# The Guide to RCEM Emergency Care ACP Credentialing

## Updated July 2021

| | |
|---|---|
| November 2018 v1.0 | 10 January 2019 |
| November 2018 v1.1 | 05 February 2019 |
| November 2018 v1.2 | 04 March 2019 |
| November 2018 v1.3 | 21 March 2019 |
| April 2020 v2 | 30 April 2020 |
| July 2021 v3 (this document) | 22 July 2021 |

# Preface

This guide is designed to support trainee Emergency Care Advanced Clinical Practitioners (EC-ACP) and established ACPs who wish to credential, as well as supervisors who are providing the clinical and educational support for the EC-ACP credentialing process. EC-ACPs should always ensure they read the latest version of this guide published on the Royal College of Emergency Medicine (RCEM) website.

The standards of performance and requirements for assessments and evidence for credentialing for the EC-ACP are set out in the Emergency Care ACP Curriculum which is available on the RCEM website. The curriculum has been endorsed by the Royal College of Nursing and the College of Paramedics. A second edition of the curriculum was approved in October 2017 and has replaced the curriculum which was in place for the pilot project.

There are two credentialing application windows each year – in Spring and Autumn. EC-ACPs intending to apply for credentialing should ensure they read the curriculum carefully.

The purpose of this guide to credentialing is to assist EC-ACPs and their supervisors in understanding the process and documentation to be used. The guide is, as the title states, a ***guide,*** and practices, processes and paperwork may be altered at the discretion of the Royal College of Emergency Medicine through the RCEM ACP Credentialing Sub-committee. For example, there are occasional changes to the checklist that must be submitted as part of the process; applicants should ensure they use the correct checklist on the RCEM website.

The Royal College of Emergency Medicine would like to thank Health Education England for their support and guidance in the development and implementation of the EC-ACP credentialing process.

# Table of Contents

Section 1: Introduction and overview of process ........ 4
Section 2: Utility of the credentialing process ........ 6
Section 3: The experience required for credentialing – working as an EC-ACP ........ 6
Section 4: The evidence required ........ 9
Section 5: Educational Supervision ........ 15
Section 6: The ACP Credentialing Panel ........ 19
Section 7: The standard ........ 20
Section 8: Gaining the required experience across the curriculum ........ 21
Section 9: Working in the department ........ 21
Section 10: Top tips for developing a programme for EC-ACP development and workforce (also useful for EC-ACPs to read!) ........ 22
Appendix one: Credentialing Outcome Form ........ 25
Appendix two: Checklist for the ES in signing the ESR ........ 27
Appendix three: Credentialing Screening Form ........ 30
Appendix four: RCEM EC-ACP Academic Component - Credentialing Declaration ........ 32
Appendix five: Patient logbook (adult cases) summary template ........ 35
Appendix six: Patient logbook (paediatric cases) summary template ........ 37

# Section 1: Introduction and overview of process

1.1 This guide sets out the arrangements for the Emergency Care Advanced Clinical Practitioner (EC-ACP) credentialing process as agreed by the Royal College of Emergency Medicine (RCEM).

1.2 The credentialing process is a mechanism whereby trainee and established ACPs in Emergency Care will present evidence of their achievements and competences to be evaluated against the RCEM Emergency Care ACP curriculum.

1.3 The EC-ACP can credential as an adult ACP, children's ACP or combined (dual adult and children's) ACP. The curriculum for each is different and the evidence required is specific to each.

1.4 A panel of Fellows of the College, Consultant Practitioners and credentialed ACPs will review the evidence and confirm there is appropriate evidence within the portfolio to demonstrate that the standard has been met.

1.5 The standard to be met is that of an CT3/ST3 in Emergency Medicine at the end of the CT3/ST3 year, competent within the relevant curriculum items. The standard is defined in the ACP curriculum on the RCEM website.

1.6 The credentialing process includes:

- collection of evidence that must be held within the RCEM ePortfolio. There is a substantial amount of evidence that must be presented - all within 5 years and the majority within the last 3 years. The EC-ACP must be an Associate Member (ACP) of RCEM to access the ePortfolio;
- completion of a checklist, countersigned by a trained educational supervisor, that confirms all evidence is present;
- completion of a minimum of:
  - ❖ three Structured Training Reports (STR) / Educational Supervisor Reports (ESR)

    **[NB: Structured Training Reports will be replaced by Educational Supervisor Reports from August 2021. STRs that are migrated from NES to Kaizen will be renamed as ESRs and hereafter will be referred to as Educational Supervisor Reports in this guide]**
  - ❖ three Faculty Educational Governance Statements (FEGS)
  - ❖ three multi-source feedback assessments (MSF)
- sign-off by the local educational supervisor (who must have attended the RCEM ACP supervisor training) confirming all evidence has been reviewed, is adequate and accurately represents the performance in the workplace;
- screening by the College Training Team to identify missing evidence or a portfolio that cannot be assessed due to excessive evidence or poor linking/layout. This screening may result in the application being returned and no further evaluation being undertaken;

- review by a minimum of two RCEM ACP Credentialing Panel members who individually review the evidence and then agree in conference the recommended outcome to be presented to the Panel;
- panel meeting (virtual or face to face) where each application will be presented with the recommended outcome to the Panel together with the rationale based on the evidence provided - discussion and agreement by the Panel (minimum six members);
- confirmation of credentialing outcome. Possible outcomes include:
    - ❖ **Credential**
    - ❖ **Immediate resubmission:** the Panel is in agreement that the ACP has met the required standard, but further clarification of existing evidence is required. Applicants are allowed three weeks to provide this clarification and no additional fee is charged.
    - ❖ **Limited resubmission:** the Panel is in agreement that the additional evidence required for the ACP to demonstrate they have met the required standard should be achievable within six months. Providing the ACP submits the additional evidence within the next credentialing window, a reduced fee is applicable.
    - ❖ **Full resubmission:** the Panel is in agreement that the ACP has failed to demonstrate they have met the required standard. The ACP may resubmit in full to a future application window and the full fee will be applicable.

  Limited feedback will be provided for those ACPs who receive an immediate, limited, or full resubmission outcome, and the supervisor may be given specific advice in some cases where it is felt that enhanced supervision may be beneficial.

1.7 It is important that trainee and established ACPs recognise the need for attaining a formal advanced practice qualification at **Level 7.** This must be a *minimum* of a Postgraduate Diploma (PGDip) but can be a full Masters, and the subject must be related to advanced clinical practice. The advanced practice programme must contain specific modules / sufficient credits for topics of history and examination, diagnostics and clinical reasoning, regardless of the title of the programme. The ACP is required to demonstrate how the learning outcomes of their completed programme modules fulfil the RCEM learning outcomes described in the academic declaration form (appendix four). This will require detailed mapping of the learning outcomes from the applicant's programme to the individual RCEM learning outcomes. This will usually mean mapping the learning outcomes of several modules to the declaration – it is unlikely that only one module in isolation will cover all RCEM required learning outcomes. Occasionally, modules from different courses may provide assurance of the learning – evidenced by the mapped learning outcomes.

1.8 All applicants are required to have an independent prescribing qualification and appropriate annotation on their respective register. The prescribing qualification should be at level 7, or level 6 if obtained *prior to* commencing ACP training.

1.9 ACPs who intend to credential should start to build their RCEM portfolio as soon as they commence the advanced practice academic qualification, even though the ACP is unlikely to be performing at the level of CT3/ST3 equivalent. This allows familiarity with the ePortfolio platform and provides a safe place to collect and store evidence for the future. It also allows reflection and feedback and demonstration of personal development.

1.10 There must be evidence provided across the entire breadth of the curriculum. Where mandated evidence is older than 3 years, this must be accompanied by reflection and new mandatory workplace-based assessments to demonstrate current practice is at the required standard. No mandatory summative assessment will be accepted if it is from three years ago or more.

1.11 ACPs who successfully credential against the relevant curriculum (adult, children, or combined) will be awarded a certificate, dated on the last day of the month of the panel decision, and will be invited to attend the College's annual diploma ceremony. Their details will be held on a register of successfully credentialed ACPs held by RCEM.

1.12 All time periods referred to within this document (and other Emergency Care ACP paperwork) are full-time equivalent.

1.13 To access the curriculum, information about the ePortfolio platform and other information relating to Emergency Care ACP developments, please visit the Emergency Care ACP pages of the RCEM website.

1.14 Individuals who have specific queries relating to credentialing or the application process that have not been addressed in this guide should contact acp@rcem.ac.uk.

