Full compliance with Data Protection and Information Governance requirements
- Report / Summary generation for ARCP
- Supervisor access mode for WPBA

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide feedback during the learning experience with the simulator</td>
<td>Slows decay in skills over time; Formative feedback and self-assessment allows individual to monitor progress; Feedback can be “built-in” to simulator training session or provided by trainer immediately or later via video debriefing</td>
</tr>
<tr>
<td>Learners engage in repetitive practice (and deliberate practice)</td>
<td>Found to be a primary factor in studies showing skills transferring to real patients; Shortens learning curves and leads to faster automaticity; simulator must be made available to achieve this – convenient location, accommodates learner schedule</td>
</tr>
<tr>
<td>Simulation is integrated into overall curriculum</td>
<td>Simulation fully integrated into overall curriculum – e.g. resuscitation, team resource management, use of equipment, patient transfer etc.</td>
</tr>
<tr>
<td>Learners practice with increasing levels of difficulty</td>
<td>Increasing the degree of difficulty increases mastery of the situation and technical skills</td>
</tr>
<tr>
<td>Adapt the simulator to complement multiple learning strategies</td>
<td>Large and small group tutorial settings; independent small-group and individual trainee practice settings</td>
</tr>
<tr>
<td>Ensure the simulator provides for clinical variation</td>
<td>Increases the number and variety of patients a learner encounters; Provides equity to smaller training programs; Provides exposure to rare encounters</td>
</tr>
<tr>
<td>Learning on the simulator should occur in a controlled environment</td>
<td>Learners make and detect mistakes without consequences; Instructors can focus on learners through “teachable moments”; Reflects educational “culture” focused on ethical training</td>
</tr>
<tr>
<td>Provide individualized (in addition to team) learning on the simulator</td>
<td>Provides reproducible, standardised experience for all learners; Learner is active participant, responsible for his/her own learning</td>
</tr>
<tr>
<td>Clearly define outcomes and benchmarks for the learners to achieve using the simulator</td>
<td>Learners more likely to master situation and skill if outcomes are clearly defined and appropriate for learner level of training</td>
</tr>
<tr>
<td>Ensure the simulator is a valid learning tool</td>
<td>Face validity – realism provides context for understanding complex principles/tasks, increases viso-spatial perceptual skills, learners prefer realism; Concurrent validity – ability on simulator transfers to real patient</td>
</tr>
</tbody>
</table>

*Table 5.1 Attributes of simulation that lead to effective learning*
5.4 EMPLOYERS

5.4.1 The LEP may not be the employer. Similarly, the employer may be the NHS but funding may come from a third party body. Regardless of who the employer is, they must ensure compliance with employment and occupational health requirements. It is recommended that a clear and binding agreement defines the duties of each party in these situations.

5.4.2 Regardless of the employer, the NHS Employment Check Standards should be applied to all trainees and trainers. These cover all the pre-employment checks required by law, those that are mandated by Department of Health policy, and those that are required for access to the NHS Care Record Service. LEPs who are also employers will be required to show evidence of their compliance with these standards.

5.4.3 PHEM practice involves working in a range of environments which are physically challenging and demanding and may place the trainee at some risk. Whilst there are no standards for physical fitness and functional capability required to undertake Emergency Medicine and Anaesthetic duties within hospital, NHS Ambulance Services undertake an assessment of functional capability and physical fitness as part of the selection process for pre-hospital work. The IBTPHEM recommend that the standard applied to Ambulance service recruitment is applied to PHEM trainee selection. The National Recruitment process will require applicants to have passed the physical assessments used for recruitment to the paramedic higher education institutions. Details of the assessments and standards will be provided.

5.5 DEANERIES

5.5.1 Postgraduate Deaneries who seek to provide PHEM training programmes should notify the IBTPHEM. The IBTPHEM will assist the Deanery in making an application to the GMC for approval of a training programme.

5.5.2 In addition to compliance with the GMC standards for Deaneries, a regional PHEM training committee should be formed which may operate under the auspices of the School of Emergency Medicine or School of Anaesthesia. The training committee will appoint a training programme director of suitable qualifications to oversee the training programme. It is suggested that the committee takes its membership from:

- PHEM Consultants
- EM Consultants
- Anaesthetic Consultants
- PICU/ICU Consultants
- Ambulance Service personnel
- Local Education Providers
- PHEM Trainees
- Lay persons
- Deanery management personnel

5.5.3 Given the number of trainees in PHEM, and the requirements for LEPs, Deaneries may decide to create arrangements for supra-regional management of training programmes. Any such arrangements must be made with full support of the participating Deaneries and LEPs.

5.5.4 Formal applications for approval of PHEM training programmes should be made by Deaneries directly to the GMC using existing processes established for specialties and sub-specialties.

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26 www.nhsemployers.org
27 Standards for Deaneries. General Medical Council, April 2010
5.5.5 The IBTPHEM has a role in supporting GMC review processes and quality managing training (see figure 3.1). In order for the IBTPHEM to review an application and confirm to the GMC that it fulfils the requirements for training in PHEM as defined by the Board, Deaneries are asked to consult with the IBTPHEM and provide:

- A detailed description of the infrastructure underpinning and supporting the training programme.
- A detailed description of how the curriculum will be delivered within the programme (including details of the anticipated trainee case volume and exposure).

A template statement of training programme assurance and compliance is provided at Annex E

5.5.6 The IBTPHEM will review training programme applications and liaise with the GMC and Deaneries. In some circumstances, and in the context of the Quality Management framework illustrated in figure 3.1, a team from the IBTPHEM will conduct a review visit, the structure and function of which will mirror existing processes for Emergency Medicine and Anaesthetic programme approval by the College of Emergency Medicine and Royal College of Anaesthetists respectively.

5.5.7 PHEM Training Programme Directors are supported by a number of Educational Supervisors usually based with local education providers. Educational Supervisors guide a number of trainees through the training programme and need to be suitably qualified to do so. A sample person specification for an Educational Supervisor is given in table 5.1 as a guide.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Essential Criteria</th>
<th>Desirable Criteria</th>
<th>How assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attainments</td>
<td>• GMC full registration</td>
<td>• PG qualification in education</td>
<td>Application Form</td>
</tr>
<tr>
<td></td>
<td>• Hold Specialist registration in Anaesthetics or Emergency Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge and Interests</td>
<td>• Knowledge of management and governance structures in medical education and training awareness of recent changes in the delivery of medical education and training nationally and locally.</td>
<td>• Evidence of relevant research and/or publications.</td>
<td>Interview</td>
</tr>
<tr>
<td></td>
<td>• Interest and enthusiasm for improving delivery of medical education and training and continuing professional development.</td>
<td>• Evidence of experience at strategic level of national or international education organisations.</td>
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<tr>
<td></td>
<td>• Knowledge of assessment methods.</td>
<td></td>
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<tr>
<td></td>
<td>• Extensive experience in PHEM service provision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Special Aptitudes</td>
<td>• Effective leadership and communications skills, motivating and developing others, approachability, good interpersonal skills.</td>
<td>• Evidence of supporting trainees .</td>
<td>Interview</td>
</tr>
<tr>
<td></td>
<td>• Evidence of delivering well evaluated teaching sessions/tutorials.</td>
<td>• Evidence of audit/research in medical education.</td>
<td></td>
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<tr>
<td></td>
<td>• Evidence of personal development in medical education.</td>
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</tbody>
</table>

*Table 5.1 A sample person specification for an Educational Supervisor.*
ANNEXES

A. Terms of Reference of IBTPHEM and it’s committees
B. PHEM Curriculum Development
C. PHEM recruitment – Person specification
D. PHEM trainee assessment tools
E. Deanery statement of training programme assurance and compliance
ANNEX A. TERMS OF REFERENCE OF IBTPHEM AND IT’S COMMITTEES

INTRODUCTION
This annex describes the terms of reference of the Intercollegiate Board for Training in Pre-hospital Emergency Medicine and describes the terms of reference for the Curriculum, Training and Assessment Committees.

INTERCOLLEGIATE BOARD – TERMS OF REFERENCE
DEFINITIONS
1. (a) In these terms of reference the words or phrases in the left hand column have the meaning in the right hand column.

