Royal College of Emergency Medicine

The Royal College of Emergency Medicine

Emergency Medicine Advanced Clinical Practitioner Curriculum 2022

Adult

Implemented September 2022

Contents

1. Introduction

1.1 Governance and strategic support

The Royal College of Emergency Medicine (RCEM) EM-ACP curriculum provides the framework for Advanced Clinical Practitioners who wish to apply for credential status with the Royal College. The RCEM ACP Curriculum Sub-Committee of the RCEM Education Committee was established in 2021 to refresh the existing curriculum, taking the RCEM medical curriculum and adapting the content for ACPs whilst retaining both the standard and breadth of practice defined in the previous RCEM ACP curriculum published in 2017.

The sub-committee is constituted of Fellows, credentialed ACPs, consultant nurses and paramedics. It has representatives from devolved nations, and ordinary Fellows and ACPs appointed after open application.

1.1.1 Stakeholder review

A full working draft of the curriculum was available for stakeholder review. This included RCEM committees, others working in Emergency Medicine (EM), the Royal College of Nursing and College of Paramedics, our lay partners through College Council, Health Education England, and NHS employers among others. The RCEM Education Committee gave approval in principle in June 2022 with the final sign off in September 2022.

The curriculum was launched in September 2022 accompanied by a programme of communication, training and engagement with ACPs and their supervisors as well as other interested parties. The RCEM electronic portfolio on the Kaizen platform was adjusted to support implementation of the curriculum.

1.2 How to use this curriculum

The curriculum is designed to lay out what is required to be a credentialed Advanced Clinical Practitioner seeing adult patients in Emergency Departments in the UK. Henceforth, this document will refer to ACPs in training and preparing for credentialing as tACPs, and ACPs at the point of credentialing as EM-ACPs.

The **Purpose Statement** outlines why emergency medicine is vital to the patients of the UK and a key element of the National Health Service and why ACPs are an integral part of the Emergency Medicine workforce.

The curriculum also describes the learning opportunities that should be provided to tACPs and how they and their supervisors can use the curriculum to develop their skills.

Generic Professional Capabilities (GPCs) are designed to foster a common set of skills, attitudes and behaviours in the workforce that might be transferrable if needed. These are comparable to the common competences described in the 2017 ACP curriculum and mirror the multi-professional capabilities described in the **Multi-Professional Framework for Advanced Clinical Practice in England**[1].

[1] https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

The expertise of an EM-ACP working within the NHS involves a wide range of knowledge and technical skills. The breadth of the clinical presentations and pathophysiological processes that need to be known by EM-ACPs are listed as the **Clinical Syllabus**. Up-to-date knowledge and understanding of the assessment and treatment of patients presenting to the Emergency Department (ED) is a fundamental part of training. Acquiring this knowledge and understanding will be by a combination of private study, departmental and regional teaching, and considerable clinical experience. Evaluation of the acquisition of this knowledge and understanding will be by a framework requiring workplace-based assessment, personal reflection, and evidence of learning, delivering and teaching. This clinical syllabus has been mapped to the 2017 ACP syllabus to demonstrate the correlation and confirm that the breadth of practice is maintained and not expanded.

The **Specialty Learning Outcomes (SLOs)** outline what an EM-ACP at the point of credentialing will be expected to be able to do, and the **level of entrustment** – or degree of independence - expected at credentialing. These are linked to the relevant GPCs in each section. Entrustment as a concept in this curriculum is a 'judgement decision' based on observation in practice and identifying the level of entrustment that the EM-ACP has reached in each SLO. It should be noted that the level of entrustment for a newly credentialed EM-ACP will be:

- **Level 2b for SLOs 1, 2, 3, 4, 7, 8 and 12**. Level 2b of entrustment is defined as *Supervisor within hospital for queries, able to provide prompt direction or assistance and trainee knows reliably when to ask for help.*
- **SLO6 has varying levels of entrustment depending on the procedural skill.**
- **Level 3 for SLOs 9, 10 and 11** reflecting the four pillars of the **Multi-Professional Framework for Advanced Clinical Practice** already achieved by EM-ACPs. Level 3 is defined as *Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*.

EM-ACP specific ACP **Key Capabilities (KCs)** are described for each of the SLOs. These are the specific contextualised aspects of the SLOs that are fundamental to the practise of EM in the UK. Key Capabilities form the basis, and are the building blocks, of how the SLOs will be assessed. EM-ACPs wishing to credential are required to demonstrate how they have developed their capability against each of these, seeking and considering feedback in each KC. The Supervisor is required to confirm whether these key capabilities have been achieved or not achieved, contributing to the overall entrustment evaluation for that SLO.

The **Descriptors** section of each Specialty Learning Outcome (SLO) give examples and further guidance for ACPs and assessors about what is required.

An entrustment decision is made by an individual assessor on each assessment and by the faculty in the faculty group meetings – as a joint decision. This must be documented clearly in the portfolio in the Faculty Educational Governance Statement (FEGS) and referenced in the Educational Supervisor Report (ESR) prior to credentialing.

1.3 Utility of assessments and the rationale for the requirement for documented workplace-based assessments for ACPs

Whilst it is recognised that the best use of training opportunities in the workplace for learners is to find areas of challenge and to seek and reflect on feedback from trainers via workplace-based observation, there is a purpose to workplace-based assessments (WPBAs) that is unique to the credentialing process.

Unlike the medical curriculum, where there is a summative assessment in the form of an examination, for EM-ACPs the credentialing process relies on the presentation of sufficient triangulated evidence. The assessment blueprint is therefore prescriptive, in that a fixed minimum number of consultant supervisor workplace-based assessments are required as evidence for credentialing, alongside many other items of evidence. It is also expected that EM-ACPs will have additional assessments completed during their training that will demonstrate the development of increasing independence and capability to support their application for credentialing. It is important for the EM-ACP to show development in all SLOs, and the breadth of evidence required for credentialing for each of the SLOs is laid out in the assessment blueprint and in the 'other evidence required' section of this document. **The Regulations for Credentialing**[2] should be read in conjunction with this curriculum.