# Section 2: Utility of the credentialing process

2.1 The credentialing process alone does not confer a license to practise or replace the need for the EC-ACP to maintain their professional registration and to ensure they revalidate for their whole scope of practice. The credential confirms that the EC-ACP has reached a specified standard of clinical care in all areas of the defined curriculum, by the presentation of evidence of delivering that standard in practice.

2.2 It is not essential for an emergency care EC-ACP to have been successfully awarded the RCEM credential for the EC-ACP to practise clinically. The arrangements for appointment and employment of the workforce, as well as the individual scope of practice within a department, is a matter for that department to determine. The credential simply confirms that evidence is presented in the portfolio showing that appropriately trained assessors have confirmed that the EC-ACP is able to practise at the described standard.

2.3 The Medical Act: it should be remembered that the legal responsibility for the patient care ALWAYS rests with the (medical) Consultant. Therefore, an EC-ACP working alongside a core or foundation trainee cannot take delegated responsibility from that trainee. They may give advice to the junior trainee based on their own experience and their scope of practice, but the final responsibility rests with the (medical) Consultant.

2.4 The credential does not imply that the ACP is recommended for working at ST4 or senior decision maker in itself. The local arrangements for workforce, individual scope of practice and responsibility should be discussed and agreed with the head of department and in the context of case mix, personal capability and team skills.

# Section 3: The experience required for credentialing – working as an EC-ACP

3.1 Emergency Care Advanced Clinical Practitioners may be from a nursing, paramedic, physiotherapist or pharmacist background. For some professions, covering the whole scope of the ACP curriculum in clinical practice may be a specific challenge.

3.2 Advanced practitioners, whether working as a trainee or established EC-ACP, will need to focus on gathering evidence for the credentialing process. There is no difference between the evidence required by an EC-ACP who has recently completed training, or an established EC-ACP who wishes to credential.

3.3 ACPs who intend to credential should start to build their RCEM portfolio as soon as they commence the advanced practice academic qualification, even though the ACP is unlikely to be performing at the level of CT3/ST3 equivalent when they enter training. It is likely, therefore, that the evidence collected in the first year or two cannot be used for the submission, particularly in terms of summative assessments. Section 4.18 describes the rules relating to currency of evidence. ACPs who have previously worked in other roles (for example Minors Emergency Practitioner) will still need up-to-date evidence that they are performing at the required level at the time of submission in this area of practice. The RCEM portfolio may be helpful for the requirements of the Higher Education Institute but there may need to be parallel evidence collected for the HEI requirements.

3.4 Established ACPs may find it more difficult to ring-fence time to secure assessments whilst also working full time. It can also be a challenge to request assessments when the ACP has been independent for some years. However the volume and level of evidence is the same for established ACPs as it is for those commencing their ACP career.

3.5 Clinical experience is key. There is a self-evident difference between the standard of performance of the practitioner new to advanced practice at the point of commencing the academic programme and developing clinical skills, and the experienced advanced practitioner who decides to credential.

3.6 For the experienced ACP, the minimum time required to collect the substantial amount of evidence required is three years for either the adult-only or paediatric-only ACP, and four years for those wishing to dual credential - both periods working a minimum of 30 hours per week (pro-rata) clinical contact.

3.7 So far, dual credentialing applications have not been as successful as adult-only or paeds-only applications. To create a portfolio which shows enough breadth and depth of the curriculum for both adults and children, will require specific programmes of experience and learning opportunities. This needs to be planned in advance. An alternative to the combined curriculum is to add paediatrics on later in a second application. In some departments, and in some working situations, this may be more feasible. In practical terms, the working week/job plan of the tACP must provide enough opportunity and experience to gain the breadth of competences. If dual accrediting from the beginning of the programme, the recommended four years should include children as part of the daily work for the whole four years. There also needs to be paeds and adult evidence throughout the common competences to demonstrate exposure to children throughout. If a tACP is adding on to adult experience over one year, this would be best achieved in a Paediatric ED to consolidate the experience; this would be difficult to achieve in a general ED.

3.8 For the practitioner new to advanced practice, there is additional time needed to develop the skills to the required standard and so, from the commencement of the academic programme,

the practitioner who is new to advanced practice will usually require five years in total for the adult-only or paediatric-only credential and six years for the dual credential, of which three years will need to be a minimum of 30 hours per week (pro-rata) clinical contact.

3.9 It is evident that gaining confidence in clinical work and experiential learning is considerably more difficult if the exposure is less than 30 hours clinical contact a week (say only one or two days a week). Complete immersion in clinical work is the best way to rapidly develop competence.

3.10 The ACP is required to upload a current Curriculum Vitae to their ePortfolio that details:

- the primary qualification of the ACP
- details of the relevant higher education programme, including institution, level and years of study
- clinical experience as an ACP with dates, working pattern (hours per week direct clinical care) and other responsibilities. This must demonstrate at least three years in *clinical practice* as an ACP (full time equivalent) with a minimum of 30 hours' clinical contact per week. Other responsibilities (education, management etc) are likely to reduce this clinical time and must be specified in the CV.
- ACPs wishing to credential in both adults and children are required to provide sufficient evidence of clinical practice in paediatrics. This should be reflective of the paediatric caseload across combined adult and paediatric EDs of approximately 25%, and ideally in a dedicated children's ED area/department. This will be assessed across the evidence submitted and will include review of the educational supervisor reports, faculty educational governance statements and logbook. This is likely to require at least four years of a minimum of 30 hours per week clinical contact if dual credentialing.
- Nurses who trained before Project 2000 will have received some paediatric-based training, although those who trained more recently will not necessarily have had this. We would expect all ACPs who are predominantly from an adult background who are now working with children to have undergone additional training in paediatric emergency medicine as appropriate. The scope of practice for ACPs is the responsibility of the individual employer to define. An ACP from an original adult background can dual credential providing the ACP submits sufficient quality evidence of the paediatric competences.
- any significant periods of absence from training, e.g. parental leave or sickness absence, should be broadly described in the CV so that it is clear how much time the applicant has spent in clinical practice as a trainee ACP (see 3.6).

3.11 The College wishes to be as inclusive as possible to all members and facilitate appropriate career progression and development. The standard of evidence that is required for credentialing needs to be consistent for all applicants and the Panel must be assured that the applicant is *currently* working at the appropriate level across the breadth of the curriculum. This must include recent evidence. For individuals who have returned from a period of prolonged absence (including maternity or paternity leave), we would recommend a period of working clinically before submission, likely to be a minimum of six months depending on the period of absence. This will provide a challenge for the ACP as the previously collected evidence may become out-of-date for submission. Any mandatory summative assessments must be repeated if outwith the last 36 months. The majority of other evidence should be within 36 months (a portfolio is unlikely to be adequate if more than 30% of the evidence is from

more than three years ago), although some evidence *would* be accepted if it is within five years and is accompanied by reflection on the progression of skills during those five years.

3.12 Individuals considering undertaking EC-ACP credentialing should have support from their employers. This process is likely to require considerable time from supervisors, additional time in focused patient contact gaining competences, and additional study leave.

3.13 It is recommended that EC-ACPs ensure that their job description and job plan encompass their entire scope of work. Whilst NHS indemnity provides standard support in the case of litigation, personal support and counselling can be invaluable. Nurses are also able to access support through the RCN https://www.rcn.org.uk/get-help/rcn-advice. Additional personal indemnity is possible through the medical indemnity companies. For example, the MDU provides personal indemnity for a bespoke fee (depending on experience). The College recommends that ACPs explore this in addition to vicarious liability offered by their employer. For self-employed/agency ACPs, personal indemnity is essential.

## Section 4: The evidence required

4.1 Evidence should be collected as per the curriculum requirements and must be saved within the RCEM ePortfolio. For RCEM ePortfolio technical support, please email eportfolio@rcem.ac.uk.

4.2 **Academic evidence:** evidence of successful completion of a PGDip (or Masters) at level 7 with the required modules MUST be included in the portfolio, and the academic declaration form (appendix four) completed appropriately. Failure to map the narrative of individual learning outcomes to the RCEM learning outcomes will be regarded as incomplete evidence. Certificates and transcripts of the PGDip/Masters are required, but only learning outcomes of modules which relate to the RCEM learning outcomes need to be uploaded. A level 6 prescribing qualification obtained before commencing ACP training is acceptable.

ACPs who have completed all but their thesis for their Masters, i.e. they have sufficient credits for a PGDip but without award of the qualification, must provide a letter from the HEI confirming that the equivalent of a PGDip has been achieved.

It may be that the tACP needs to gain additional credits over and above their original advanced practice qualification in order to complete modules relevant to the ACP curriculum. This should be considered at the beginning of the process and the additional modules undertaken early in the training period.