<table>
<thead>
<tr>
<th>The Board</th>
<th>The Intercollegiate Board For Training In Pre-Hospital Emergency Medicine (IBTPHEM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Lead Colleges</td>
<td>The Royal College of Surgeons of Edinburgh (through the Faculty of Pre-Hospital Care)</td>
</tr>
<tr>
<td></td>
<td>The Royal College of Anaesthetists</td>
</tr>
<tr>
<td></td>
<td>The College of Emergency Medicine</td>
</tr>
<tr>
<td></td>
<td>The Royal College of General Practitioners</td>
</tr>
<tr>
<td>Other Organisations</td>
<td>The Royal College of Physicians of London</td>
</tr>
<tr>
<td></td>
<td>The Royal College of Paediatrics and Child Health</td>
</tr>
<tr>
<td></td>
<td>The Royal College of Psychiatrists</td>
</tr>
<tr>
<td></td>
<td>The Joint Committee on Surgical Training of the Royal Colleges of Surgeons of England, Edinburgh and Glasgow</td>
</tr>
<tr>
<td></td>
<td>The Joint Royal Colleges of Physicians Training Board of the Royal Colleges of Physicians of London, Edinburgh and Glasgow</td>
</tr>
<tr>
<td></td>
<td>The Faculty of Intensive Care Medicine</td>
</tr>
<tr>
<td></td>
<td>The Intercollegiate Committee for Training in Paediatric Intensive Care Medicine (ICTPICM)</td>
</tr>
<tr>
<td></td>
<td>The Academy of Medical Royal Colleges</td>
</tr>
<tr>
<td></td>
<td>The Defence Medical Services</td>
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<tr>
<td></td>
<td>The Departments of Health for England, Scotland, Northern Ireland and Wales (joint representative)</td>
</tr>
</tbody>
</table>

Pre-hospital Emergency Medicine is defined in the following sub-paragraph:

(b) Subject to paragraph 4(a) of these terms of reference Pre Hospital Emergency Medicine means that area of medical care required for seriously ill or injured patients before they reach hospital or during transfer between hospitals. The main area of care will be for critically ill patients.

CONSTITUTION
2. (a) Following agreement by the Colleges and Faculties concerned, the Board’s constitution shall be:

   (i) A Chairman

   (ii) Two members each nominated by:
        The Royal College of Surgeons of Edinburgh (Faculty of Pre-Hospital Care)
        The Royal College of Anaesthetists
        The College of Emergency Medicine
        The Royal College of General Practitioners
(iii) One Member each nominated by:
The Royal College of Paediatrics and Child Health
The Royal College of Physicians of London
The Royal College of Psychiatrists
The Joint Committee on Surgical Training
The Joint Royal Colleges of Physicians Training Board
(iv) Chair of IBTPHEM Curriculum Committee
(v) Chair of IBTPHEM Training Committee
(vi) Chair of IBTPHEM Assessment Committee
(vii) Trainee representative
(viii) Lay representative
(ix) Co-Opted Members from
The Conference of Postgraduate Medical Deans
The Defence Medical Services
The Departments of Health of England, Scotland, Northern Ireland and Wales (Joint)
The Faculty of Intensive Care Medicine
The Intercollegiate Committee for Training in Paediatric Intensive Care Medicine
(x) Any additional co-optees required to inform discussions, as decided at a meeting of the Board.

(b) Only full members of the Board shall be entitled to vote. The Chairman shall not have an independent vote, but only a casting vote in the event of the votes on any matter otherwise being equal.

(c) The Chairman, who shall be nominated by one of the Lead Colleges, shall serve for a maximum period of two years and may not be nominated for a second term. The nominating body will rotate between the Royal College of Surgeons of Edinburgh (through the Faculty of Pre-Hospital Care), the College of Emergency Medicine, the Royal College of Anaesthetists and the Royal College of General Practitioners.

(d) The new Chairman shall be nominated by the appropriate Lead College one year before the end of the serving Chairman’s term of office. The Chairman-elect will then serve as Vice-Chairman for that year. On completion of his/her term of office the retiring Chairman will serve as Vice-Chairman until the nomination of a Chairman-elect.

(e) In the event of the Chairman relinquishing office during his or her first year of office the current Vice-Chairman will occupy the chair until a new Chairman has been nominated, to take office immediately, together with the nomination of a new Chairman-elect.

(f) In the event of the Chairman relinquishing office during his or her second year of office the current Vice-Chairman will assume the chair for a two-year term and a new Vice-Chairman will be nominated at the earliest opportunity.

(g) If the nominated period of a member of the Board who is subsequently nominated as Chairman or Vice-Chairman expires before the end of the term of office, then he/she will extend his/her period on the Board to complete a full term as Chairman or Vice-Chairman.

(h) Members shall serve for three years and, if nominated again by their nominating body, will be eligible to serve for one more term of the same period. No Board member may serve for longer than a total of six years, excluding any period spent as Chairman or Vice-Chairman.

(i) In the event of a member ceasing, for whatever reason, to be a member of the Board before the completion of the term of service for which that member was nominated, the body responsible for the nomination shall nominate another person to serve for the unexpired period of the term. Such a term of office shall be disregarded in relation to any subsequent term or terms of service for which that person may be nominated.

(j) A single nominated member from another interested Faculty or College may be appointed to the Board at some future date, with the agreement of a two thirds majority of the current Board members.
THE POWERS, OBJECTS AND FUNCTIONS OF THE BOARD

3. The powers of the Board shall be such as may be delegated to it by the Colleges and Faculties on all matters related to training in Pre-Hospital Emergency Medicine whether to be exercised by the formulation of recommendations by the Board subject to the approval of and, where appropriate, amendment by the Colleges and Faculties, before being put into effect by the Board or whether, when the delegation so provides, by the taking of decisions to be given effect directly by the Board without the requirement of such prior approval. Such further powers may from time to time be delegated to the Board by the Colleges and Faculties, as may be necessary for the proper performance of the functions specified in these terms of reference.

FUNCTIONS RELATING TO SCOPE AND STATUS OF PRE HOSPITAL EMERGENCY MEDICINE

4. Included amongst the matters delegated to the Board by the Colleges and Faculties shall be the functions of:

   (a) Keeping the definition of pre-hospital emergency medicine under review and, if it should appear necessary or desirable, of making, from time to time appropriate modifications to the definition having, when necessary, undertaken such consultations for that purpose as shall appear desirable to the Board.

In addition:

5. The Principal objects and Functions of the Board, within the terms of the delegation by the Colleges and Faculties, shall be:

   (a) to keep under review the practice of pre-hospital emergency medicine;
   (b) to determine the duration, content and assessment of training in pre-hospital emergency medicine and make recommendations to individual Colleges, Faculties and to the General Medical Council (GMC);
   (c) to recommend minimum standards for training in an environment recognised for training by the relevant Colleges and Faculties;
   (d) to act, if requested, as the advisory body to the GMC on applications received by the Colleges and Faculties, from individual training units for recognition for training purposes;
   (e) to exercise in relation to pre-hospital emergency medicine such other training and education functions on behalf of the Colleges and Faculties as would be relevant to a sub specialty;
   (f) to institute, through the Colleges and Faculties and in conjunction with the GMC, mechanisms of accreditation and assessment, as required, for awarding qualifications in pre-hospital emergency medicine.

6. ADMINISTRATION

   (a) It shall be a function of the Board to initiate and keep under review the administrative arrangements necessary for the performance of the Board’s function.
   (b) One of the Lead Colleges will act as agent for the Board for the purpose of ensuring compliance with regulatory matters including annual sub-specialty reporting. This Lead College will ordinarily be the College that holds the chair.

7. FINANCES

   It shall be a function of the Lead Colleges to approve the recommendations of the Board, concerning the funds needed for administration, accommodation and other costs, including, for example, those connected with members’ expenses, registration of trainees, the development of databases, the conduct of assessment procedures and meetings of advisors. The Board will prepare regular budgets for those costs and oversee the receipt and expenditure of all sums connected therewith. In exercising this function it will be the responsibility of the Board to achieve the greatest possible economy and at the same time to seek to make the activities of the Board self-financing.
To this end the Board will produce a detailed annual budget delineating its proposals for the generation of income from its activities, by such means as fees in respect of registration for training and of admission to formal assessment procedures, charging for publications where appropriate, and through the recovery of expenses in relation to visits to units on behalf of the GMC for the purpose of assessment and approval.

One of the Lead Colleges will act as agent for the Board for the purpose of receiving, holding and expending any monies, subject to the recovery of any sums in accordance with the aforementioned agreement. This College shall furnish the other Lead Colleges with periodical statements of accounts at intervals of not more than one year.

Any proposed initiative or other action on the part of the Board, that would lead to an overspend of the planned and agreed budget, must be agreed in advance by the Lead Colleges. Unforeseen circumstances, that would lead to an overspend of the planned and agreed budget must be brought to the notice of the Lead Colleges immediately. The costs associated with the Board’s activities will be met by the Lead Colleges on a pro rata basis, depending upon the relative number of Board members from each Lead College. With each Lead College having two Board members, the current share will be 25% of the total.

Travel and subsistence costs will be borne by those Colleges, Faculties and organisations represented by the individual Board members.