2. The Purpose statement of the RCEM ACP Curriculum

The RCEM ACP curriculum has a clear and stated purpose based on the scope of practice of credentialed advanced clinical practitioners in Emergency Departments, and the service, individual patient and population needs. The curriculum defines the capabilities that the EM-ACP is expected to demonstrate for the College to credential the ACP and describes the expected standard and required evidence. The College recognises that many credentialed EM-ACPs, and working ACPs who are yet to credential, are working at a higher standard of entrustment or independence than this curriculum defines in some or all areas of this curriculum. This document focuses on what is required to credential and post credentialing personal development is a matter for individuals and their supervisors and line managers.

The purpose of the RCEM Adult ACP Curriculum is to train ACPs to work in the ED within the multi-disciplinary team, providing urgent and emergency care to all adult undifferentiated patients attending ED nationwide, 24/7, 365 days every year. This includes providing expert clinical care within the multi-professional team for the resuscitation of sick and injured patients. In addition, the EM-ACP will provide care across the full spectrum of acute illness and injury, physical and mental health needs that present to a modern-day ED. They will be able to improve quality, teach and supervise junior colleagues and deliver key administrative tasks. An RCEM credentialed EM-ACP will function as an autonomous practitioner within the adult department, knowing when to ask for help and with the supervisor within the hospital for queries and able to provide prompt direction or assistance.

[2] *Regulations for Credentialing*

Since the EM-ACP has already completed a postgraduate course of study at level 7 which encompasses the four pillars of Advanced Practice AND will commonly have had extensive experience as a senior clinician in their base profession, the EM-ACP can reasonably be expected to demonstrate higher autonomy and expertise in the domains of leadership and management, education and research.

EM-ACPs are a fundamental and critical part of the multi-professional workforce that is required to meet the ever-increasing demand on emergency care. It is therefore imperative that the adult curriculum is fulfilled in its entirety to enable the EM-ACP to contribute to the activity within the team.

2.1 The aims of the RCEM adult ACP curriculum

This curriculum seeks to provide a clear, flexible training pathway for tACPs training in EM and focusing on adult patients The curriculum articulates the standard required to work as a credentialed EM-ACP seeing adults. It should be read in conjunction with the **Regulations for Credentialing[3].** Additional guidance and advice on the credentialing process will be available and updated regularly on the College website.

2.2 The scope of EM practice

Adult EM-ACPs are required to display a wide range of knowledge, skills, behaviours and attributes reflecting the broad nature of the specialty in practice. By the point of credentialing, adult EM-ACPs will be skilled in caring for adult patients with critical illness, injury, mental health problems, frailty, and many other complex conditions. They will be able to competently complete practical procedures related to the clinical care of such patients, will be expert communicators with strong interpersonal skills, will have strong situational awareness and be adept at the management of potentially highly complex situations. EM-ACPs' EM-specific clinical skills and knowledge will be developed and evidenced through achievement of 11 adult SLOs.

RCEM Specialty Learning Outcomes for credentialed EM-ACPs

Specialty Learning Outcome	Adult
SLO 1	Care for physiologically stable adult patients presenting to acute care across the full range of complexity
SLO 2	Support the clinical team by answering clinical questions and making safe decisions
SLO 3	Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop
SLO 4	Care for acutely injured adult patients across the full range of complexity
SLO 6	Deliver key procedural skills in adults

[3] *Regulations for Credentialing*

SLO 7	Deal with complex and challenging situations in the workplace
SLO 8	Provide clinical leadership to the department in the context of the multi-professional team
SLO 9	Support, supervise and educate
SLO 10	Participate in research and managing data appropriately
SLO 11	Participate in and promote activity to improve the quality and safety of patient care
SLO 12	Manage, Administer and Lead

2.3 Training pathway

2.3.1 Previous experience before entering the academic and clinical training pathway

The multi-professional advanced practice workforce is a strength of emergency medicine and ACPs are appointed to emergency departments according to the service needs and practitioners experience. Whilst professional training for nursing or paramedic professions provides a foundation most likely to support advanced training, other allied health care professionals and pharmacists also study at advanced practice level and can utilise the curriculum structure, portfolio and assessment tools to work towards credentialing. Practitioners from these professions will be able to credential against this curriculum on presentation of the required evidence. The breadth of previous experience, particularly around procedural skills and case mix will mean that other professions may need additional time to credential.

Entry into the credentialing pathway will be defined locally but it is recommended that a suitable entry point would be 5 years post-registration with a minimum of 3 years emergency/acute care experience and the practitioner working at enhanced practice level. All tACPs and EM-ACPs must be registered with either the NMC, HCPC or GPC. All time periods contained within this document refer to full-time equivalent.

2.3.2 Academic training

EM-ACPs will have undertaken an *accredited* educational programme in advanced practice (or similar title) and gained a level 7 award (minimum PGDip) with a minimum of 120 credits. All modules must be at level 7. If the programme is not accredited by HEE, then the EM-ACP must complete the Academic Credentialing Declaration in the RCEM ePortfolio by mapping the learning outcomes of the modules they have undertaken to the learning outcomes required by RCEM. The modules must cover 'history taking and physical assessment', and 'clinical decision making and diagnostics'.

2.3.3 Independent prescribing

Independent non-medical prescribing level 7 must be held at submission for credentialing. The exception to this is where the EM-ACP attained a level 6 NMP

certificate *before* commencement of EM-ACP training and can provide evidence of competence and daily utilisation of prescribing.

2.3.4 Clinical experience within the training pathway to credentialing

The development of capability to entrustment level 2b takes a considerable amount of time. The minimum time that must be completed before submission is three years full time, 30 hours delivery of direct clinical contact per week (pro-rata). Any other activity (non-clinical time) will be additional to this, e.g. time for study, QI, etc.

This clinical contact should be direct clinical care, not supervision or departmental coordination. It will take three years (full time equivalent) to develop the experience, maturity and judgement to perform at the expected level of a credentialed ACP. Documenting progression through the entrustment levels is key to demonstrating the development of the range of capabilities. The tACP will need sufficient patient contact (as evidenced by patient numbers) to cover the breadth of the clinical experience and collect sufficient evidence. Progression must be documented in the Faculty Educational Governance Statement entrustment decisions at the end of each year of training; the EM-ACP must have achieved level 2b in the relevant clinical SLOs (various levels for SLO 6 – procedural skills) and level 3 in the supporting SLOs (9, 10, 11) before credentialing.