4.3 **Educational Supervisor Report (ESR)** (formerly known as the **Structured Training Report**)**:** the trainee EC-ACP must have three Educational Supervisor Reports at yearly intervals indicating how the tACP is making progress. These should be completed in discussion with the trainee EC-ACP. For established ACPs two ESRs may be acceptable but should include clear evidence of continued skills development and the final report must explain why there are not three. Paper STRs scanned in will be accepted from before 2019. ESRs that are entered retrospectively are not helpful.

4.4 **Faculty Educational Governance Statement (FEGS):** it is recognised that the individual Educational Supervisor has a significant responsibility in signing off that the ACP is ready to be credentialed. The purpose of the FEGS is that all consultant faculty (both medical and non-medical) who are contributing to training can state that they too feel the ACP is working at a

level equivalent to an Emergency Medicine trainee at the end of CT3/ST3. For trainee ACPs there must be three FEGS at yearly intervals, but the minimum for an experienced ACP who is credentialing is one FEGS prior to submission that explicitly states that the individual is operating at that level and confirmed by all present. The FEGS must also refer to the scope of practice across the breadth of the curriculum and the emergency department caseload. Failure to refer to the level and scope of practice in the FEGS will lead to an incomplete submission. FEGS that are entered retrospectively are not helpful as they are unlikely to represent the true opinion at the time.

4.5 **Personal reflection (red man blue man / curriculum item rating):** the ACP should enter some reflection for each competence / presentation. This personal reflection should guide the reviewer to the pertinent evidence which demonstrates the competence and their development towards the standard required for credentialing. The reflection should analyse their own competence (level 7 writing) – not just a description of the activity or list of evidence, but *how* the evidence demonstrates the competence. Whilst an experienced ACP may be able to demonstrate level 4 in many common competences, it is unlikely that most EC-ACPs will be at level 3 or 4 in more than four of the common competences. Evidence is required to demonstrate higher levels of attainment, without which the portfolio will be returned.

**NB: from August 2021, red man / blue man will be replaced by 'curriculum item rating' within the Kaizen ePortfolio platform.**

4.6 **Logbook output (curriculum item rating):** for the supervisor, this is a summary view where the ES confirms that they have reviewed all the evidence AND seen the ACP in practice and, using the descriptors in the curriculum, can confirm they are at the appropriate level. This must be completed for common competences and the presentations and procedures. It is expected that there is a comment that provides that assurance of competence against each of the elements, and it is recommended that supervisors complete this over a period of time so that the narrative provided is helpful and relevant. These comments can reference the descriptors in the curriculum to demonstrate how the supervisor and ACP have reviewed the curriculum requirements and can satisfy the detail. It is unlikely that the EC-ACP will be at level 3 or 4 in more than four of the common competences. The ACP should have 'achieved' the majority of the presentations, and no more than 4 of the 7 procedures that can be assessed by CbD should be "some experience".

4.7 **Volume of evidence:** all competences, presentations and procedures in the curriculum, including the common competences, must have some evidence provided against them. The number of items and type of evidence will vary for each competence. For common competences it is likely that there will be more items of evidence but for the individual presentations and procedures we recommend a maximum of 7 items (excluding e-learning). More items than this makes review of the portfolio difficult; less than this suggests a lack of experience. For common competences, a maximum of 10 items is appropriate. E-learning is strongly encouraged as a way of developing knowledge – but e-learning modules are not sufficient evidence for a competence. If there are more than five modules linked to an individual competence, the portfolio will be rejected at the screening stage as it precludes effective review of more substantial evidence.

In general terms, one piece of evidence can be used for up to two competences, occasionally three, except for the ACAT-EM which can cover up to five competences. One common competence can be covered at the same time as a clinical competence on one assessment form.

4.8 **Evidence for dual credentialing:** for those who are credentialing in both adults and children at the same time, in addition to the mandated assessments for paediatrics there must be specific paediatric-related evidence in a minimum of 25% of all other presentations and competences. This is to ensure that there is sufficient contact with children for the ACP who is dual credentialing. This is a considerable amount of work, hence the requirement for extended time in training. This will need to be *in addition* to the adult evidence and made relevant in context for that competence or presentation, e.g. consent in children and consent in adults.

4.9 Experienced ACPs who have already been practising in this role for some years will have accumulated evidence in their CPD and professional portfolio over this time. This may be suitable to upload and utilise but should be accompanied by reflection on their current practice and development of expertise since the original evidence was gathered. Note should be taken of the rules around currency of evidence (section 4.18).

4.10 **Assessments vs other evidence:** throughout the curriculum there are competences, presentations and procedures for which a mandated assessment – usually summative by a consultant - is required. These are identified on the checklist. All other elements of the curriculum can be evidenced by a range of items including summative and formative assessments, as well as other types of evidence listed below. Failure to provide the mandated summative assessments is a critical factor in unsuccessful credentialing.

4.11 **Mandated summative assessments:** all mandated assessments for specific presentations / procedures are SUMMATIVE and must be on a summative form. Except where specified, they must all be completed by a consultant.

All summative assessments must be on the ePortfolio forms - scanned paper forms will not be accepted. Care should be taken that the case selected for assessment is relevant and that the assessment focuses on that competence. The narrative comments (things done well, learning points and action points) in the summative assessments are as important as the "marks" and care should be taken to describe what was discussed, and why actions are being recommended as a result of the assessment. These comments are critical for the Panel to understand the discussion that occurred. The Panel will only see the narrative, so to suggest further learning points relating to managing the main presentation would raise concerns that ST3 level practice has not been demonstrated. Similarly, it is expected that action points would be in relation to approaching highly complex procedures or presentations – not "gain more experience". If there are action points, there must be evidence that these have been addressed in subsequent assessments or further learning and reflected on in the curriculum item rating comments for that presentation / procedure.

4.12 **Other summative assessments:** tACPs may find it helpful to have summative assessments by other staff which can be evidence for any of the other presentations / procedures. These should be completed by either an ST4 equivalent or above doctor or consultant practitioner. If there are action points or learning, there should be evidence that these are addressed subsequently with reflections in the curriculum item ratings.

4.13 **Formative assessments:** formative assessments are a useful tool for supporting the development of skills. These may be by consultants or other practitioners and can include suggestions for development – with subsequent evidence of that development or learning. Whilst not mandatory, it is expected that at least 50% of the clinical presentations will have a formative or summative assessment as this demonstrates engagement with training processes.

4.14 **Other evidence:** whilst many presentations do not require consultant summative assessments, it is essential that there is evidence in the portfolio of other activity in addition to WBAs. This should demonstrate the developmental journey of the trainee ACP and might include formative assessments, e-learning, or study days to consolidate learning – perhaps teaching delivered by the trainee ACP or reflections culminating in another WBA – summative where mandated, or formative. Reflection on these other elements of evidence is critical and should be at level 7 analysis - why and what the impact on the ACP was of this activity, what they might do differently or how they may become more expert, rather than a simple description of what the activity was.

Other evidence that may demonstrate competence includes:

- teaching plans / presentations accompanied by personal reflection and/or feedback
- e-learning certificates with reflection on the impact on their clinical care
- audit and quality improvement work with reflection and data to show the impact
- individual case reflections.

Further details of acceptable evidence are in the RCEM curriculum.

4.15 **Logbook of cases seen:** there must be a summary sheet / table indicating the numbers of patients seen in the various parts of the department and the outcomes (admitted/discharged) spit into adults and children if dual credentialing. Suggested templates for adult and paediatric cases are included as appendix five and six. It is also desirable to have a detailed list of patients that gives the area (resus, majors, ambulatory, minors, short stay), age (adult / child), acuity, diagnosis and disposition (admitted/discharged). If this is not possible from the hospital system, within the summary table there should be an explanation and confirmation by the Educational supervisor that the ACP has been involved in the full breadth of case mix and acuity. This detailed list should cover the last three years. Care must be taken to remove all patient identifiable information.

If there are relatively small numbers in the portfolio, then an explanation from the supervisor to account for this must be provided. It would be expected that, over a three-year period, the ACP would see a minimum of 2,000 patients and that 15% of those would be critically ill or injured patients for an adult-only ACP. Similar numbers and complexity are expected for a children-only ACP. There should also be evidence of patient contact with ambulatory type patients with minor injuries to demonstrate curriculum coverage. For ACPs who are dual credentialing, there should be at least 500 children in addition to the adults across the breadth of the age groups and curriculum.

4.16 **Multi-source feedback (MSF):** three MSFs at yearly intervals are required. Each MSF should include a minimum of 4 consultants.