**GENERAL PROFESSIONAL RESPONSIBILITIES**

8. All members of the Board will be responsible for its professional activities. The Lead Colleges will be additionally responsible for the governance of the Board’s activities, in terms of its financial responsibilities and professional indemnity.

The Board shall:

(a) take any action necessary, not specifically indicated in the foregoing functions, to meet any requirement resulting from the provisions of the European Specialist Medical Qualifications Order 1995, and

(b) Act in accordance with any lawful requirements of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003, the General Medical Council or the Colleges.

**FUTURE REVISIONS**

9. Any recommendations from the Board for changes to the constitution shall be put to the Colleges and Faculties for their approval.

10. The constitution shall be regularly reviewed by the Board and, in the first instance, two years after inception of the Board’s activities.

*December 2010*
CURRICULUM COMMITTEE - TERMS OF REFERENCE

1. PURPOSE

1.1 To make recommendations to the IBTPHEM with regard to any of the functions specified in paragraph 2, having first consulted any other committees of the IBTPHEM with respect to any matter falling within the terms of reference of that committee; and, subject to the approval of the IBTPHEM, to take such action as is necessary or to ensure that action is taken by the appropriate body or persons.

2. RESPONSIBILITIES

2.1 To provide guidance on all aspects of PHEM curriculum development and review with specific reference to:

2.1.1 Review of the PHEM sub-specialty curriculum in line with GMC requirements.
2.1.2 Development of the PHEM sub-specialty curriculum to include the core CCT specialties of:
   - General Practice,
   - Intensive Care Medicine,
   - Acute Internal Medicine,
   - Paediatrics,
   - Relevant surgical specialties.
2.1.3 Application to the GMC for approval of PHEM as sub-specialties of the core CCT specialties listed in 2.1.2.

2.2 To take into account new clinical and service developments, reports from sources such as trainees, educational supervisors, programme directors, Deaneries, local education providers (LEPs), and patients with regard to curriculum content and review.

2.3 In consultation with the Training and Assessment Committees, provide an update to the GMC on the deliverability of the curriculum following a year of the subspecialty training (i.e. by 31 July 2013).

2.4 In consultation with the Training and Assessment Committees, administer the IBTPHEM curriculum based Virtual Learning Environment (VLE).

2.5 To amend and update the relevant sections of Sub-specialty Training in Pre-hospital Emergency Medicine: A guide for trainees, trainers, local education providers, employers and Deaneries (the Guide) as necessary.

2.6 To compile the curriculum section of the annual report on PHEM sub-specialty training to the GMC.

3. MEMBERSHIP

3.1 The committee shall comprise:

- a Chairman who shall be appointed by the IBTPHEM
- a representative of the Curriculum Committee (or equivalent) from each of:
  - College of Emergency Medicine
  - Royal College of Anaesthetists
  - Royal College of General Practitioners
  - Royal College of Paediatrics and Child Health
  - Faculty of Intensive Care Medicine
  - The Intercollegiate Committee for Training in Paediatric Intensive Care Medicine
  - The Joint Committee on Surgical Training
  - The Joint Royal Colleges of Physicians Training Board
  - The Royal College of Psychiatrists
3.2 The Committee may with also co-opt any person who appears to the Chairman to be specially qualified to assist the Committee.

4. MEETINGS

4.1 The Committee shall hold at least three meetings per year and may, when necessary and with the prior approval of the Chairman of the IBTPHEM, meet more frequently.

4.2 The quorum of the Committee shall be 5 members (not co-opted) and must include the Chair of the Committee or a nominated deputy who is a member of the IBTPHEM.

5. REPORTING AND REVIEW

5.1 Minutes will be prepared after each meeting and presented to the IBTPHEM for approval.

5.2 These Terms of Reference shall be reviewed by the Curriculum Committee at its first meeting in every calendar year and any recommended changes shall be submitted to the IBTPHEM for approval.

December 2011

TRAINING COMMITTEE - TERMS OF REFERENCE

1. PURPOSE

1.1 To make recommendations to the IBTPHEM with regard to any of the functions specified in paragraph 2, having first consulted any other committees of the IBTPHEM with respect to any matter falling within the terms of reference of that committee; and, subject to the approval of the IBTPHEM, to take such action as is necessary or to ensure that action is taken by the appropriate body or persons.

2. RESPONSIBILITIES

2.1 To provide guidance on all aspects of sub-specialty training in PHEM with specific reference to:
   2.1.1 Local and National recruitment to PHEM sub-specialty training.
   2.1.2 The content and structure of all phases of PHEM training programmes.
   2.1.3 The process for reviewing training programme applications and making recommendations to the GMC regarding training programme approval.
   2.1.4 The process for reviewing trainee progression and making recommendations to the GMC regarding sub-specialist registration.

2.2 To maintain a register of training programmes, trainers, trainees and their progress through training.

2.3 To provide guidance to Deaneries and Local Education Providers (LEPs) regarding:
   2.3.1 The requirements for educational and clinical supervisors (trainers).
   2.3.2 The PHEM structured training report.

2.4 To advise Deaneries on the adaptation of individual training programmes to enable such training to be undertaken on a flexible basis or to be modified in any way to meet exceptional or unusual circumstances.

2.5 To administer the IBTPHEM Trainer Workshops.
2.6 To administer, in collaboration with the Faculty of Pre-hospital Care, the PHEM ePortfolio.

2.7 To liaise with core specialty schools, training programmes and colleges on issues relevant to PHEM sub-specialty training.

2.8 To amend and update the relevant sections of Sub-specialty Training in Pre-hospital Emergency Medicine: A guide for trainees, trainers, local education providers, employers and Deaneries (the Guide) as necessary.

2.9 To compile the training section of the annual report on PHEM sub-specialty training to the GMC.

3. MEMBERSHIP

3.1 The committee shall comprise:
   - a Chairman who shall be appointed by the IBTPHEM
   - a representative of the Training Programme Director from each approved PHEM training programme
   - a trainee representative from an approved PHEM training programme
   - a representative from the Lead Deanery
   - a representative from the Curriculum Committee
   - a representative from the Assessment Committee

3.2 The Committee may with also co-opt any person who appears to the Chairman to be specially qualified to assist the Committee.

4. MEETINGS

4.1 The Committee shall hold at least three meetings per year and may, when necessary and with the prior approval of the Chairman of the IBTPHEM, meet more frequently.

4.2 The quorum of the Committee shall be 5 members (not co-opted) and must include the Chair of the Committee or a nominated deputy who is a member of the IBTPHEM.

5. REPORTING AND REVIEW

5.1 Minutes will be prepared after each meeting and presented to the IBTPHEM for approval.

5.2 These Terms of Reference shall be reviewed by the Training Committee at its first meeting in every calendar year and any recommended changes shall be submitted to the IBTPHEM for approval.

December 2011
ASSESSMENT COMMITTEE - TERMS OF REFERENCE

1. PURPOSE

1.1 To make recommendations to the IBTPHEM with regard to any of the functions specified in paragraph 2, having first consulted any other committees of the IBTPHEM with respect to any matter falling within the terms of reference of that committee; and, subject to the approval of the IBTPHEM, to take such action as is necessary or to ensure that action is taken by the appropriate body or persons.

2. RESPONSIBILITIES

2.1 To provide guidance on all aspects of assessment in PHEM with specific reference to:
   2.1.1 The structure and content of the overall assessment system for PHEM
   2.1.2 The use of recommended assessment tools
   2.1.3 The structure, content and conduct of phase 1(a) local formative assessments
   2.1.4 The structure, content and conduct of phase 1(b) and phase 2 national summative assessments

2.2 To administer, in collaboration with the lead colleges, the national summative assessments.

2.3 In consultation with the Curriculum and Training Committees, provide an update to the GMC on the burden, deliverability and costs of the assessment system following a year of the subspecialty training (i.e. by 31 July 2013).

2.4 Keep under review the methods of assessing or appraising the achievements of individual trainees during the course of, and at the completion of, training.

2.5 Conduct formal evaluations of the assessment system and the individual assessments.

2.6 To maintain the PHEM assessment blueprint and amend and update the relevant sections of Sub-specialty Training in Pre-hospital Emergency Medicine: A guide for trainees, trainers, local education providers, employers and Deaneries (the Guide) as necessary.

2.7 To compile the assessment section of the annual report on PHEM sub-specialty training to the GMC.

3. MEMBERSHIP

3.1 The committee shall comprise:
   • a Chairman who shall be appointed by the IBTPHEM
   • a representative from each approved PHEM training programme
   • a representative from the Lead Deanery
   • a representative from the Curriculum Committee
   • a representative from the Training Committee

3.2 The Committee may with also co-opt any person who appears to the Chairman to be specially qualified to assist the Committee.

4. Meetings

4.1 The Committee shall hold at least three meetings per year and may, when necessary and with the prior approval of the Chairman of the IBTPHEM, meet more frequently.