EM-ACPs can progress to credentialing working part time, providing they have time in clinical practice equivalent to 30 hours a week for three years. However, because evidence submitted must be recent or have appropriate reflection and evidence of continued professional development, there may be challenges for those who work less than full time in a particular SLO or syllabus presentation/condition.

Mandatory consultant supervisor assessments must all be within three years of submission. If these are not within timescale, they will need to be repeated.

Other assessments which are older than three years may be submitted as evidence but reflection on progress since the assessment will be required.

EM-ACPs should be in active practice for the three months immediately prior to submission. The final FEGS and ESR must be completed within the last three months, and both must be based on current capability as observed in the clinical workspace.

The programme does not require any particular sequencing of SLOs although it is recommended that the tACP starts with SLO1 and works through to the later SLOs as confidence and experience grows.

For tACPs wishing to credential in both the adult and children's curriculum, it is anticipated that the ACP will require a minimum of 4 years, 30 hours clinical content per week (or pro-rata). Given the magnitude of the evidence required, it may be appropriate to credential in adults first and subsequently in children at a later date. This may also allow focused experience in one area or another which can support the learning process. The regulations deal with the issue of complementary evidence in adult and children's portfolio to minimise duplication.

3. Organisation and content of the curriculum - content of learning

3.1 Regulation and professional skills

3.1. a Professional regulation

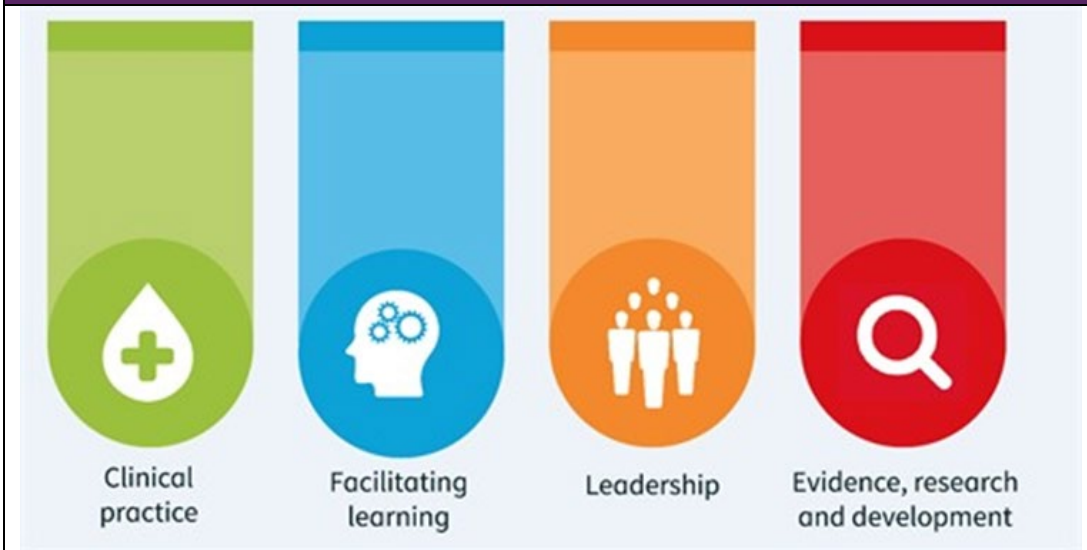
Advanced Clinical Practitioners will always be accountable to their respective regulatory body (HCPC, NMC or GPC), whatever the level or context of their capabilities (HEE, 2017[4]). EM-ACPs should ensure that they always practice within their own scope of practice and according to the Standards of Proficiency relevant to their regulatory body.

Advanced clinical practice defines a level of practice, not only in the clinical domain but across the 4 pillars of advanced practice, which also include leadership and management, education, and research and quality improvement (defined by HEE, National Leadership and Innovation Agency for Healthcare – NHS Wales, NHS Education for Scotland). Coupled with the General Professional Capabilities (GPCs) and respective professional codes, this provides a robust framework of professional accountability and practice.

The EM-ACP should note that the decisions relating to scope of practice in any given institution is a matter for the institution and not the Royal College of Emergency Medicine.

3.1. b Four pillars of advanced practice vs generic professional capabilities (GPCs)

NHS Advanced practice framework pillars



Generic professional capabilities framework: domains	
Domain 1	Professional values and behaviours
Domain 2	Professional skills
Domain 3	Professional knowledge

[4] https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

Domain 4	Capabilities in health promotion and illness prevention
Domain 5	Capabilities in leadership and team working
Domain 6	Capabilities in patient safety and quality improvement
Domain 7	Capabilities in safeguarding vulnerable groups
Domain 8	Capabilities in education and training
Domain 9	Capabilities in research and scholarship

The domains within the General Medical Council's **Generic Professional Capabilities Framework**[5] are incorporated into the RCEM EM-ACP curriculum. This is to maintain synergy with the professional skills defined by the General Medical Council for doctors. They strongly align with advanced practice frameworks used in the UK nations and mirror competences within many HEI Master's level awards in advanced clinical practice.

3.2 Adult EM-ACP Specialty Learning Outcomes (SLOs)

There are eleven RCEM Adult ACP Specialty Learning Outcomes, seven of which are patient-facing relating directly to patient care or activity in the clinical workplace. These are the **Clinical SLOs**.

The remaining four relate to supporting activities that take place away from the ED clinical areas but are also essential to the development of the credentialed ACP in EM. These are the **Supporting SLOs**.

The RCEM Adult ACP SLOs are listed below. The tACP at the point of credentialing should have reached entrustment level 2b in the clinical SLOs (except where specified in SLO6) with demonstrable evidence for all the key capabilities described. They should be able to:

- take on all but the most difficult and complex cases and know when to ask for support from others
- provide support and supervision for junior colleagues within their scope of practice
- contribute to the senior multi-disciplinary leadership team in the department.