4.17 **The checklist** for credentialing must be completed correctly and signed off by the named Educational Supervisor. This should be uploaded to the personal library as a Word document. It should be noted that the checklist used must be the correct checklist for the specific credentialing window.

The checklist must identify the single most appropriate/relevant item (or items if two are required) that the ACP wishes to be considered as the primary evidence for the mandated assessments/elements. This should be entered into the checklist with the title, type and date of the evidence. This checklist will take the ACP some hours to complete. Checklists which list multiple items of evidence per element will be rejected.

4.18 **Currency of evidence and the standard required**: mandated summative assessments must be within three years.

Evidence that is older than three years MUST be accompanied by evidence that the learning has been refreshed (for example, previous courses should have an update) and reflection on what has happened since - how their practice has developed, their new skills, etc. The exception to this is the postgraduate academic qualification which may be more than five years old. A portfolio is unlikely to be adequate if more than 30% of the evidence is from more than three years ago. No mandatory summative assessment will be accepted if it is from three years ago or more.

Any evidence that is older than five years will not be accepted *unless* there is reflection on how their performance has improved since the evidence was initially obtained. This allows prior experience and evidence of learning, teaching, audit and QI to be utilised, but this should be limited; fresh evidence is more impactful.

ACPs should be reminded that they were unlikely to be at the standard of an ST3 when they entered advanced practice years ago. In most cases, the development of the competences to the correct standard will take three years or more of practice as an EC-ACP. Even those who have many years of experience as EM nurses or paramedics will not be working at ST3 level in advanced practice when first entering this role.

4.19 **Common competence assessments:** an assessment for a common competence should be exclusively looking at that competence (e.g. history taking, safe prescribing, etc). For example, it is not appropriate to link a CbD for an acute presentation competence to two or three common competences just to attain coverage of the curriculum.

4.20 **Major and acute presentations:** as described in 4.11, there are specified mandatory consultant summative assessments for some presentations. All other summative or formative assessments provided as evidence for the major and acute presentations can be either in mini-CEX or CbD format (or ACAT). The balance of observed clinical contact assessments compared to office-based discussions must be maintained to demonstrate adequate observed practice; hence there should be at least 50% of all WBAs in the mini-CEX format for the assessments of the clinical presentations (mandatory assessments and all other assessments).

4.21 **Self entered forms** must not be used for summative workplace-based assessments as they cannot be verified by the consultant. Self-entered forms will not be accepted and thus will be considered missing.

4.22 The **ESLE and ACAT** used for time management and teamworking must be focused on these competences. For example, the time management assessment must include sufficient numbers of patients over time to demonstrate this skill. Teamworking must reflect and comment on interactions with members of the team.

4.23 **Relevance:** assessments should appropriately reflect the item in the curriculum, for example a WBA on arterial line must focus on insertion of a line, not on analysis of blood gases. The CbD for the airway must explore the airway management elements of airway.

4.24 **Descriptors:** reviewing the descriptors in the curriculum are key to ensuring the assessment evidence provides the Panel with the assurance that the ACP is competent in this area. For example, the PP21 secondary assessment has to look at the care beyond the primary assessment and resuscitation. This should be beyond the first evaluation and include review, planning definitive treatment and a full search for underlying causes.

4.25 Specific presentations may need different evidence. For example, a department may not see significant numbers of major trauma and so a major trauma case for mini-CEX would be difficult. In this instance, a minor trauma which is dealt with, followed by a formal discussion about what would have been different if there were significant injuries, would be appropriate. Whilst the ETC/ATLS is not a *substitute* for the consultant summative assessment required, it does help some triangulation of competence.

4.26 **Practical procedures:** all practical procedures must have summative assessments using the DOPS tool - in most cases by a consultant supervisor (see curriculum and checklist for details). Consequently, it is expected that all procedures are “achieved”. Where a CbD is permitted as the tool for assessment, it is expected that the evaluation may be “some experience” in 4 of the 7, recognising that in some departments the ACP may not be permitted to perform the procedure for local governance reasons. There should always be an appropriate explanation from the Educational Supervisor as to why it is not possible to “achieve” a particular competence.

4.27 **The role of simulation:** simulation courses, including life support courses, can be used as evidence where specified.

Simulation for some rare presentations, such as anaphylaxis, is acceptable, but the EC-ACP MUST have led the scenario and have a completed consultant assessment where relevant. It must be clear at the beginning of the description that it is a simulation and why that is being used.

BLS can be assessed in a simulation rather than on a cardiac arrest, but the form must confirm that this was undertaken by the practitioner *in the presence of* an appropriate assessor who is aware of the standard required. There must be a DOPs for BLS whether sim or in clinical care, in addition to the ALS certificate.

Procedures that require a summative DOPs that can be completed on sims are IO insertion and transcutaneous pacing.

Exceptionally, departments or regions may set up a simulated procedural course for the seven procedures that can be assessed by CbD. The portfolio must include a description of the programme and role of the ACP, and confirmation that a formal face-to-face assessment was undertaken for the procedure must be provided. Without this, skills lab sessions will not be accepted in lieu of patient contact.

4.28 **ACPs as instructors:** in some procedures or presentations, it is acceptable that the evidence provided is an assessment of the ACP instructing on a practical procedure or a case scenario. In these instances, the assessment ***must*** focus on the technical skills, not just the teaching skills. A normal life support instructor assessment will not focus on this and therefore the assessor must be aware of the requirement. Such experience and documentation can be used as evidence towards a competence but cannot be used as the summative assessment which must be performed with a real patient.

4.29 **Audit or QI**: evidence must include evidence of actions completed and evaluation of the impact of those actions following recommendations or agreement by stakeholders. The role of the ACP in the audit and QI must be clear. There must be a formal assessment of the audit or QI using the appropriate form and an element of personal reflection in the reflective notes section of the portfolio.

4.30 **Life support courses:** certificates should be accompanied by reflection on the impact of the course on the care they deliver; this should be in the reflective notes section of the portfolio.

Certificates should be uploaded to the ‘certificates and exams’ section and be confirmed by the Educational Supervisor.

**In summary, the final submission for credentialing must include:**

- a completed checklist, valid for the current application window and the curriculum covered, that confirms all evidence of competence is present (including an up-to-date CV covering all the applicant’s clinical experience and training), and which is signed-off by the named Educational Supervisor who meets the requirements of 5.1. The checklist should be uploaded to the personal library as a Word document.
- evidence of completion of an appropriate academic award
- three Educational Supervisor Reports (at yearly intervals) which summarise the progress made
- three Faculty Educational Governance Statements (at yearly intervals) which summarise the views of the named faculty on the ACP and the standard required. The final FEGS must confirm that the faculty present have seen the ACP demonstrate clinical practice at a level equivalent to an EM trainee at the end of CT3/ST3 in all relevant areas of the curriculum/department and is ready to credential.
- three MSFs (at yearly intervals).

# Section 5: Educational Supervision

5.1 Each EC-ACP MUST have a named Educational Supervisor for the final sign-off on the checklist **who is a substantive Consultant on the GMC Specialist Register in Emergency Medicine, is a member of RCEM and who has attended RCEM ACP Supervisor Training.** The named Educational Supervisor must be present in the final faculty meeting to input into the FEGS. ACPs are recommended to ensure their Educational Supervisor has attended the RCEM ACP supervisor training.

5.2 The named Educational Supervisor is confirming, by countersigning the checklist, that they understand the standard, that they have examined all the evidence and believe it is complete as required by the credentialing process.

5.3 The named Educational Supervisor will be responsible for ensuring other colleagues involved in assessing the trainee EC-ACP understand the requirements, including the standard expected.

5.4 Other supervisors and assessors who are responsible for assessing the EC-ACP in other placements, for example acute medicine, ambulatory care, anaesthetics, etc., should be made aware of the process and standard by the named Educational Supervisor, and given some information about the process and aims of credentialing. They must be familiar with the assessment tools used.

5.5 **PEM Educational Supervisors and departments where supervisors have not attended RCEM ACP supervisor training or are not eligible to complete sign off:** Supervisor training is not mandatory for day-to-day educational supervision but is highly recommended. If the regular Educational Supervisor (i.e. the ES who meets regularly with the EC-ACP) does not fulfil the requirements in 5.1, they may continue to provide educational supervision,

mentoring and support whilst the EC-ACP is training, even if they are not eligible at that time to complete final sign-off. However, the ES should have read this guidance and must liaise directly with an RCEM-trained EM supervisor on the standards expected. The final sign-off on the checklist ***must*** be completed and signed by the named Educational Supervisor who has completed RCEM ACP supervisor training. The ES providing the final sign off must be present at the final faculty meeting to hear the comments.