4.2 The quorum of the Committee shall be 5 members (not co-opted) and must include the Chair of the Committee or a nominated deputy who is a member of the IBTPHEM.

5. REPORTING AND REVIEW

5.1 Minutes will be prepared after each meeting and presented to the IBTPHEM for approval.

5.2 These Terms of Reference shall be reviewed by the Assessment Committee at its first meeting in every calendar year and any recommended changes shall be submitted to the IBTPHEM for approval.

December 2011
ANNEX B. PHEM CURRICULUM DEVELOPMENT

INTRODUCTION

The clinical practice of Pre-hospital Emergency Medicine (PHEM) reflects a discrete body of knowledge, skills and competencies. In this annex, the development of the competence framework for PHEM is described.

Competence frameworks describe the range of work activities needed to deliver a service. They represent a set of statements defining the relevant underpinning knowledge, technical skills and non-technical skills - collectively referred to as competences. (3) When related to methods of learning, training and assessment, levels of clinical practice and standards of performance, these competences lie at the heart of a curriculum. An agreed competence framework allows a curriculum for PHEM education, training and clinical practice to be developed which complies with the General Medical Council’s standards. (4)

HISTORICAL PERSPECTIVE

Even before its inception in 1996, founder members of the Faculty of Pre-hospital Care were active in articulating the scope of clinical practice underpinning pre-hospital care. A formative group developed the Diploma in Immediate Medical Care in 1988 and the generic course in Pre Hospital Emergency Care (PHEC) in association with the British Association for Immediate Care in 1992.

The Faculty has subsequently been active in articulating the scope of clinical practice underpinning all aspects and levels of pre-hospital care. This has included hosting consensus conferences, developing approval and accreditation systems for a wide variety of training courses and introducing, through the production of the Manual of Core Material, the concept of a common generic curriculum for all levels of pre-hospital care. (5) The Diploma and Fellowship examinations in Immediate Medical Care have come to be recognised internationally as benchmarks for basic clinical and operational practice.

In addition to this national educational activity, several operational services across the UK have developed apprenticeship style training programmes aimed at ensuring practitioners had the knowledge and skills required to operate safely within their local service. However, it was the Emergency Medical Charity, Magpas that first introduced the concept of an all-encompassing competence framework based on evidence of unmet need and clinical demand. Following an operational activity analysis and audit of clinical activity and outcomes between 1997 and 2000, Magpas set up a working group to articulate ‘core competences’. The group reported in November 2001 and their framework formed the basis of their first formal ‘Emergency Medical Team’ training programme in January 2003. This framework was published in early 2005. (2)

In November 2005, the Faculty, together with Magpas, the London Helicopter Emergency Medical Service (HEMS) and the East Anglian Ambulance Service, hosted a joint competence framework consensus development meeting. The meeting was structured around ten 90-minute themed discussions based on the Magpas framework (table B.1). Each discussion commenced with a brief contextual introduction to the theme or ‘work role’ followed by 20 minutes of whole group brainstorming around the activities required to fulfill this role. Small group sessions were then used to attempt to define some of the knowledge, technical skills and non-technical skills underpinning these activities. The whole group then reviewed the themes, the lists of grouped activities (referred to as units) and the underpinning elements of competence. (3)

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28 www.magpas.org.uk
29 Members of the working group: John Eaton (General Practice), Robin Glover (Emergency Medicine), John Hedges (General Practice), Pam Kenny (General Practice), Juergen Klein (Anaesthesia and Intensive Care), Simon Lewis (Emergency Medicine), Rod Mackenzie (Emergency Medicine), Paul Silverston (General Practice), John Scott (General Practice and Paramedic Practice), Howard Sherriff (Emergency Medicine) and Luke Twelves (General Practice).
30 Attendees at the meeting (Orton Hall, Peterborough, November 2005): Marcus Bailey (Paramedic Practice), John Black (Emergency Medicine), Graham Chalk (Paramedic Practice), Rachel Clements (Emergency Medicine), James French (Emergency Medicine), James Hickman (General Practice), Simon Lewis (Emergency Medicine), Rod Mackenzie (Emergency Medicine), Cliff Reid (Emergency Medicine and Intensive Care), Malcolm Russell (General Practice and Military Medicine), John Scott (General Practice and Paramedic Practice), Lynda Sibson (Paramedic and Nursing Practice) and Matthew Wyse (Anaesthesia)
In October 2006, a nationwide questionnaire survey of opinion leaders within UK organisations responsible for pre-hospital care was conducted. Once the results were disseminated in October 2008, it became clear that there was strong agreement related to the scope of PHEM practice and a continued desire amongst practitioners to fully define the underpinning competence framework. The Faculty established the Faculty Curriculum Advisory Group (FCAG) in October 2008 to meet this desire and take forward the competence framework workstream of the Faculty’s sub-specialty development programme.

**CREATING THE PHEM CURRICULUM – STAGE 1: THE FCAG PROCESS**

The role of FCAG was to advise the Faculty on a competence framework, which would encapsulate the underpinning knowledge, technical skills and non-technical skills of a newly ‘qualified’ consultant level practitioner in PHEM (level 8 on the Skills for Health framework). Membership of FCAG was open to all those with an interest in PHEM, regardless of professional status or group. Invitations were sent to all those involved in the previous development activity, with a request to cascade the invitation to other healthcare professionals active in the delivery of PHEM. Eighty eight participants accepted the invitation to join FCAG (listed in the acknowledgements below). Once formed, FCAG utilised a modified nominal group technique (table B.2). (8,9)

Three physical meetings were held over a 12 month period and in different UK locations (Peterborough, December 2008; London, April 2009; Edinburgh, August 2009). Distillation of the ideas generated at the physical meetings was achieved through the creation of focus groups and the use of a web based project management and collaboration software suite. Emphasis was placed on developing activity or ‘unit’ level competences. Once a full set of unit level competences were derived, all FCAG members were surveyed on their level of agreement. Although this final survey led to some refinement of the language used to describe units, there was unanimous agreement on the overall content of the framework amongst the 38 respondents (see acknowledgements – respondents are indicated by an asterisk).
(1) **Introduction and explanation:** This stage was repeated at each physical meeting and detailed explanation was provided on the FCAG website.

(2) **Generation of ideas:** In contrast to the standard Nominal Group technique, where individual participants generate ideas in isolation, we formed small groups of individuals from different professional backgrounds and asked them to consider a ‘theme’ or work role. Theme Leads were then chosen to collate and co-ordinate further discussion around each theme and its constituent units.

(3) **Sharing of ideas:** Ideas about the units were shared at the physical FCAG meetings and all of the ideas generated around each theme and its units were placed on the FCAG website. There was inevitable debate about language and content at this stage.

(4) **Group discussion:** Frank and open discussion on the FCAG website message and write boards was encouraged, as well as generation of new ideas or changes in categorisation. This process was facilitated by each of the nominated Theme Leads. A ‘theme of the week’ process was employed to encourage equity of focus. Physical FCAG meetings also allowed each of the Theme Leads to present the collation of ideas around the themes and the units they should contain, and supported further discussion about these.

(5) **Voting and ranking decisions:** An online survey of the derived competence framework was developed (www.surveymonkey.com). A five point Likert scale was used to grade participants agreement with the 81 units.

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**Table B.2. Modified FCAG Nominal Group stages.**

**FCAG RECOMMENDATIONS**

The derived competence framework relates to what should be expected of a newly ‘qualified’ consultant in PHEM in the UK. In the competence framework, themes are overarching areas of professional practice. There are six sub-specialty specific and four generic competence themes within the proposed framework (table B.3).

Each theme comprised a number of discrete work roles or activities which are referred to as units. There were 81 units in the proposed framework. Each unit consisted of grouped or related elements of underpinning knowledge, technical skill and non-technical skill — otherwise referred to as ‘competences’. The individual competences are those deemed to be necessary to fulfill the work role or activity and, pending final elucidation, are not reported here. The inter-relation of the six related sub-specialty specific themes and the four generic or cross-cutting themes is illustrated in figure B.1.
1. Working within emergency medical systems
2. Providing pre-hospital emergency medical care
3. Using pre-hospital equipment
4. Supporting rescue and extrication
5. Supporting safe patient transfer
6. Supporting emergency preparedness and response

A. Good medical practice
B. Clinical governance
C. Team resource management
D. Operational practice

Table B.3. PHEM Competence Themes

Figure B.1. Original FCAG Competence framework schematic
DISCUSSION

The central methodology used in developing the competence framework was consensus opinion. Consensus meetings and workshops are commonly used methods for developing a collective opinion – especially where research evidence may be lacking or contradictory. A modified Nominal Group technique was chosen over other consensus development methods because the literature suggests that it generates a greater quantity of unique ideas and results in a marked increase in perceived group satisfaction with the outcome over other methods. (8,9) This is clearly important if the competence framework is to be acceptable nationally.