[5] https://www.gmc-uk.org/-/media/documents/generic-professional-capabilities-framework--2109_pdf-70417127.pdf

3.2.1 SLO 1: Care for physiologically stable adult patients presenting to acute care across the full range of complexity

SLO 1: Care for physiologically stable adult patients presenting to acute care across the full range of complexity	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** Gather appropriate information, perform a relevant clinical examination and be able to formulate and communicate a management plan that prioritises the adult's and, where relevant, the family's choices that are in their best interests, knowing when to seek help **KC2.** Assess and formulate a management plan for adult patients over the age of 16 who present with complex medical and social needs **KC3.** Assess and manage all adults attending the ED. These capabilities will apply to patients attending with both physical and psychological ill health at all ages **KC4.** Assess and formulate a management plan for adult patients who present with complex medical and social needs or who manifest as one of the frailty syndromes **Entrustment level 2b:** With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help.
Descriptors	**General** • Demonstrates professional behaviour with regard to patients, carers, colleagues and others • Delivers patient-centred care including shared decision making • Takes a relevant patient history including patient symptoms, concerns, priorities and preferences • Performs accurate clinical examinations • Shows appropriate clinical reasoning by analysing physical and psychological findings • Formulates an appropriate differential diagnosis • Formulates an appropriate diagnostic test and management plan, taking into account patient preferences, and the urgency required • Explains clinical reasoning behind diagnostic and clinical management decisions to patients / carers / guardians and other colleagues

- Appropriately selects, manages and interprets investigations
- Recognises need to liaise with specialty services and refers where appropriate
- Demonstrates awareness of the needs of vulnerable adults attending the acute care sector
- Demonstrates professional behaviour with regard to patients, carers, colleagues and others
- Recognises when care would be more appropriately delivered by other healthcare professionals
- Able to provide ongoing management of patients in a CDU/ observational medicine setting, be able to estimate risk and utilise diagnostic tests appropriately and make safe discharge plans, liaising with other services effectively when needed
- Demonstrates awareness of the legal framework and ethical issues relating to adults in the ED including consent and confidentiality.

Adult Mental Health

- Assesses and initially manages adult patients presenting with features consistent with mental illness by taking account of their psychiatric and medical history, mental state examination, vital signs and available investigations
- Makes a competent assessment of an adult patient's suicide risk, taking into account circumstances and known risk factors
- Professionally and compassionately assesses a patient in crisis
- Safely manages acutely disturbed behaviour
- Manages the patient threatening to abscond
- Works collaboratively with Psychiatry Liaison staff and other agencies (including the Police) where necessary when caring for patients with mental health problems
- Contributes effectively to multi-disciplinary care for frequently attending patients with mental illness
- Identifies risk factors for suicide and/or absconsion and mitigates these by appropriate nursing/security observation
- Competently manages the physical/wound care and toxicological consequences of self-harm
- Understands safeguarding responsibilities
- Safely manages aggressive or disturbed behaviour via de-escalation techniques as well as assisting with physical and chemical restraint (rapid tranquilisation) by providing clinical oversight

- Communicates effectively with psychiatry liaison colleagues, nursing staff, security and the police when necessary
- Understands the legal frameworks underpinning the care of the psychiatric patient, as relevant to the ED and ED observation areas
- Respects patient autonomy but understand when a patient lacking capacity should have investigations or treatment made in their best interests

Older patients with complex co-morbidity in the ED

- Able to interact with frail older people, especially those with cognitive impairment, and their carers and families
- Able to assess for frailty syndromes: falls and fragility fractures, immobility, incontinence, polypharmacy, end of life care, delirium and “non-specific presentations”
- Aware of physiological pitfalls in assessment and management of frail older people including in trauma and resuscitation
- Aware of the evidence base underpinning the utility of investigations and interventions in frail older people
- Aware of safeguarding issues in older people and recognises that some of the presenting symptoms could be manifestations of non-accidental injury (NAI)
- Aware of mental health presentations in older people and liaison services
- Aware of pharmacokinetics and pharmacodynamics in frail older people and its interaction with existing polypharmacy
- Aware of medicolegal framework and associations for managing older people with cognitive impairment
- Aware of various models of care delivery for improving quality of care for frail older people including frailty decision units, ambulatory frailty pathways, role of multi-disciplinary teams in the ED
- Aware of design principle for EDs to improve person-centred outcomes for older people including structure, resources and processes.

Adult Safeguarding (see SLO7)

- Knows and understands the ways in which patients may present with physical, sexual, emotional abuse and domestic violence
- Knows and understands how patients may present who are victims of human trafficking and modern slavery
- Able to recognise patterns of injury which might suggest elderly abuse

	• Understands their role in raising concerns and able to reliably document concerns, conversations with other professionals, and detailed descriptions of history or examination findings as appropriate • Understands the importance of seeking help and sharing information with experienced colleagues and other agencies involved with safeguarding • Able to assess capacity and understand deprivation of liberty safeguards.
GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 3: Professional knowledge** • professional requirements • national legislation • the health service and healthcare systems in the four countries **Domain 4: Capabilities in health promotion and illness prevention** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement **Domain 7: Capabilities in safeguarding vulnerable groups**

3.2.2 SLO 2: Support the ED team by answering clinical questions and making safe decisions

SLO 2: Support the ED team by answering clinical questions and making safe decisions	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** Understand how to apply clinical guidelines **KC2.** Understand how to use diagnostic tests in ruling out key pathology, and be able to describe a safe management plan, including discharge where appropriate, knowing when help is required **KC3.** Be aware of the human factors at play in clinical decision making and their impact on patient safety **KC4.** Support the medical, nursing and administrative team in answering clinical questions **KC5.** Make safe decisions for discharge, with appropriate advice for management beyond the ED, including when taking over other clinicians' patients **KC6.** Provide advice and support for colleagues working within the ACP's own scope of practice and delegated authority. **Entrustment level 2b:** Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help.
Descriptors	• Competent in ECG, clinical image and biochemical assay interpretation • Aware of the cognitive psychology of decision making • Understands basic diagnostic test methodology and how to use diagnostic tests effectively • Understands the fundamentals of decision rule design • Aware of the strengths and limitations of using guidelines, e.g. NICE • Demonstrates capability in dealing with complexity and uncertainty • Shares decision making by informing patients, prioritising patients' wishes, and respecting their beliefs, concerns and expectations • Aware of the human factors at play in clinical decision making and their impact on patient safety • Aware of key steps in diagnostic reasoning • Able to describe strategies for dealing with uncertainty