This will also allow ACPs to train in Paediatric EDs where their consultants may not be members of RCEM, ***providing*** there is adequate liaison with an Educational Supervisor who meets the requirements of 5.1 and who can complete the final sign-off in conjunction with the paediatric EM consultant. The named Educational Supervisor responsible for final sign-off must have worked alongside the EC-ACP during the training and review the checklist with the regular ES and EC-ACP.

5.6 The Educational Supervisor will be responsible for meeting regularly with the EC-ACP to review progress against the curriculum and undertake some of the mandatory assessments. This should be an opportunity to review the evidence, check on labelling and curating within the portfolio, and ensure the requirements for scanning paper evidence, etc. are followed.

5.7 In addition to the Educational Supervisor Report (ESR), the Educational Supervisor will be expected to complete the curriculum item rating to rate the EC-ACP on all of the competences. This allows the College to be assured that the ES has confirmed that the EC-ACP is competent in all competences. The EC-ACP should be at least level 2 on all common competences – equivalent to the level of a CT3/ST3 doctor at the end of that year - and have achieved the majority of presentations. In addition to the curriculum item rating, comments should be entered to support the ES rating decision.

5.8 Educational supervision of an EC-ACP preparing to credential is likely to take as much time, if not more, than for an EM trainee. The College recommends 0.25PA per EC-ACP supervised within the consultant job plan.

5.9 All consultant Educational Supervisors should be approved supervisors under the GMC approval process for educational and clinical supervision.

5.10 Summative assessments must be by substantive EM consultants (please see 5.11 for guidance on locum EM consultants) except where relevant consultants in other specialties are summatively assessing areas of their expertise, e.g. anaesthetics, ICU, paeds and acute medicine. These non-EM consultants must be substantive and accredited by the GMC as a Clinical Supervisor, and the ES should verify this and that the regulations have been followed. It is the Educational Supervisor's responsibility to ensure that other consultants who have signed off summative assessments are familiar with the credentialing principles, understand the standard required and the evidence needed. We recommend that the ES discusses this with them before they work with the ACP.

5.11 On a day-to-day clinical basis in the department, the clinical supervision offered by a locum consultant can be invaluable in supporting the ACP and developing their skills. Formative, or even summative assessments, can be completed by a locum consultant as part of the body of evidence and for personal development of the ACP. However, for a mandated summative consultant assessment, the assessor must be a substantive EM consultant as above, unless the named Educational Supervisor is able to confirm the locum is an RCEM member, has undertaken training in supervision and is on the specialist register. In these cases the ES must make a note of this in the ESR.

5.12 All Educational and Clinical Supervisors should participate in the faculty educational governance statement (FEGS) – this includes consultant practitioners, senior ACPs and consultants in other specialties. This is a critical part of the confirmation of the standard reached and constitutes important evidence to be considered in the process.

5.13 Non-medical assessors who carry out workplace-based assessments (WBAs) should be trained in the use of WBA and familiarise themselves with the curriculum.

5.14 The assessment tools are expected to be used in a productive, developmental way. For that reason, the interaction between the assessor and the EC-ACP should be interrogative, not simply confirmatory. For example, the assessor is expected to ask questions such as “what if” and “why” when discussing a case in a CbD and, in the mini-CEX and DOPs, there should be enquiry as to why they undertook the procedure, how they elicited the history or made the diagnosis. Similarly, there should be enquiry as to why the clinical signs were evident (or not) and the use of the investigations.

5.15 Mandatory summative assessments should include adequate comments/narrative, both about the specific case but also the discussion. This is particularly important in the CbD, but also for mini-CEX and DOPS. A minimum of 50% of the mandatory WBAs must be directly observed with a mini-CEX or DOPS. Overall, 50% of all WBAs (formative and summative) should be mini-CEX or DOPs.

5.16 When the named Educational Supervisor reviews and signs off the evidence, it is important to include comments against each competence in the ePortfolio. Ideally these should be entered regularly over time to demonstrate formative feedback and progression – comments early in the training suggesting more experience is needed will be acceptable if there is a later comment suggesting that experience is now evident from the performance.

5.17 Faculty meetings are critical for discussing problems and to ensure colleagues are understanding the process.

## Supporting the tACP in preparing for the Panel

5.18 Remember, the Panel will be spending a considerable amount of time to review a significant number of portfolios. This time is currently four to five hours per applicant. If the named Educational Supervisor is NOT spending at least that amount of time in checking the evidence before signing, then it is likely that important elements will be overlooked and the tACP will not be successful.

5.19 The checklist is the key. The RCEM office will screen the application initially and, if the evidence is not provided (or the checklist incomplete), the tACP will be unsuccessful. The checklist must be fully completed - legibly and correctly. You should be confident that you have found the evidence and that it *does* demonstrate THAT competence, e.g. an anaesthetic competence instead of sedation will be unacceptable, a DOPS instead of a CbD will be unacceptable *even if the WBA says the candidate is at the standard.* The Panel will only look at the item of evidence suggested for the competence and, if it is not acceptable, then the application will be unsuccessful.

5.20 The checklist must be the correct checklist for the submission window and for the curriculum covered.

5.21 There should be one item of evidence listed for each competence on the checklist (unless two are required) – not multiple items of evidence for each competence on the checklist.

### Supervision explained

Supervision activities and who is eligible to undertake them are described below and in the table on page 19:

- **Final sign-off for the portfolio (logbook output and ESR)** must be completed by the named Educational Supervisor who:
  - is a member of the RCEM in good standing
  - is on the specialist register in Emergency Medicine
  - is employed as a substantive consultant
  - has completed RCEM ACP supervisor training
  - is recognised by the GMC as a supervisor.

- **Educational supervision and educational meetings** must be undertaken by an Educational Supervisor who meets the criteria as described above for final sign-off, OR:
  - is employed as a substantive consultant in EM or Paeds EM, **AND**
  - has undertaken training in supervision, **AND**
  - is recognised by the GMC as a supervisor.

- **Clinical supervision and sign-off for summative consultant assessments** must be undertaken by a supervisor who meets the criteria as described above for final sign-off, **OR**:
  - is employed as a substantive consultant in EM, Paeds EM or a relevant specialty, **AND**
  - has undertaken training in supervision, **AND**
  - is recognised by the GMC as a supervisor.

  In some cases, a locum consultant in Emergency Medicine who is on the specialist register in Emergency Medicine, has undertaken training in supervision, and is recognised by the GMC as a supervisor, may be judged by the named Educational Supervisor to be a suitable assessor for consultant assessments and may sign off a summative assessment. The Educational Supervisor must note this in the ESR.

- **Assessment of non-consultant mandatory WBAs** must be undertaken by an assessor who meets the criteria as above, **OR**:
  - is expert in the procedure, **AND**
  - is a substantive employee in the Trust or is employed as a locum consultant in EM, **AND**
  - is confirmed as understanding the standard by the named ES, **AND**
  - is identified as a suitable assessor.

| | Meets the requirements of 5.1 | Substantive consultant in other specialty | Locum Consultant in EM | Non-medical consultant or senior ACP |
|---|---|---|---|---|
| Educational supervision with final sign-off on the portfolio and completion of the ESR | ✓ | | | |
| Educational supervision – ongoing meetings and discussion | ✓ | ✓ (PEM only) | | |
| Clinical supervision | ✓ | ✓ | ✓ | ✓ |
| Assessments summative | ✓ | ✓ | ✓ (If approved by named ES) | |
| Assessments non-summative | ✓ | ✓ | ✓ | ✓ |

# Section 6: The ACP Credentialing Panel

6.1 The evidence presented is considered by a panel of consultants (RCEM Fellows), consultant practitioners and credentialed ACPs.

6.2 The EC-ACP is not present at the Panel - hence the importance of the completed checklist.

6.3 All ACP Credentialing Panel members will be appointed and trained by the Royal College of Emergency Medicine.

6.4 The ACP Credentialing Panel will be responsible for reviewing the evidence presented in the ePortfolio and agreeing an outcome.

6.5 A Panel will normally consist of a minimum of six assessors, with a minimum of two Fellows in good standing with the RCEM.

6.6 The RCEM office will screen each portfolio and reject those without the required evidence (final decision rests with the Chair of the Panel).

6.7 Applicants will be required to ensure their evidence is complete 8 weeks prior to the date of the ACP Credentialing Panel. Any evidence submitted after this 8-week window will not be considered except in exceptional circumstances and at the sole discretion of the Chair of the ACP Credentialing Sub-Committee.