FCAG addressed the question: What activities constitute the clinical practice of a newly qualified consultant level sub-specialist in PHEM? What was surprising although reassuring throughout this process was that there was very little dissent about the answers. Most debates centered around the language used to articulate the framework units rather than the content. For example, there was inter-specialty discussion regarding the use of the term “critical care”. Where such debates occurred, the final decision regarding terminology rested with the majority opinion.

A consistent message conveyed at all FCAG meetings and on the online collaboration site was that ‘this all made sense’ and reflected the reality of current PHEM practice. This may explain the observed steady decline in engagement from a number of individuals. We hoped that participation would be optimized by having different locations for physical meetings and by utilizing web based collaboration software. In reality, some individuals expressed dislike for the software and some only attended the nearest meeting – thus limiting their own engagement. Others found the software difficult to use and others reported feeling intimidated by the lack of anonymity and the presence of senior personalities in the group. As a result, physical meetings and online debates and discussions were only consistently supported by approximately half of the full FCAG.

The final survey of agreed themes and units had a response rate of only 43% if the 88 original FCAG members are used as the denominator. In fact, these 38 respondents represented the core of FCAG in terms of engagement and the response rate may therefore be misleading. Nonetheless, we were disappointed with the limited response from the wider FCAG membership. We attribute this to perceived or actual difficulty in using online surveying software or perhaps a wider acquiescence bias. Despite the reduced number, those that did respond represented a diverse mix of healthcare professionals and the consensus on the agreed units within the framework was 100% - thus negating any further voting rounds.

COMPLETING THE PHEM CURRICULUM – STAGE 2: ARTICULATION OF ELEMENTS.

FCAG was dissolved and its work absorbed into the Curriculum, Training and Assessment (CTA) sub-committee of the IBTPHEM. The CTA sub-committee continued to use the modified Nominal Group technique to articulate the specific underpinning knowledge, technical skills and non-technical skills within each unit in the framework and relate these to methods of learning and assessment (see Section 2)

FCAG CONTRIBUTORS

Funding for FCAG administration and physical meetings was provided by the Faculty of Pre-hospital Care and Magpas. Richard Browne, Simon Lewis, John Scott and Alistair Steel provided significant contributions to this report. The Faculty extends its gratitude to those who gave of their time freely to support FCAG. Individuals who completed the final FCAG survey at the conclusion of the process are highlighted with an asterisk.

Gordon Allison (General Practice and Military Medicine), Bruce Armstrong (Nursing Practice), Jonathan Benger (Emergency Medicine), John Black (Emergency Medicine), Anthony Bleetman (Emergency Medicine), Mark Bloch* (Anaesthesia and Intensive Care), Anne Booth* (Anaesthesia), Dave Bramley* (Emergency Medicine), Philip Brown (General Practice), Richard Browne* (Anaesthesia), Mark Byers (General Practice and Military Medicine), Brian Carlin* (Paramedic Practice), Chris Carney (General Practice), Nick Castle (Nursing and Paramedic Practice), Graham Chalk (Paramedic Practice), David Cooksley* (Emergency Medicine), Gareth Davies (Emergency Medicine), Rob Dawes* (Anaesthesia), Charles Deakin* (Anaesthesia), Tristan Dyer* (Emergency Medicine), Dan Ellis* (Emergency Medicine and Intensive Care), Richard Fairhurst (General Practice and Emergency Medicine), Jeremy Field* (Anaesthesia), Mark Folman (General Practice), Mark Forrest* (Anaesthesia and Intensive Care), James French (Emergency Medicine), Will Glazebrook (Emergency Medicine), Ian Greaves (Emergency Medicine), Phil Grieve* (Paramedic Practice), Andy Griffiths (General
REFEREnCES


## PHEM TRAINING PROGRAMME RECRUITMENT – PERSON SPECIFICATION

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Essential</th>
<th>Desirable</th>
<th>When Evaluated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Qualifications</strong></td>
<td>MBBS or equivalent medical qualification</td>
<td>Higher qualifications in PHEM e.g. Diploma in Immediate Medical Care (Dip IMC) of the Royal College of Surgeons of Edinburgh</td>
<td>Application form Pre-employment check</td>
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<tr>
<td></td>
<td>FRCA primary or equivalent at time of application</td>
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<td>OR</td>
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<td></td>
<td>MCEM or equivalent at time of application</td>
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<tr>
<td><strong>Eligibility</strong></td>
<td>Holds full registration with the GMC at time of appointment and holds a current licence to practice</td>
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<td>Application form Selection centre Pre-employment check</td>
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<tr>
<td></td>
<td>Holds a National Training Number in Anaesthesia or Emergency Medicine</td>
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<td>OR</td>
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<tr>
<td></td>
<td>Holds CCT in Anaesthesia or Emergency Medicine</td>
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<tr>
<td></td>
<td>Eligible to work in the UK</td>
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<tr>
<td><strong>Fitness to practise</strong></td>
<td>Is up to date and fit to practise safely</td>
<td></td>
<td>Application form References</td>
</tr>
<tr>
<td><strong>Career progression</strong></td>
<td>Successful ARCP at ST4 in Emergency Medicine or Anaesthesia</td>
<td></td>
<td>Application form Selection centre</td>
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<tr>
<td></td>
<td>Ability to provide complete details of employment history</td>
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<tr>
<td><strong>Health</strong></td>
<td>Meets professional health requirements (in line with GMC standards / Good Medical Practice)</td>
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<td>Application form Pre-employment health screening Ambulance service fitness test</td>
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</table>
### PHEM TRAINING PROGRAMME RECRUITMENT – PERSON SPECIFICATION (CONT.)

<table>
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<tr>
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<th>Desirable</th>
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<tr>
<td><strong>Clinical Experience</strong></td>
<td>Minimum 6 months training in an approved training post in Emergency Medicine at CT1 or equivalent Minimum 6 months training in an approved training post in Anaesthesia at CT1 or equivalent</td>
<td>Clinical experience in PHEM Paediatric critical care and transfer experience</td>
<td>Application form</td>
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<tr>
<td><strong>Clinical Skills</strong></td>
<td>Provider status in ATLS, ALS and APLS or equivalent.</td>
<td>Instructor status in ATLS and ALS Provider status in MIMMS or equivalent Provider or instructor status in Pre-hospital life support courses e.g. PHTLS</td>
<td>Application form</td>
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<td><strong>Academic skills</strong></td>
<td>Evidence of scholarly activity to support training</td>
<td>Publications / presentations related to PHEM</td>
<td>Application form</td>
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<tr>
<td><strong>Personal skills</strong></td>
<td>Self-motivated Good management of own training to date</td>
<td>Training in team resource management</td>
<td>Application form</td>
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<tr>
<td><strong>Probit</strong></td>
<td>Professional Integrity: Demonstrates probity (displays honesty, integrity, aware of ethical dilemmas, respects confidentiality) Capacity to take responsibility for own actions</td>
<td></td>
<td>Application form</td>
</tr>
<tr>
<td>Criteria</td>
<td>Essential</td>
<td>Desirable</td>
<td>When Evaluated</td>
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<tr>
<td>Commitment to Specialty</td>
<td>Demonstrable interest in and understanding of the specialty</td>
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<td></td>
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<td>Interview References</td>
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<tr>
<td></td>
<td>All applicants to have demonstrable skills in written and spoken English adequate to enable effective communication about medical topics with patients and colleagues demonstrated by one of the following:</td>
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<td></td>
<td>That applicants have undertaken undergraduate medical training in English; or</td>
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<td></td>
<td>Have achieved the following scores in the academic International English Language Testing System (IELTS) in a single sitting within 24-months at time of application – Overall 7, Speaking 7, Listening 7, Reading 7, Writing 7.</td>
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<td>If applicants believe they have adequate communication skills but do not fit into one of these examples they must provide supporting evidence.</td>
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<td>Language Skills</td>
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<td>Interview / Selection centre</td>
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ANNEX D. PHEM TRAINEE ASSESSMENT TOOLS

Examples of the assessment tools recommended in section 4 are provided in this appendix along with guidance notes for rating satisfactory or unsatisfactory performance.