	• Always demonstrates appropriate professional values and behaviours, supporting colleagues, respecting differences of opinion, and working as a collaborative member of a team • Able to provide effective feedback on clinical reasoning and decision making to other ACPs and junior clinicians
GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 3: Professional knowledge** • professional requirements • national legislation • the health service and healthcare systems in the four countries **Domain 4: Capabilities in health promotion and illness prevention** **Domain 5: Capabilities in leadership and teamworking** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement

3.2.3 SLO 3: Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop

SLO3: Identify sick adult patients, be able to resuscitate and stabilise and know when it is appropriate to stop	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** Initiate management of all adult life-threatening conditions including peri-arrest and arrest situations in the ED **KC2.** Care for adult ED patients and their relatives and loved ones at the end of the patient's life **KC3.** Initiate or take over as resuscitation team leader **Entrustment level 2b:** With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help

Descriptors	
	• Identifies an acutely ill patient by taking account of their medical history, clinical examination, vital signs and available investigations • Integrates clinical findings with timely and appropriate investigations to form a differential diagnosis and an initial treatment plan • Acquires the special skills needed to manage the adult patient, e.g. airway management, vascular access • Arranges definitive airway management (including calling for appropriate specialists) providing advanced airway support up to supraglottic device • Initiates and maintains advanced airway support (up to supraglottic device with support when intubation and pharmacological intervention is needed) • Recognises and initiates when non-invasive respiratory support (NIV) is required. • Arranges intravenous fluids and inotropic drugs as clinically indicated, recognising when central venous access is required and monitored by invasive monitoring techniques • Manages life-threatening cardiac and respiratory conditions including peri-arrest and arrest situations • Formulates and initiates ongoing treatment plan for a critically ill acute surgical or acute medical patient post resuscitation, including those with sepsis, and institutes timely antimicrobial therapy with an aim for ongoing stabilisation • Communicates effectively and in a timely manner with fellow members of the multi-disciplinary team including those from other specialties and completes accurate legible and contemporaneous entries in the medical record • Arranges escalation of care when required and provides a succinct structured handover of the relevant patient details including treatment to that point • Recognises a patient is in danger of deterioration or requires further treatment and provides explicit instructions regarding an ongoing treatment plan and responds promptly should a further review be required • Understands when it is appropriate to end resuscitation, and is cognisant of the specific care needs of patients and their loved ones when this decision has been made • Recognises the potential for organ donation in certain end of life situations and is aware of associated best practice guidelines and legislation relevant to the country of practice • Demonstrates effective consultation skills in challenging circumstances

	• Demonstrates compassionate professional behaviour and clinical judgement • Respects patient autonomy and understands when and how they should use advance directives and living wills • Can offer constructive, useful feedback in this domain to junior clinicians/practitioners • Participates in a team debrief following an adult resuscitation/trauma • Whilst assessing and treating a patient the ACP must maintain optimum safety for the patient by recognising the limitations of the environment, the available equipment and personnel and employing best practice guidelines where these exist • Recognises the limitations of ED level of care and employs appropriate admission criteria for critical care • Recognises, assesses and initiates management for acutely ill adults across the spectrum of single or multiple organ failure • Recognises and manages the patient with sepsis and employs local infection control policies • Assists with or performs safely and effectively the clinical invasive procedures to maintain cardiovascular, renal, and respiratory support. • Undertakes and evaluates laboratory and clinical imaging investigations to manage patients in resus with organ failure of dysfunction • Manages the ongoing medical/surgical needs and organ support of patients during a critical illness, including the holistic care of patients and relatives • Plans and communicate the appropriate discharge of patients from resus to health care professionals, patients and relatives • Supports the management of end-of-life care within the reus room environment with patients, relatives and the multi-professional team • Able to communicate effectively, with structured listening, providing understandable information and checking for understanding when breaking bad news
GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions;

	prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 3: Professional knowledge** • professional requirements • national legislation • the health service and healthcare systems in the four countries **Domain 4: Capabilities in health promotion and illness prevention** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement **Domain 7: Capabilities in safeguarding vulnerable groups**

3.2.4 SLO 4: Care for acutely injured adult patients across the full range of complexity

SLO4: Care for acutely injured adult patients across the full range of complexity	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** Be an effective member of the multidisciplinary trauma team **KC2.** Be able to assess, investigate and manage low energy injuries in stable adult patients **KC3.** Be able to initiate assessment, investigations and management of adult patients attending with all injuries, regardless of complexity **KC4.** Be able to initiate or take over leadership of the Trauma Team **Entrustment level 2b:** With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help

Descriptors	
	• Able to perform primary/secondary trauma survey • Has examination skills required to identify/diagnose injury including vascular and neurological consequences • Appropriately uses investigations including XR/CT/US/MRI to confirm presence/consequences of injury • Provides basic management of wounds, soft tissue injuries, fractures and dislocations including local anaesthetic techniques • Provides safe use of basic local anaesthetic techniques e.g., digital nerve block, fascia iliaca block • Uses a range of techniques for wound closure (simple dressing, suturing, skin adhesive, steri-strips). • Knows the fundamentals of management of fractures and dislocations (slings, splints, basic plastering, manipulation as appropriate) • Able to recognise when foreign bodies need removal from the eye and ear • Provides opportunistic advice on accident prevention • Understands the pathophysiology and management of injury (including specific populations e.g. elderly, paediatric and pregnancy • Understands the social/economic consequences of injury upon individuals • Estimates a timeline of healing and gives general and specific safety net advice on concerning features of potential complications • Understands the importance of considering safeguarding of vulnerable adult patients • Participates in local/national audit and research into trauma care • Involvement in a multi-disciplinary team in trauma care including medical and other practitioners • Aware of local/regional/national trauma protocols and guidelines • Aware of human factors/non-technical skills that affect performance of team caring for trauma patient • Able to participate in a multi-professional team brief after major trauma resuscitation Older patients with trauma in the ED • Applies CT guidelines for suspected head and cervical spine injuries • Provides initial care for patients with fractured neck of femur • Understands the impact of injury on patients with markers of frailty

GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 3: Professional knowledge** • professional requirements • national legislation • the health service and healthcare systems in the four countries **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement **Domain 7: Capabilities in safeguarding vulnerable groups**

3.2.5 SLO 6: Deliver key procedural skills

The approach to SLO 6 differs from that of the other SLOs. There is a recognition that EM-ACPs will be required to undertake a range of procedures to patients in all areas of the ED and of variable acuity.