6.8 Applicants will be required to include a completed checklist in their portfolio, countersigned by their named Educational Supervisor at this 8-week window.

6.9 At the credentialing assessment, the only question for the Panel is whether the evidence is sufficient. The Panel are unable to assess the competence of the EC-ACP, hence the need for the ES to be closely involved in the assessments, to undertake many themselves, and to ensure assessors understand the standard required.

6.10 There are two possible outcomes at the credentialing panel: credential or resubmission. For those applicants receiving an outcome requiring resubmission, there are three sub-categories - immediate, limited and full resubmission - depending on the type and level of evidence still to be provided (see section 1.6 for further details).

6.11 Outcomes will be recorded on a Credentialing Outcome Form (see appendix one).

6.12 ACP Credentialing Panel members will also provide feedback to trainee ACPs via the Credentialing Outcome Form (appendix one). For those who have not met the requirements, limited feedback with specific requirements and potential timescales will be provided.

6.13 ACPs who have successfully met the curriculum requirements will receive a certificate and will be added to the register of credentialed Emergency Care ACPs. They will also be invited to attend the annual RCEM diploma ceremony.

6.14 An ACP who has submitted their portfolio to be considered for credentialing has the right of appeal against the outcome. The sole ground for appeal is if there is evidence of a procedural irregularity in the conduct of the credentialing process (including administrative error).

Appeals will not be granted on the grounds that:

- an applicant was not aware of, or did not understand, guidance relating to the credentialing process
- an applicant's Educational Supervisor signed off the checklist as complete
- the applicant disputes the judgement of the Panel that the evidence provided is not sufficient or does not confirm competence.

A copy of the appeals procedure is available on the RCEM website.

# Section 7: The standard

7.1 The standard required is that of the Core Trainee at the end of CT3/ST3 in all competences described in the EC-ACP curriculum.

7.2 This standard can be described as the practitioner being able to look after the majority of the cases in the Emergency Department, albeit they will require support and guidance on a significant number of cases, and for most of the cases in the resuscitation room.

7.3 All common competences and presentations must be signed off by the EC-ACP and the named Educational Supervisor.

7.4 In the portfolio, the EC-ACP and their Educational Supervisor are able to identify the ACP as having had "some experience" of presentations. Since we are expecting the EC-ACP to have adequate experience in the whole EC-ACP curriculum in order to be credentialed, use of this should be limited. "Some experience" would normally signify that the EC-ACP does understand the presentation or procedure but that they have not independently managed the presentation.

All elements of the curriculum that require a mandatory summative assessment must be "achieved". The only exception is the seven procedures that may be assessed by CbD where "some experience" will be accepted in four procedures.

Elements of the curriculum that do not require a mandatory summative assessment should also be achieved – a maximum of two presentations only will be permitted to be "some experience".

7.5 All common competences must be at level 2 (or above). It is unlikely the EC-ACP will be at a higher level in more than a few common competences.

## Section 8: Gaining the required experience across the curriculum

8.1 Many ACPs are very experienced. For new ACPs who are experienced nurses, paramedics, physiotherapists or pharmacists, the shift to the clinician medical model may be a challenge. The same standard as seen in a medical trainee of cognitive reasoning, diagnostic skills and decision making must be demonstrated. RCEM recognises that the case mix in many departments is varied and getting exposure to the full range of case mix might be challenging for some ACPs, including the paediatric experience or acute medical related cases/skills.

8.2 For EM trainees this is overcome by the acute medicine and paediatric attachments in the ACCS programme. For ACPs therefore, a secondment or placement in acute medicine, or ambulatory medicine, may support the development of some skills. Time focused on paediatric competences is essential to those who wish to credential across adults and children.

8.3 Much of the anaesthetic and ITU competences for ACCS trainees are not required for ACPs. However, there are some critical skills that are included in the curriculum and the EC-ACP must be able to demonstrate a working knowledge of those skills even if they do not themselves regularly carry out that procedure. These competences are mostly acquired by spending time in the resuscitation room or with ACCS trainees as a short secondment.

8.4 Life support courses are specified for each curriculum. It should be noted that not all ATLS courses take non-medics as full participants, but the RCS England is helpful in identifying courses that will. In practice it may be easier to find an ETC course than an ATLS course that accepts non-medics. Note that the Paediatric EC-ACP must also do a trauma course, either ATLS or ETC.

8.5 If a trainee is a life support instructor, the same standard of evidence is required and, ideally, an instructor certificate should be provided. If this is not available, evidence of teaching within the last three years, with the programme and feedback included, will be accepted. If the ACP wishes to use their teaching as evidence for a procedure, then an assessment of the technical content of the teaching must be submitted by a trained assessor who understands the standard. This will only be accepted as part of the evidence and, where relevant, there must be an additional mandated WBA.

## Section 9: Working in the department

9.1 It can be helpful to give titles to EC-ACPs which differentiate the trainee from those who are more experienced. For example, some departments use Trainee, Junior and Senior as they progress. This is a matter for local discussion. This helps to define their level of independence and will support, particularly in the early years, their designation as still learning. This is particularly important to avoid them being pulled into nursing duties or non-practitioner roles when the staffing gets tough.

9.2 There is no stipulation as to the nature of the working pattern required – or where the EC-ACP should work. However, since the EC-ACP role is anticipated to be 24/7, we would recommend that the EC-ACP participates in a 24/7 rota, including night shifts, and the impact of this pattern of working on the individual is discussed and clarified from the start. This is a matter for local negotiation and discussion.

9.3 We would recommend that trainee EC-ACPs are employed solely in that role. Departments have employed trainee EC-ACPs in dual roles, such as Senior Sister 50% and Trainee EC-ACP 50%, and subsequently found trainees struggle to progress.

9.4 The EC-ACP may benefit from having specific shifts identified as "credentialing shifts" where it is made clear to the team that the EC-ACP will be working on their assessments and competences. Likewise, where feasible in the consultant team, a shift for a named consultant to perform WBAs is helpful covering both medical trainees and ACPs.

# Section 10: Top tips for developing a programme for EC-ACP development and workforce (also useful for EC-ACPs to read!)

This section is developed from top tips from supervisors who have had extensive experience in supervising and running EC-ACP development programmes. We are keen to receive other tips from colleagues, please email ACP@rcem.ac.uk.

10.1 ACPs can form an important part of your substantive and permanent workforce. They are valuable! In order to attract and support ACPs, paying for MSc and/or life support courses in return for commitment to work for three years in the department is a fair agreement.

10.2 Developing a cohort of ACPs will take time – it is unlikely that there will be large numbers of locally available credentialed ACPs for some years. Therefore, a medium to long term strategy and business case will be required to develop that cohort. The department must therefore commit to the development of this workforce and the benefits that will accompany the investment. Resources required include:

- cost of the HEI postgraduate course
- backfill for the staff during the academic component
- backfill for supervised practice, at least at first
- time for consultant educational supervision and formal workplace-based assessments, including ESLEs
- time for formal education for the tACPs and their teachers.

10.3 Having a learning agreement with the EC-ACP is critical. This should define how many WBAs can be expected over a given period, how often the ES and EC-ACP will meet, as well as the objectives for the next period of practice.

10.4 Joint appointments with the HEI and joint activities (recruitment and appraisal) can be extremely useful in supporting ongoing development and identifying any learners who may be struggling with the academic or clinical components. Triangulation of performance across the academic path and clinical experience is crucial.

10.5 A learning agreement can be translated into a "learning menu", a document which others can access that lists what the EC-ACP still has outstanding; this helps to focus shop-floor experience and access to WBAs.

10.6 The MSF can be a really useful tool for the EC-ACP. This will highlight how their new role is developing, and be important as a positive reinforcement, but may also shed light if the EC-ACP is struggling with how to present themselves/manage the interaction with other specialties or the ED doctors. This may, however, need a robust discussion in terms of how to guide and direct future performance.

10.7 Some skills may be better achieved by attendance at clinics, for example cardiology defibrillation clinics, neurology, ambulatory care for LPs, etc. This will need exploring locally.

10.8 Rotations across regions may support development of some competences or allow access to a different case mix. Shared induction, HR processes and teaching programmes spread the quantity of work involved.

10.9 Consideration should be given as to how to make a shift positive for all learners – so identifying with the doctors and tACPs who needs what assessments and their focused training needs – and, at the end of a shift, a learning debrief – what have we learnt, what will we refresh/review for next time? This takes thought and preparation but will benefit both medical and EC-ACP learners and develop an educational culture.