1. Mini-Clinical Evaluation Exercise (CEX)
   - Initial operational approach
   - Initial clinical approach
   - History and information gathering
   - Examination
   - Clinical decision making and judgment
   - Communication with patient, relatives, staff
   - Overall plan
   - Adherence to Good Medical Practice

2. Case Based Discussion (CBD)
   - Underpinning principles
   - Safety issues
   - Record keeping
   - Team management
   - Diagnosis
   - Treatment
   - Planning for subsequent care
   - Clinical reasoning
   - Overall clinical care
   - Adherence to Good Medical Practice

3. Direct Observation of Procedural Skill (DOPS)
   - Clinical indication
   - Appropriately deals with issues related to consent
   - Appropriate preparation
   - Technical skills
   - Situational awareness and clinical judgement
   - Safety, including prevention and management of complications
   - Post procedure management
   - Professionalism, communication and consideration for patient, relatives and colleagues
   - Documentation
   - Adherence to Good Medical Practice

4. Acute Care Assessment Tool (ACAT-PHEM)
   - Clinical Assessment
   - Medical record keeping
   - Clinical management
   - Time management
   - Management of the team
   - Medical leadership
   - Equipment and resource management
   - Patient safety
   - Handover
   - Overall Clinical Judgment
   - Adherence to Good Medical Practice

5. Teaching Observation (TO)

6. Audit Assessment (AA)

7. Multi-source Feedback (MSF)
# INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

## MINI-CLINICAL EVALUATION EXERCISE (CEX)

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<th>Training Phase:</th>
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<td>Registration no:</td>
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<td>Grade of assessor:</td>
<td>Date</td>
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### Clinical scenario observed

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### Formative? | Summative?

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<th>Please TICK to indicate the standard of the trainee’s performance in each area</th>
<th>Not observed</th>
<th>Further core learning needed</th>
<th>Demonstrates good practice</th>
<th>Demonstrates excellent practice</th>
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</thead>
<tbody>
<tr>
<td>Initial operational approach</td>
<td>Must address learning</td>
<td>Should address learning</td>
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<tr>
<td>Initial clinical approach</td>
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<tr>
<td>History and information gathering</td>
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<td>Examination</td>
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<td>Clinical decision making and judgment</td>
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<td>Communication with patient, relatives, staff</td>
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<td>Overall plan</td>
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<tr>
<td>Adherence to Good Medical Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE
### MINI-CLINICAL EVALUATION EXERCISE (CEX) (CONT.)

<table>
<thead>
<tr>
<th>Trainee Name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor Name:</td>
<td>Registration no:</td>
</tr>
<tr>
<td>Grade of Assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Areas of strength

### Areas for improvement

### Action plan

<table>
<thead>
<tr>
<th>If summative:</th>
<th>Fail</th>
<th>Pass</th>
<th>Good Pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor Signature:</td>
<td></td>
<td></td>
<td>Trainee Signature:</td>
</tr>
</tbody>
</table>
## GUIDANCE NOTES FOR RATING SATISFACTORY OR UNSATISFACTORY PERFORMANCE
### MINI-CLINICAL EVALUATION EXERCISE (CEX)

The following table provides descriptors of unsatisfactory performance in a CEX which can be used for providing feedback to the trainee.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Descriptors of unsatisfactory performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial approach</td>
<td>Scene safety, personal safety and/or dynamic risk assessment were omitted or undertaken haphazardly</td>
</tr>
</tbody>
</table>
| Scene survey, history & information gathering | Scene survey was omitted or haphazard
History taking was not focused
Critical symptoms or symptom patterns were not recognized
Failure to gather all the important information from the patient or other sources, missing important points
Non-engagement with the patient or inappropriate delegation
Unable to elicit history in difficult circumstances – busy, noisy, multiple demands |
| Examination | Failure to detect/elicit and interpret important physical signs
Failure to maintain dignity and privacy when possible |
| Monitoring & investigations | Failure to use appropriate monitoring and/or diagnostic tests with recognition of need for reassessment |
| Clinical decision making & judgement | Failure to identify the most likely diagnosis in a given situation
Failure to construct a likely differential diagnosis
Failure to identify patients who require hospitalisation or not
Failure to recognise atypical presentation
Failure to recognise urgency of case
Failure to select the most effective treatments
Failure to make decisions in a timely fashion
Decisions made which do not reflect clear understanding of underlying principles
Failure to reassess patient
Lack of anticipation for need of interventions and slow to respond to changes in patient’s condition
Failure to review effect of interventions |
| Communication with crew, patient, relatives, other staff | Communication skills with colleagues
• Failure to listen to other views
• Failure to discuss issues with the team
• Failure to follow the lead of others when appropriate
• Rude behaviour
• Failure to give clear and timely instructions
• Failure to seek advice
Communication with patients
• Failure to elicit concerns, understanding or expectations of the patient,
• Failure to inform patient and educate when appropriate
• Failure to protect patient’s dignity when possible
• Insensitivity to patient’s opinions, hopes or fears
• Failure to explain plans and risks of treatment when appropriate in a way the patient could understand |
| Overall care | Failure to ensure that the patient is in a safe monitored environment
Failure to anticipate or recognise complications
Failure to focus sufficiently on safe practice
Failure to follow published standard guidelines or protocols
Failure to follow infection control measures
Failure to safely administer medication |
# INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

## CASE BASED DISCUSSION (CBD)

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name:</td>
<td>Registration no:</td>
</tr>
<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Case discussed**

**Curriculum elements covered**

<table>
<thead>
<tr>
<th>Underpinning principles</th>
<th>Safety issues</th>
<th>Record keeping</th>
<th>Team management</th>
<th>Diagnosis</th>
<th>Treatment</th>
<th>Planning for subsequent care</th>
<th>Clinical reasoning</th>
<th>Overall clinical care</th>
<th>Adherence to Good Medical Practice</th>
</tr>
</thead>
</table>

**Formative?**

**Summative?**

<table>
<thead>
<tr>
<th>Please TICK to indicate the standard of the trainee’s performance in each area</th>
<th>Not observed</th>
<th>Further core learning needed</th>
<th>Must address learning</th>
<th>Should address learning</th>
<th>Demonstrates good practice</th>
<th>Demonstrates excellent practice</th>
</tr>
</thead>
</table>

**Please TICK to indicate the standard of the trainee’s performance in each area**

- Underpinning principles
- Safety issues
- Record keeping
- Team management
- Diagnosis
- Treatment
- Planning for subsequent care
- Clinical reasoning
- Overall clinical care
- Adherence to Good Medical Practice
INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE CASE BASED DISCUSSION (CBD) (CONT.)

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name:</td>
<td>Registration no:</td>
</tr>
<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Areas of strength**

<table>
<thead>
<tr>
<th>Areas for improvement</th>
</tr>
</thead>
</table>

**Action plan**

<table>
<thead>
<tr>
<th>If summative:</th>
<th>Fail</th>
<th>Pass</th>
<th>Good pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor Signature:</td>
<td>Trainee Signature:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
GUIDANCE NOTES FOR RATING SATISFACTORY OR UNSATISFACTORY PERFORMANCE

CASE BASED DISCUSSIONS (CBD)

The following table provides descriptors of expected or satisfactory behaviour

<table>
<thead>
<tr>
<th>Domain</th>
<th>Expected behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record keeping</td>
<td>Records should be legible and signed and dated. Should be structured and include provisional and differential diagnoses, initial clinical findings &amp; monitoring data.</td>
</tr>
<tr>
<td>Review of clinical findings &amp; monitoring</td>
<td>Undertook appropriate clinical examination &amp; monitoring. Results are recorded and correctly interpreted with appropriate reassessments.</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>The correct provisional diagnosis was achieved with an appropriate differential diagnosis. Were any important conditions omitted?</td>
</tr>
<tr>
<td>Treatment</td>
<td>Emergency treatment on scene and during transfer was correct, thoroughly documented and response recorded including adverse events.</td>
</tr>
<tr>
<td>Planning for subsequent care &amp; handover of care</td>
<td>Clear plan demonstrating expected clinical course, recognition of and planning for possible complications and instructions to team and patient (if appropriate). Evidence of thorough handover to the provider of ongoing care.</td>
</tr>
<tr>
<td>Clinical reasoning</td>
<td>Able to integrate the history, examination and investigative data to arrive at a logical diagnosis and appropriate treatment plan taking into account the patient’s co-morbidities and any special considerations for the relevant patient group</td>
</tr>
<tr>
<td>Patient safety issues</td>
<td>Able to recognize effects of systems, process, environment and staffing on patient safety issues</td>
</tr>
<tr>
<td>Overall clinical care</td>
<td>The case records and the trainees discussion should demonstrate that this episode of clinical care was conducted in accordance with good clinical practice and to a good overall standard</td>
</tr>
<tr>
<td>Incident debrief</td>
<td>There should be evidence that the incident has been debriefed</td>
</tr>
</tbody>
</table>