Foundation procedures Foundation procedures are those that would be familiar and commonly used in everyday practice for an experienced ED practitioner who is about to embark on Adult ACP training and would therefore need a simple sign off by the ACP educational supervisor. Those practitioners moving from other clinical areas where they are not commonly using these skills will need to demonstrate documented competence of each of these foundation skills. This would normally take three months to complete and should be the focus of development in the initial phase of ACP training as they are the basic skills on which the EM-ACP builds to acquire core and additional skill. These foundation skills can be assessed by trained assessors suitable for each procedure (e.g. practice educator). All tACPs, regardless of background, will need to evidence continued practice and competence.

Core procedural skills are those which an EM-ACP, upon credentialing, must be able to complete safely and independently, regardless of the area they work in. Assessment will be by consultant DOPS, except for those marked * which may be by a trained assessor.

Additional procedural skills cover those skills which some ACPs may carry out in their practice but, for others, may not be routinely carried out in their area of work or at their level of training. The ACP Educational Supervisor (in conjunction with local

faculty) must define which procedures must be achieved by DOPS and can be carried out safely and independently by the tACP, and which may be covered by CbD (plus sim DOPS if required). Post-credentialing, the Adult EM-ACP may continue to develop their practice and obtain independence in additional procedures via further assessment and assignment of entrustment levels.

On credentialing, the following entrustment levels must be reached:

- **Foundation procedures:** Level 4
- **Core procedural skills:** Level 3
- **Additional procedural skills:** Level 2b for those which are expected to be carried out in practice, Level 1 for those which are not carried out by the ACP themselves

SLO 6: Deliver key procedural skills	
Foundation ACP Procedures to entrustment level 4 Assessed by trained assessors suitable for each procedure **OR** Overall Educational Supervisor sign-off	Within 3 months of start of training, tACPs will be able to competently and independently perform the following procedures: • Venepuncture and IV cannulation • Prepare and administer IV medications and injections, including infusion of blood products • Take blood cultures from peripheral sites • Injection of local anaesthetic to skin • Use a range of techniques for wound closure (simple dressing, suturing, skin adhesive, steri-strips) • Injection – subcutaneous and intramuscular • Perform a 12-lead ECG • Perform peak flow measurement • Urethral catheterisation (male and female) • Airway care including simple adjuncts • Aseptic technique
Core ACP Procedures to entrustment level 3 by DOPS and real patient except for those marked ^ which can be in sim situation (1:1) but must still be DOPS Those marked * can be assessed by a non-consultant assessor	• Arterial blood gas sampling* • Pleural aspiration of air • Manipulation of fracture/dislocation • Plastering* • Vascular access in emergency – IO*^ • External pacing^ • DC cardioversion* • Non -invasive ventilation* • ED Management of life-threatening haemorrhage • Airway management (including iGEL/LMA) without drugs

Additional ACP Procedures to minimum entrustment level 1 and can be assessed by CbD. If the ACP is expected to perform these in practice, they must be at entrustment level 2b as evidenced by a DOPS.	• Chest drain: Seldinger and open technique • Establish invasive monitoring CVP • Establish invasive monitoring arterial line • Vascular access in emergency – femoral vein • POCUS Fascia iliaca block • POCUS vascular access • Lumbar puncture • Procedural sedation in adults • Resuscitative thoracotomy • Lateral canthotomy • Emergency delivery
Key Capabilities	At point of credentialing, an Adult EM-ACP will have: **KC1.** the clinical knowledge to identify when core EM procedural skills are indicated **KC2.** the knowledge and psychomotor skills to perform EM Core procedural skills safely and in a timely fashion **Entrustment level 3:** With Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision **KC3.** the knowledge and psychomotor skills to perform those EM Additional procedural skills which are regularly practiced in their department by ACPs, safely and in a timely fashion - **Entrustment level 2b:** With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help **KC4.** for those procedures not carried out by ACPs in their ED (as confirmed by the ES), the tACP will be able to explain the procedure, understand complications involved and diagnostic value for relevant procedures. **Entrustment level 1**
GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

3.2.6 SLO 7: Deal with complex and challenging situations in the workplace

SLO 7: Deal with complex and challenging situations in the workplace	
Key Capabilities	At point of credentialing, the Adult EM-ACP will: **KC1.** know how to reduce the risk of harm to themselves whilst working in emergency medicine and acute care **KC2.** understand the personal and professional attributes of an effective emergency medicine clinician **KC3.** be able to effectively manage their own clinical workload **KC4.** be able to deal with common challenging interactions in the workplace **KC5.** be able to work effectively with patients who appear angry or distressed **KC6.** have expert communication skills to negotiate or manage complicated or troubling interactions **KC7.** be able to negotiate or manage complicated or troubling interactions **KC8.** behave professionally in dealings with colleagues and team members within the ED **KC9.** work professionally and effectively with those outside the ED Entrustment level 2b: With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help

Descriptors	• Knows how to safely deal with violent or threatening situations
	• Able to handle common but challenging situations
	  ○ self-discharge against advice
	  ○ capacity assessment
	  ○ adult safeguarding issue
	  ○ Police/FME enquiries
	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups
	• Behaves in accordance with ethical and legal requirements
	• Demonstrates ability to offer apology or explanation when appropriate
	• Demonstrates ability to contribute within the clinical team in ensuring that medical legal factors are considered openly and consistently