10.10 Supervision is critical and, whilst your department will benefit from ACPs, it should be noted that the quantity of supervision required will be significant and therefore a critical review of your total supervision obligation is crucial before starting a programme.

10.11 ACPs must be seen to be progressing. For many new ACPs the role is challenging as they go from being an experienced leader in their previous role to being new and challenged by the alternative approach to diagnosis, the decision making required and the need to develop independence. Being an EC-ACP is not for everyone and the role of the ES is to manage training performance. There should be milestones and achievements built into the initial contract with the EC-ACP which detail progression, including success in the higher education programme as well as the achievement of the WBAs. Credentialing is the apex of achievement but supporting the development of the skills and ability to be safe and effective on the shop floor is the core business for the ES.

10.12 RCEM does not mandate a formal ARCP (annual review of competence progression) but we believe there are benefits in running such a process. This can be run alongside the appraisal process as a personal development and performance review.

10.13 An Educational Supervisor who is a recently appointed Consultant may be the perfect ES for the EC-ACP. They will be very familiar with the RCEM ePortfolio, having recently used it themselves, and will be able to support and direct the easiest ways to link, navigate and save items.

10.14 Evidence that is scanned in must be saved as documents/PDFs, not JPEGs (which are too large). They should be named logically with the type of document, the competence number covered and text, and date of achievement (not date of scanning). The document must be scanned as a single document, not a page per document.

10.15 Previous evidence can be helpful. However, for many ACPs it is easier just to collect new evidence than to try to find the old evidence and update with notes and reflection.

10.16 Clinical supervision is key, and the department must determine that there is sufficient capacity for clinical supervision of the EC-ACP as well as the foundation, core and higher specialty trainees. Trainee ACPs may benefit from a non-medical supervisor in addition to their Educational Supervisor. This person may be an established EC-ACP who is able to support and guide the trainee in their role transition.

10.17 ACPs should be clearly visible on the rota alongside the medical trainees. This allows the total number of trainees requiring supervision on any individual shift to be known and catered for. Supervising a large number of trainees with one consultant will result in a poor experience for everyone involved, including the patients.

10.18 Every time evidence is uploaded it must be linked. A library full of evidence is not useful if it is not linked. However, linking one item to more than three competences is unlikely to be appropriate.

10.19 Similarly, the educational supervision does take the entire proposed tariff of 0.25 PA per week, perhaps even more so than doctor supervisees. The team job plan should reflect the total time needed for the supervision of all trainees of all professions.

10.20 Some departments have developed a “breakfast club” process of early morning meetings as a group with peer discussion and learning. This enables frank discussion of problems, peer tutoring and coaching, and a sense of team development.

10.21 Plan the academic education into the programme – when will the prescribing module be? Try to get the history and examination module first to allow the EC-ACP to get on with practice.

10.22 The departmental middle grade and nursing staff must understand what the programme is trying to achieve, who the EC-ACPs are, and their requirements. Otherwise there will be confusion of roles and expectations.

10.23 The whole or part of the portfolio can be downloaded into a PDF to be used for the academic component with the university – or for the revalidation portfolio.

# Appendix one: Credentialing Outcome Form

| Forename | Surname | Regulatory body and membership number |
| --- | --- | --- |
| | | |

| Primary qualification (institution and year awarded) |
| --- |
| |

| Master's Degree (institution and year awarded) |
| --- |
| |

| Date of credentialing assessment | |
| --- | --- |

| Panel members | | |
| --- | --- | --- |
| | | |
| | | |
| | | |

| Training / work history (including location) | Start date | End date |
| --- | --- | --- |
| | | |
| | | |

| Evidence considered by the panel and known to the trainee | | | | | |
| --- | --- | --- | --- | --- | --- |
| **1** | ePortfolio | ☐ | **2** | ESR | ☐ |
| **3** | Checklist | ☐ | **4** | FEGS | ☐ |

| Panel outcome |
| --- |
| **Further evidence required** |
| |
| **If further evidence is required** |
| |
| **Panel feedback** |

| | | | |
|---|---|---|---|
| | | | |
| **Chair of Panel's signature** | | **Date** | |

# Appendix two: Checklist for the ES in signing the ESR

| | | |
|---|---|---|
| **Overview** | • Has the correct checklist been used? The RCEM website will publish a link to the checklists valid for the current credentialing window. | |
| **Academic** | • Have the academic qualification transcripts and certificates been uploaded? Are they all level 7 and are all modules correct?<br>• Has the academic declaration form been completed with the learning outcomes from academic modules mapped against the learning outcomes required by the College? | |
| **CV** | • Does the CV clearly evidence three years of full time ACP practice with a minimum of 30 hours a week clinical contact (not doing the other senior nurse or educator roles) and their previous experience? If not, is there an explanation?<br>• Is there evidence of experience of children for those who are dual credentialing? This should be dedicated time in the PED or the children's area. | |
| **Faculty educational governance statements** | • Are there three FEGS at yearly intervals?<br>• Does the most recent FEGS (preferably within a month of submission) specifically state that the tACP is ready to credential and is practising at CT3/ST3 level across the breadth of the department/curriculum in the opinion of all the consultants present? | |
| **ESR completion** | • Are there three ESRs at yearly intervals? If not, what is the explanation?<br>• Have you made comments on the assessments – summarising or explaining any exceptions, unsatisfactory?<br>• Have you referenced the previous ESR and/or learning objectives and how they have been met in this period?<br>• Be clear about additional achievements that demonstrate competence, particularly for common competences.<br>• If there are areas needing development, be clear if these mean the individual is not operating at ST3 level or just part of on-going professional development – and what they will be doing about it.<br>• Be clear that the tACP is ready for credentialing and has reached and demonstrated the standard. | |

| | | |
|---|---|---|
| **Work** | • Is there a logbook and evidence of adequate clinical contact and experience? This should include children if relevant. Does this show the minimum number of 2000 patient contacts across the breadth of acuity and location? If dual credentialing, are there also 500 or more children cases? If there are not sufficient patient numbers, what is the explanation? | |
| **Logbook output (curriculum item rating)** | • Have you reviewed all evidence, and does it confirm you think they are at the correct level?<br>• Have you read the CC descriptors to see what a level 2 needs to include – and have you commented on why the evidence does or does not support your assertion of level 2 (or higher)? Why have you said this person is higher than level 2 (if you have)?<br>• Is there a comment on all presentations and procedures in the main curriculum to demonstrate you have seen the evidence and believe it confirms the standard? | |
| **Mandated assessments** | • Are all the mandated assessments completed on the correct form and by the correct assessor – describing the right discussion for that presentation/competence?<br>• Is the balance of CbD and mini-CEX appropriate or not sufficient evidence of direct observation?<br>• Are there any mandated assessments by a locum consultant – and, if so, have you explained why you feel they are suitable to assess in the ESR? | |
| **Procedures** | • Where required, are these done on DOPS forms, and are the assessors eligible to sign them off?<br>• Is the evidence the right type of evidence? Is there too much "discussion" of what you would do (CbD) and not enough evidence of actually doing procedures? | |
| **Consultant assessors** | • Do you know all the assessors – have you explained to them the level required, particularly if they are not EM consultants? Are they all eligible to be assessors? Are any locum consultants appropriate – i.e. long-term locum, RCEM members, trained assessors? | |
| **Other elements** | • For elements such as QIP /audit, etc., are you satisfied that the evidence supports the level required and the descriptors in the curriculum? Is the audit loop closed, or the QIP have 2-3 PDSA cycles? | |

| | | |
|---|---|---|
| **General comments** | • Are there too many items of evidence for each competence or too little (we recommend a maximum of seven with more permitted for common competences)?<br>• Does one WBA get linked to more than three competences? If so, there needs to be some tidying before submission and then reassess.<br>• Are WBAs simply 'tick-box' rather than any learning points or note of discussion? The WBAs need to be rich in information and show the depth and breadth of knowledge.<br>• Are all the WBAs completed within a short period of time, suggesting a retrospective filling in of forms? Whilst practically this may be necessary, it reduces the validity of the evidence, unless there are contemporaneous reflections by the trainee on the case demonstrating their learning points. Having the majority of the evidence completed in a short window, say two weeks, raises concerns for the Panel. | |
| **Other evidence** | • Is there sufficient evidence of other activity, demonstrating a commitment to life-long learning and helping others, as well as reflection? | |
| **Checklist** | • Is each section completed?<br>• Can you find the single piece of evidence that they are asking the Panel to consider and is it appropriate? | |