The following table provides descriptors of unsatisfactory behaviour

<table>
<thead>
<tr>
<th>Observed behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did not understand the indications and contraindications to the procedure</td>
</tr>
<tr>
<td>Did not properly explain the procedure to the patient</td>
</tr>
<tr>
<td>Did not understand relevant anatomy</td>
</tr>
<tr>
<td>Failed to prepare properly for the procedure</td>
</tr>
<tr>
<td>Did not communicate appropriately with patient, crew or staff</td>
</tr>
<tr>
<td>Aseptic precautions were inadequate</td>
</tr>
<tr>
<td>Did not perform the technical aspect of the procedure correctly</td>
</tr>
<tr>
<td>Failed to adapt to unexpected problems in the procedure</td>
</tr>
<tr>
<td>Failed to demonstrate adequate skill and practical fluency</td>
</tr>
<tr>
<td>Was unable to complete the procedure</td>
</tr>
<tr>
<td>Did not complete relevant documentation</td>
</tr>
<tr>
<td>Did not issue clear post procedural instructions to patient, crew or staff</td>
</tr>
<tr>
<td>Did not maintain an appropriate professional demeanour</td>
</tr>
</tbody>
</table>
## INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

### DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS)

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name:</td>
<td>Registration no:</td>
</tr>
<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Procedure assessed</th>
<th>Curriculum elements covered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Formative?</th>
<th>Summative?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Please TICK to indicate the standard of the trainee’s performance in each area</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Not observed</strong></td>
</tr>
<tr>
<td>Clinical indication</td>
<td></td>
</tr>
<tr>
<td>Appropriately deals with issues related to consent</td>
<td></td>
</tr>
<tr>
<td>Appropriate preparationtion</td>
<td></td>
</tr>
<tr>
<td>Technical skills</td>
<td></td>
</tr>
<tr>
<td>Situational awareness and clinical judgement</td>
<td></td>
</tr>
<tr>
<td>Safety, including prevention and management of complications</td>
<td></td>
</tr>
<tr>
<td>Post procedure management</td>
<td></td>
</tr>
<tr>
<td>Professionalism, communication and consideration for patient, relatives and colleagues</td>
<td></td>
</tr>
<tr>
<td>Documentation</td>
<td></td>
</tr>
<tr>
<td>Adherence to Good Medical Practice</td>
<td></td>
</tr>
</tbody>
</table>
**INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE**
**DIRECT OBSERVATION OF PROCEDURAL SKILLS (DOPS) (CONT.)**

<table>
<thead>
<tr>
<th>Trainee name:</th>
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</tr>
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<tr>
<td>Assessor name:</td>
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<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Areas of strength

### Areas for improvement

### Action plan

If summative: | Fail | Pass | Good pass |
|-------------|------|------|-----------|

Assessor Signature: | Trainee Signature:
### INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

**ACUTE CARE ASSESSMENT TOOL ACAT-PHEM**

<table>
<thead>
<tr>
<th>Trainee name:</th>
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</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Procedure assessed**

<table>
<thead>
<tr>
<th>Curriculum elements covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Please TICK to indicate the standard of the trainee’s performance in each area**

<table>
<thead>
<tr>
<th></th>
<th>Not observed</th>
<th>Further core learning needed</th>
<th>Demonstrates good practice</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Must address learning</td>
<td>Should address learning</td>
</tr>
</tbody>
</table>

- Clinical Assessment
- Medical record keeping
- Clinical management
- Time management
- Management of the team
- Medical leadership
- Equipment and resource management
- Patient safety
- Handover
- Overall Clinical Judgement
- Adherence to Good Medical Practice
**Trainee name:** | **Training Phase:**  
---|---
**Assessor name:** | **Registration no:**  
**Grade of assessor:** | **Date**

### Areas of strength

### Areas for improvement

### Action plan

<table>
<thead>
<tr>
<th>If summative:</th>
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</tr>
</thead>
</table>
Assessor Signature: | Trainee Signature:
GUIDANCE NOTES FOR RATING SATISFACTORY OR UNSATISFACTORY PERFORMANCE
ACUTE CARE ASSESSMENT TOOL (ACAT)

The following table provides descriptors of expected or satisfactory behaviour

<table>
<thead>
<tr>
<th>Assessment domains</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical assessment and clinical cases covered</td>
<td>Quality of focused history and examination to arrive at appropriate diagnosis – made by direct observation and note review of no more than 5 cases</td>
</tr>
<tr>
<td>Medical record keeping</td>
<td>Quality of recording of patient encounters including documentation of drug administration</td>
</tr>
<tr>
<td>Investigations and triage</td>
<td>Quality of trainee’s choice of investigations &amp; appropriateness of triage to next level of care</td>
</tr>
<tr>
<td>Management of patients</td>
<td>Quality of treatment given to patients (assessment, investigation and treatment)</td>
</tr>
<tr>
<td>Time management</td>
<td>Prioritisation of patients</td>
</tr>
<tr>
<td>Management of the shift &amp; team working</td>
<td>Appropriate relationship with and involvement of other pre-hospital care providers and emergency services</td>
</tr>
<tr>
<td>Clinical leadership</td>
<td>Appropriate delegation and supervision to colleagues within the multidisciplinary team</td>
</tr>
<tr>
<td>Handover</td>
<td>Quality of handover of care of patients in the receiving Emergency department or specialty ward</td>
</tr>
<tr>
<td>Patient safety</td>
<td>Recognises effects of systems, process, environment and crew composition on patient safety issues</td>
</tr>
<tr>
<td>Overall clinical judgement</td>
<td>Quality of trainee’s clinical thinking based on clinical assessment, interpretation of monitoring with appropriate prediction of anticipated clinical course; safe and appropriate management including triage to appropriate level of ongoing clinical care; use of resources sensibly</td>
</tr>
</tbody>
</table>
# INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

## TEACHING OBSERVATION (TO)

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name:</td>
<td>Registration no:</td>
</tr>
<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
<tr>
<td>Teaching topic/title</td>
<td>Curriculum elements covered</td>
</tr>
<tr>
<td>Number of learners</td>
<td></td>
</tr>
<tr>
<td>Teaching environment</td>
<td></td>
</tr>
<tr>
<td>Length of teaching session</td>
<td></td>
</tr>
</tbody>
</table>

### Please TICK to indicate the standard of the trainee's performance in each area

<table>
<thead>
<tr>
<th>Not observed</th>
<th>Further core learning needed</th>
<th>Demonstrates good practice</th>
<th>Demonstrates excellent practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Must address learning</td>
<td>Should address learning</td>
</tr>
</tbody>
</table>

- Introduction of self
- Gained attention of group
- Gave expected learning outcomes
- Key points emphasised
- Good knowledge of subject
- Logical sequence
- Well paced
- Clear concise delivery
- Good use of tone/voice
- Appropriate use of resources
- Encouraged group participation
- Effective use of questioning
- Appropriate use of teaching methods
- Encouraged questions from group
- Dealt with questions appropriately
- Summarised key points at end

---

**ANNEXES**
<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name:</td>
<td>Registration no:</td>
</tr>
<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

Please TICK to indicate the standard of the trainee's performance in each area:

- Not observed
- Further core learning needed
- Demonstrates good practice
- Demonstrates excellent practice
- Must address learning
- Should address learning

Met learning outcomes

Kept to time limit

Overall performance

### Areas of strength

### Areas for improvement

### Action plan

<table>
<thead>
<tr>
<th>If summative:</th>
<th>Fail</th>
<th>Pass</th>
<th>Good pass</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor Signature:</td>
<td></td>
<td></td>
<td>Trainee Signature:</td>
</tr>
</tbody>
</table>
# INTER-COLLEGIATE BOARD FOR TRAINING IN PRE-HOSPITAL EMERGENCY MEDICINE

## AUDIT ASSESSMENT (AA)

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor name:</td>
<td>Registration no:</td>
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<tr>
<td>Grade of assessor:</td>
<td>Date</td>
</tr>
</tbody>
</table>

### Audit Title

<table>
<thead>
<tr>
<th>Curriculum elements covered</th>
</tr>
</thead>
</table>

### Please TICK to indicate the standard of the trainee's performance in each area

<table>
<thead>
<tr>
<th>Criteria Chosen</th>
<th>Not observed</th>
<th>Further core learning needed</th>
<th>Demonstrates good practice</th>
<th>Demonstrates excellent practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard chosen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audit methodology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Results and interpretation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conclusions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presentation of audit findings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recommendations made as a result</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan for implementation of change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actions undertaken to implement change</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adherence to Good Medical Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Areas of strength

- Area 1
- Area 2

### Areas for improvement

- Area 1
- Area 2

### Action plan

<table>
<thead>
<tr>
<th>Assessor Signature:</th>
<th>Trainee Signature:</th>
</tr>
</thead>
</table>
# Inter-collegiate Board for Training in Pre-hospital Emergency Medicine