	• Interacts effectively with hospital colleagues when handing over the care of patients, in particular when this appears troublesome.
	• Liaises effectively with healthcare professionals outside the hospital about patient care
	• Understands the effect on the team of stress and fatigue
	• Supports EM team members in challenging or distressing circumstances
	• Works within a legal framework for shop floor work
	• Is aware of specific legislation:
	  ○ Data Protection Act
	  ○ Information Governance
	  ○ Freedom of Information Act
	  ○ Caldicott Report
	  ○ Mental Health Act
	  ○ Mental Capacity Act
	  ○ Deprivation of Liberty Safeguards
	  ○ Children's Act
	  ○ Advance Directives
	  ○ DNAR Decisions
	  ○ Organ and Tissue Donation
	• Able to judge issues of safeguarding for adults and children (also see SLO1)
	• Behaves at all times in a professional manner
	• Aware of own limitations and ability to ask for help as necessary

GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 5: Capabilities in leadership and team-working** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement **Domain 7: capabilities in safeguarding vulnerable groups**

3.2.7 SLO 8: Lead the ED shift

SLO 8: Lead the ED shift	
Key Capabilities	At point of credentialing, the Adult EM-ACP will: **KC1.** have an awareness of others' workload and support other staff members **KC2.** be able to function as part of the senior clinical team in the ED overnight **KC3.** be able to provide support to ED staff of various levels and disciplines on the ED shift **KC4.** be able to liaise with the rest of the acute / urgent care team and wider hospital as part of the senior ED team **KC5.** be able to maintain situational awareness throughout the shift to ensure safety is optimised **KC6.** be able to anticipate challenges, generate options, make decisions and communicate these effectively to the team as part of the senior ED team **Entrustment level 2b:** With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help

Descriptors	Would be able to commence initial management with no supervisor involvement
	
	• Knows how to safely deal with violent or threatening situations
	• Able to handle common but challenging situations:
	  ○ self-discharge against advice
	  ○ capacity assessment
	  ○ adult safeguarding issue
	  ○ Police/FME enquiries (acting within legal frameworks)
	• Aware of national legislation and legal responsibilities, including safeguarding vulnerable groups
	• Behaves in accordance with ethical and legal requirements
	• Demonstrates ability to offer apology or explanation when appropriate
	• Demonstrates ability to ensure that medical legal factors are considered openly and consistently
	• Interacts effectively with hospital colleagues when handing over the care of patients, in particular when this appears troublesome.
	• Liaises effectively with healthcare professionals outside the hospital about patient care

GPCs	**Domain 5: Capabilities in leadership and team-working** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement

3.2.8 SLO 9: Support, supervise and educate

SLO 9: Support, supervise and educate	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** set learning objectives for, and deliver, a teaching session that demonstrates growing expertise throughout their ACP training **KC2.** deliver effective feedback to a junior colleague or allied health professional **KC3.** undertake training and supervision of members of the ED team in the clinical environment **KC4.** prepare and deliver teaching sessions outside of the clinical environment, including simulation, small-group work and didactic teaching **KC5.** provide effective constructive feedback to colleagues, including debrief **KC6.** understand the principles necessary to mentor and appraise junior colleagues **Entrustment level 3:** *Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*.
Descriptors	• Delivers effective teaching and training to a variety of staff across various professional backgrounds • Delivers effective feedback with action plan • Able to supervise junior colleagues in their clinical assessment and management of patients • Able to supervise junior colleagues in carrying out appropriate practical procedures
GPCs	**Domain 1: Professional values and behaviours** **Domain 8: Capabilities in education and training**

3.2.9 SLO 10: Participate in research and managing data appropriately

SLO 10: Participate in research and managing data appropriately	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** search the medical literature effectively and know how to critically appraise studies **KC2.** appraise, synthesise and communicate research evidence to develop EM care **KC3.** actively participate in research **Entrustment level 3:** *Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*.
Descriptors	• Manages clinical information/data appropriately • Understands principles of research and academic writing • Demonstrates ability to carry out critical appraisal of the literature • Understands the role of evidence in clinical practice and demonstrates shared decision making with patients • Demonstrates appropriate knowledge of research methods, including qualitative and quantitative approaches in scientific enquiry • Demonstrates appropriate knowledge of research principles and concepts and the translation of research into practice • Follows guidelines on ethical conduct in research and consent for research • Understands public health epidemiology and global health patterns • Recognises potential of applied informatics, genomics, stratified risk and personalised medicine and seeks advice for patient benefit when appropriate
GPCs	**Domain 3: Professional knowledge** • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries **Domain 9: Capabilities in research and scholarship**

3.2.10 SLO 11: Participate in and promote activity to improve the quality and safety of patient care

SLO 11: Participate in and promote activity to improve the quality and safety of patient care	
Key Capabilities	At point of credentialing, the Adult EM-ACP will be able to: **KC1.** contribute effectively to a departmental quality improvement project **KC2.** provide clinical leadership on effective Quality Improvement work **KC3.** describe their involvement and show an understanding of QI methods and reflect on a Quality Improvement Project they have been involved in **KC4.** be able to support and develop a culture of departmental safety and good clinical governance **Entrustment level 3:** *Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision*.
Descriptors	• Makes patient safety a priority in clinical practice • Raises and escalates concerns where there is an issue with patient safety or quality of care • Demonstrates commitment to learning from patient safety investigations and complaints • Shares good practice appropriately • Contributes to, and delivers, a minimum of one completed quality improvement project during training • Understands basic Human Factors principles and practice at individual, team, organisational and system levels • Understands the importance of non-technical skills and crisis resource management • Recognises and works within limit of personal competence • Avoids organising unnecessary investigations or prescribing poorly evidenced treatments
GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty

	• clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 3: Professional knowledge** • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries **Domain 4: Capabilities in health promotion and illness prevention** **Domain 5: Capabilities in leadership and teamworking** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement

3.2.11 SLO 12: Manage, administer and lead

SLO 12: Manage, administer and lead	
Key Capabilities	At point of credentialing, the Adult EM-ACP will: **KC1.** Have experience of handling a complaint, preparing a report, and be aware of the relevant medico-legal directives **KC2.** Have an awareness of the investigative process for critical incidents, participate and contribute effectively to department clinical governance activities and risk reduction projects **KC3.** Have an awareness of the staff rota process, being aware of relevant employment law and recruitment activities including interviews and involvement in induction **KC4.** Be able to effectively represent the ED at inter specialty meetings **Entrustment level 2b:** With Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help