# Appendix three: Credentialing Screening Form

| To be completed by RCEM | | |
|---|---|---|
| **Forename** | **Surname** | **Regulatory body and membership number** |
| | | |

| **Curriculum** | | | | | |
|---|---|---|---|---|---|
| **Adult only** | ☐ | **Paediatrics only** | ☐ | **Dual** | ☐ |

| **Primary qualification (HEI / year awarded)** |
|---|
| |
| **Master's Degree (HEI / year awarded)** |
| |

| Screening criteria | Yes | No |
|---|---|---|
| CV demonstrates a minimum of three years (WTE) of complete clinical practice as a tACP at the time of submission (minimum 30 hours per week WTE in EM) | ☐ | ☐ |
| Advanced practice qualification at Level 7 (minimum of Postgraduate Diploma) | ☐ | ☐ |
| Independent prescribing qualification at Level 7 (or Level 6 if awarded prior to entering training) | ☐ | ☐ |
| All academic transcripts are present (if the ACP has completed all but the thesis for their Master's, i.e. they have enough credits for a PGDip, but without award of the qualification, there must be a letter from the University confirming that the ACP has achieved the equivalent of a PGDip) | ☐ | ☐ |
| Academic declaration form completed with the learning outcomes from the academic modules mapped against the RCEM learning outcomes stipulated in the guidance | ☐ | ☐ |
| Checklist complete (all pages uploaded to ePortfolio) and signed / countersigned by an Educational Supervisor who is a substantive consultant on the GMC Specialist Register for Emergency Medicine, is a member of RCEM, and has undergone RCEM ACP supervisor training. Word version available. | ☐ | ☐ |
| Mandatory courses are in date at time of submission | ☐ | ☐ |
| Educational Supervisor Report (ESR) covering each year of training (minimum of three in total) | ☐ | ☐ |
| Faculty Educational Governance Statement (FEGS) covering each year of training (minimum of three in total) | ☐ | ☐ |

| | | |
|---|---|---|
| Minimum of three MSF summary reports with at least 15 respondents, of which four are EM consultants | ☐ | ☐ |
| Maximum of 7 items of evidence (excluding eLearning) submitted for each competency in the curriculum (up to 10 items may be submitted for common competences) | ☐ | ☐ |
| One item of evidence (two if both adult and paediatric evidence is required) identified on the checklist as the most appropriate / relevant for consideration | ☐ | ☐ |
| Are all common competences self-assessed at level 4? If yes, refer to the ACP Credentialing Panel. | ☐ | ☐ |
| Minimum of 2000 patients for adult-only and paeds-only ACPs, minimum of 2000 adults plus 500 children for dual ACPs, or explanation. | ☐ | ☐ |
| **Screening outcome** | | |
| All screening criteria met – proceed with application | | ☐ |
| All screening criteria not met – refer to ACP Credentialing Panel | | ☐ |
| **Comments** | | |
| | | |

| | | | | |
|---|---|---|---|---|
| **Panel decision if all criteria have not been met** | **Proceed** | ☐ | **Do not proceed** | ☐ |

# Appendix four: RCEM EC-ACP Academic Component - Credentialing Declaration

| Forename | Surname | NMC / HCP / GPC no. |
|---|---|---|
| | | |
| **Title of academic programme (e.g. Advanced Clinical Practice)** | | |
| | | |
| **Academic award (i.e. PGDip / MSc / Doctorate)** | | |
| | | |
| **Awarding institution** | | |
| | | |
| **Academic modules and learning outcomes** | | |
| | | |
| **History taking and physical assessment** | | |

| College required learning outcome | Module learning outcome that meets this requirement (give name of module and full text of outcome) |
|---|---|
| Elicit a focused history to establish the possible cause of the presentation in all ages | |
| Establish relevant previous history including drug history and social elements that may contribute to a presentation | |
| Gather relevant information from a range of other sources including relatives, carers and medical records, particularly where this may be sensitive information | |
| Recognise the challenges of gathering complex and sensitive information | |
| Demonstrate an accurate physical examination of all body systems in simple and complex situations in all ages, and consider the findings in the context of the patient presentation | |
| Synthesise the findings of the history and examination to make a differential diagnosis and formulate a management plan | |

| | |
|---|---|
| Demonstrate judgement in communication and data gathering within the patient encounter and make appropriate recordings | |
| Distinguish and articulate the difference between normal and abnormal in the context of the patient presentation | |
| Ensure patient privacy, dignity and confidentiality is maintained throughout the clinical assessment | |
| Critically consider the place of the skills of history taking and physical examination within the context of advanced clinical practice | |
| **Clinical decision-making and diagnostics** | |
| **College required learning outcome** | **Module learning outcome that meets this requirement (give name of module and full text of outcome)** |
| Demonstrate an understanding of the decision-making process in advanced clinical practice | |
| Utilise a range of sources of knowledge and information, as well as decision support tools, to come to a sound clinical judgement | |
| Critically evaluate decision support tools in the clinical context to support rapid decision-making and resuscitation in all ages | |
| Manage uncertainty and the associated risks in the diagnostic process and communicate this appropriately with the patient | |
| Engage the patient in shared decision-making, providing sufficient and clear information to support the decision-making | |
| Communicate and record the rationale for decision-making to others when making a decision and the importance of that record | |
| Evaluate decisions in the light of the clinical outcome | |

| | |
|---|---|
| Critically evaluate the contribution of clinical tests (laboratory, imaging and near patient testing) to the clinical decision-making in the light of accuracy and cost of those clinical tests as well as the epidemiology of the condition | |
| Utilise clinical tests in an effective manner to supplement the clinical assessment. This will require reviewing the risks of over or under utilisation of investigations, statistical utility of investigations balancing the cost with benefit to maximise the impact on patient care. | |

# Appendix five: Patient logbook (adult cases) summary template

| Patient logbook summary (adult cases) | | Training year | ACP 1 / 2 / 3 | Period covered | | |
|---|---|---|---|---|---|---|
| Name | | Registration no. | | Hospital site | | |
| | | | | | | |
| Month | Patient total | Resus cases | Majors cases | Ambulatory / minors cases | Admitted | Discharged |
| August 20XX | | | | | | |
| September 20XX | | | | | | |
| October 20XX | | | | | | |
| November 20XX | | | | | | |
| December 20XX | | | | | | |
| January 20XX | | | | | | |
| February 20XX | | | | | | |
| March 20XX | | | | | | |
| April 20XX | | | | | | |
| May 20XX | | | | | | |
| June 20XX | | | | | | |
| July 20XX | | | | | | |
| Totals | | | | | | |

| Overall totals | | | | |
|---|---|---|---|---|
| **Year** | **Resus** | **Majors** | **Ambulatory / minors** | **Overall total** |
| **1** | | | | |
| **2** | | | | |
| **3** | | | | |
| **Total** | | | | |

| I can confirm this is an accurate account of the patients seen, according to the data available | |
|---|---|
| **ACP name** | |
| **Signature** | |
| **Educational Supervisor name** | |
| **Signature** | |

# Appendix six: Patient logbook (paediatric cases) summary template

| **Patient logbook summary (paediatric cases)** | | | | | **Training year** | ACP 1 / 2 / 3 | **Period covered** | August 20XX – July 20XX | |
|---|---|---|---|---|---|---|---|---|---|
| **Name** | | | | | **Registration no.** | | **Hospital site** | | |
| | | | | | | | | | |
| **Month** | **Patient total** | **Age category** | | | **Resus cases** | **Majors cases** | **Ambulatory / minors cases** | **Admitted** | **Discharged** |
| | | **0-1** | **1-5** | **5+** | | | | | |
| **August 20XX** | | | | | | | | | |
| **September 20XX** | | | | | | | | | |
| **October 20XX** | | | | | | | | | |
| **November 20XX** | | | | | | | | | |
| **December 20XX** | | | | | | | | | |
| **January 20XX** | | | | | | | | | |
| **February 20XX** | | | | | | | | | |
| **March 20XX** | | | | | | | | | |
| **April 20XX** | | | | | | | | | |
| **May 20XX** | | | | | | | | | |
| **June 20XX** | | | | | | | | | |
| **July 20XX** | | | | | | | | | |
| **Totals** | | | | | | | | | |

| Please provide overall totals for paediatric age categories for whole training period | | |
|---|---|---|
| 0 - 1 years | 1 - 5 years | Over 5 years |
| | | |

| Overall totals for paediatric cases | | | | |
|---|---|---|---|---|
| Year | Resus | Majors | Ambulatory / minors | Overall total |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| Total | | | | |

| I can confirm this is an accurate account of the patients seen, according to the data available | |
|---|---|
| ACP name | |
| Signature | |
| | |
| Educational Supervisor name | |
| Signature | |