## Multi-Source Feedback (MSF)

### Trainee name: Training Phase:

<table>
<thead>
<tr>
<th>Grading System</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>** UNKnown**</td>
<td>Performance Does Not Meet Expectations</td>
<td>Performance Partially Meets Expectations</td>
<td>Performance Meets Expectations</td>
<td>Performance Exceeds Expectations</td>
<td>Performance Consistently Exceeds Expectations</td>
</tr>
<tr>
<td><strong>Not Observed</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

### Good Clinical Care

<table>
<thead>
<tr>
<th>1-5 or UK</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medical knowledge and clinical skills</td>
</tr>
<tr>
<td>2</td>
<td>Problem-solving skills</td>
</tr>
<tr>
<td>3</td>
<td>Note-keeping – clarity; legibility and completeness</td>
</tr>
<tr>
<td>4</td>
<td>Emergency Care skills</td>
</tr>
</tbody>
</table>

Additional comments on this doctor’s clinical care

### Relationships with patients

<table>
<thead>
<tr>
<th>1-5 or UK</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Empathy and sensitivity</td>
</tr>
<tr>
<td>2</td>
<td>Communicates well with all patient groups</td>
</tr>
<tr>
<td>3</td>
<td>Treats patients and relatives with respect</td>
</tr>
<tr>
<td>4</td>
<td>Appreciates the psycho-social aspects of patient care</td>
</tr>
<tr>
<td>5</td>
<td>Offers explanations</td>
</tr>
</tbody>
</table>

Additional comments on this doctor’s relationships with patients
## Inter-Collegiate Board for Training in Pre-Hospital Emergency Medicine Multi-Source Feedback (MSF) (Cont.)

<table>
<thead>
<tr>
<th>Trainee name:</th>
<th>Training Phase:</th>
</tr>
</thead>
</table>

### Grading System

<table>
<thead>
<tr>
<th>Grade</th>
<th>Performance</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNKNOWN</td>
<td>Performance</td>
<td>Does Not Meet Expectations</td>
<td>Partially Meets Expectations</td>
<td>Meets Expectations</td>
<td>Exceeds Expectations</td>
<td>Performance Consistently Exceeds Expectations</td>
</tr>
<tr>
<td>Not Observed</td>
<td>Does Not Meet Expectations</td>
<td>Partially Meets Expectations</td>
<td>Meets Expectations</td>
<td>Exceeds Expectations</td>
<td>Consistently Exceeds Expectations</td>
<td></td>
</tr>
</tbody>
</table>

### Relationship with Colleagues

<table>
<thead>
<tr>
<th>Relationship</th>
<th>1-5 or UK</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Is a team-player</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Asks for others’ point of view and advice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Encourages discussion Empathy and sensitivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Is clear and precise with instructions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Treats colleagues with respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Communicates well (incl. non-verbal communication)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Is reliable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Can lead a team well</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Takes responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 “I like working with this doctor”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Additional comments on this doctor’s clinical care**
### Grading System

<table>
<thead>
<tr>
<th>UNKnown</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Observed</td>
<td>Performance Does Not Meet Expectations</td>
<td>Performance Partially Meets Expectations</td>
<td>Performance Meets Expectations</td>
<td>Performance Exceeds Expectations</td>
<td>Performance Consistently Exceeds Expectations</td>
</tr>
</tbody>
</table>

### Teaching and training

<table>
<thead>
<tr>
<th>1-5 or UK</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Teaching is structured</td>
</tr>
<tr>
<td>2</td>
<td>Is enthusiastic about teaching</td>
</tr>
<tr>
<td>3</td>
<td>This doctor’s teaching sessions are beneficial</td>
</tr>
<tr>
<td>4</td>
<td>Teaching is presented well</td>
</tr>
<tr>
<td>5</td>
<td>Uses varied teaching skills</td>
</tr>
</tbody>
</table>

**Additional comments on this doctor’s clinical care**

### Global ratings on this door

<table>
<thead>
<tr>
<th>1-5 or UK</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Overall how do you rate this Dr compared to other Sub-specialist PHEM Trainees</td>
</tr>
<tr>
<td>2</td>
<td>How would you rate this trainee’s performance at this stage of training</td>
</tr>
<tr>
<td>3</td>
<td>Do you have any concerns over this Dr’s probity or health?</td>
</tr>
</tbody>
</table>

**Additional comments on this doctor’s relationships with patients**
ANNEX E. DEANERY STATEMENT OF TRAINING PROGRAMME ASSURANCE AND COMPLIANCE

INTRODUCTION

The IBTPHEM works with Deaneries to ensure that a trainee has the best possible training opportunities as part of a GMC approved Deanery PHEM training programme.

The information in this annex must be provided to the IBTPHEM by the training programme host Deanery in order to allow the IBTPHEM to review the programme and make recommendations to the GMC.

SECTION 1. HOST DEANERY DETAILS

1.1 Please provide the details for:
   (a) Host Deanery for Programme.
   (b) Host School.
   (c) Chair of Training Committee or Head of School.
   (d) PHEM Training Programme Director.
   (e) Locality / Sector 32

1.2 Please provide the details for any additional deaneries if the proposed programme crosses deanery areas of responsibility.

SECTION 2. TRAINING SCHEME DETAILS

2.1 Please provide details of all training locations, services or environments which trainees will be placed in or rotate through in the programme. 33

2.2 For each training location, service or environment in the programme, please provide, where relevant:
   (a) A copy of the Deanery Learning and Development Agreement (or equivalent)
   (b) A copy of the Care Quality Commission registration

2.3 For each training location, service or environment in the programme, please confirm:
   (a) Compliance with GMC Standards for Training
   (b) Registration with the Intercollegiate Board for Training in Pre-hospital Emergency Medicine.

2.4 Please provide details of the structure of training schemes available within the training programme with specific reference to:
   (a) Scheme of training (A, B or C).
   (b) Numbers of Locally and/or Nationally Recruited posts

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32 The locality/sector is a geographical area. It could be a deanery or a part of it, or more than one deanery if a programme crosses deanery boundaries.

33 Training environments can be defined as the organisations in which trainee doctor’s train; these may include Acute or Ambulance Trusts, independent providers (NHS funded or other) Defence Medical Services placements and so on.
SECTION 3. TRAINING CAPACITY

3.1 Please indicate the maximum training capacity (that is, the highest number of whole-time equivalent trainees, who could be within the training programme at one time) that this programme can accommodate.

3.2 Exposure to patients and certain indicative procedures is important for trainees. Please provide the following for the geography of the training programme and detail how these figures have been derived.

   (a) Total primary scene patients attended.
   (b) Total secondary ED retrieval / transfers undertaken.
   (c) Total pre-hospital emergency anaesthetics
   (d) Total pre-hospital procedural sedations

3.3 Given the shift and rota patterns of a trainee within the proposed training programme, any secondments and other doctors operating in non-training posts within the system, please provide the exposure rate per trainee per 6 months WTE for the indicators below (and detail how these figures have been derived). If there are several rotations, please indicate figures for each.

   (a) Primary scene patients attended per 6 months WTE.
   (b) Secondary ED retrieval / transfers undertaken per 6 months WTE.
   (c) Pre-hospital emergency anaesthetics per 6 months WTE.
   (d) Total pre-hospital procedural sedations per 6 months WTE.

SECTION 4. CURRICULUM FRAMEWORK

4.1 Please provide a description of how the training programme will comply with the following standards:

   (a) The duties, working hours and supervision of trainees must be consistent with the delivery of high quality, safe patient care.
   (b) There must be clear procedures to address immediately any concerns about patient safety arising from the training of doctors.
   (c) Trainees must be supported to acquire the necessary skills and experience through induction, effective educational supervision, an appropriate workload, personal support and time to learn.
   (d) The requirements set out in the approved PHEM curriculum must be delivered.
   (e) Standards for trainers: Trainers must provide a level of supervision appropriate to the competence, experience and phase of training of the trainee.
   (f) Education and training must be planned and maintained through transparent processes which show who is responsible at each stage.
   (g) The educational facilities, infrastructure and leadership must be adequate to deliver the curriculum. Simulation is an essential part of the PHEM curriculum and assessment framework and appropriate facilities must be adequate to deliver simulator based training.
SECTION 5. HOST DEANERY ASSURANCE

5.1 To be completed by the Training Programme Director (or their equivalent)

I confirm that I am responsible for the management of the above programme on behalf of the Deanery and that the programme complies with the GMC’s generic training standards and will deliver the competencies defined in the current PHEM curriculum.

Name:

Signature:

Date:

Contact details (including address, telephone number and email address)

5.2 To be completed by the Postgraduate Dean

In my opinion this programme will deliver the curriculum and the outcomes required.

Name:

Signature:

Date:

Contact details (including address, telephone number and email address)