Descriptors	• Involved in the response to complaints in a variety of formats including verbal response, written response and face to face meetings • Aware of how to construct a report for the coroner/procurator fiscal and/or legal services using information available from clinical notes • Familiar with some of the tools associated in serious adverse event reporting such as RCA/ 5 Whys/Fishbone analysis • Participates in divisional / inter specialty / Clinical governance meetings • Aware of the interplay of various agencies in the NHS and how they interrelate in the evolving NHS Landscape • Understand the impact of wider determinants of health and workforce challenges that contribute to ED attendance • Demonstrates a high level of communication skills in all of the above
GPCs	**Domain 1: Professional values and behaviours** **Domain 2: Professional skills** • practical skills • communication and interpersonal skills • dealing with complexity and uncertainty • clinical skills (history taking, diagnosis and medical management; consent; humane interventions; prescribing medicines safely; using medical devices safely; infection control and communicable disease) **Domain 3: Professional knowledge** • professional requirements • national legislative requirements • the health service and healthcare systems in the four countries **Domain 4: Capabilities in health promotion and illness prevention** **Domain 5: Capabilities in leadership and teamworking** **Domain 6: Capabilities in patient safety and quality improvement** • patient safety • quality improvement

3.3 Clinical Syllabus

The RCEM EM-ACP curriculum, being outcome based, is structured around the actions that a credentialed EM-ACP needs to be able to do. Underpinning these actions is the clinical knowledge that informs them.

The breadth of that clinical knowledge is described below in the **Clinical Syllabus**. It defines the scope of presentations or clinical conditions that an EM-ACP may encounter in the workplace, and therefore need to know about. These lists are to be used to give a context to the **Programme of Learning** (see section 4) that supports the delivery of the curriculum. tACPs are expected to develop their knowledge base in each of these presentations or conditions. This might be done in formal teaching, self-directed learning and use of online resources

This knowledge is not assessed in an examination, unlike medical trainees. Therefore, there is an imperative to ensure the EM-ACP has had adequate experience and they have the underlying knowledge base (including basic sciences) to support their clinical work in all areas of the clinical syllabus.

tACPs are expected to collect evidence to support their credentialing against all elements of the syllabus. These may be reflective notes, case studies, attendance at training days, eLearning certificates, assessments for development and, where mandated, consultant supervisor assessments. EM-ACPs will be expected to know about relevant basic sciences as well as relevant epidemiology, differential diagnoses, investigation and management of these conditions.

The clinical syllabus is included in the ePortfolio for the tACP to collect evidence and evaluate their experience, tracking their breadth of capability. The ACP Educational Supervisor will be required to confirm that all presentations and conditions have been covered with sufficient experience by the tACP. This is part of the final sign-off for credentialing and the tACP and ACP Educational Supervisor should discuss the syllabus and review evidence regularly to ensure the breadth is covered.

System / specialty	Clinical presentations		Conditions/ issues	
Resus	RP1	Acute airway obstruction	RC1	Choking
	RP2	Anaphylaxis / Anaphylactoid reaction	RC2	Stridor
	RP3	Cardiorespiratory arrest	RC3	Organ donation
	RP4	Major trauma		
	RP5	Respiratory failure		
	RP6	Sepsis		
	RP7	Shock		
	RP8	Unconsciousness		
Allergy	AP1	Acute allergy	AC1	Drug allergy
	AP2	Anaphylactoid reactions		
	AP3	Angioedema		
	AP4	Urticaria		
Cardiology	CP1	Chest pain	CC1	Acute Coronary Syndromes
	CP2	Breathlessness	CC2	Myocardial infarction
	CP3	Palpitations	CC3	Arrhythmias
	CP4	Transient loss of consciousness	CC4	Cardiac failure
			CC5	Cardiac tamponade
			CC6	Congenital heart disease
			CC7	Diseases of the arteries, including aortic dissection
			CC8	Diseases of myocardium
			CC9	Hypertensive emergencies
			CC10	Pacemaker function and failure
			CC11	Pericardial disease
			CC12	Sudden cardiac death
			CC13	Valvular heart disease
Dermatology	DP1	Dermatological manifestations of systemic illness	DC2	Cutaneous drug reactions
	DP2	Rashes	DC3	Eczema
			DC4	Erythroderma
			DC5	Infections of skin and soft tissues
			DC6	Necrotising Fasciitis
			DC7	Pressure ulcers
			DC8	Purpuric rash including Henoch Schonlein Purpura
			DC9	Stevens-Johnson Syndrome
			DC10	Toxic-epidermal necrolysis
			DC11	Urticaria

Ear, nose and throat	EP1 EP2 EP3 EP4 EP5 EP6 EP7	ENT foreign bodies ENT injuries Epistaxis Hearing loss Painful ear Sore throat Vertigo	EC2 EC3 EC4 EC5 EC6 EC7 EC8 EC9 EC10 EC11 EC12 EC13 EC14 EC15	Epiglottitis Glandular Fever LMN facial nerve palsy Meniere's Disease Nasal fractures Otitis externa Otitis media Pharyngitis Post-tonsillectomy bleed Tonsillitis T racheostomy emergencies Quinsy Salivary gland disease Vestibular neuritis
Elderly care	ElP1 ElP2 ElP3 ElP4 ElP5 ElP6 ElP7 ElP8 ElP9 ElP10	Delirium Deterioration in mobility Falls Fragility fractures Frailty (adults only) Hypothermia Incontinence Increasing care needs Memory loss Unsteadiness / balance disturbance	ElC1 ElC2 ElC3 ElC4 ElC5 ElC6 ElC7 ElC8	Comprehensive geriatric assessment Acute confusion Ceiling of care and end-of-life care Dementia – cognitive impairment Fragility fractures Mobility Osteoporosis Pharmacology considerations in the older patient
Endocrinology	EnP1 EnP2 EnP3	Addisonian Crisis Hyperglycaemia Hypoglycaemia	EnC1 EnC2 EnC3 EnC4 EnC5 EnC6	Adrenal disorders Diabetic ketoacidosis Diabetes mellitus and complications including diabetic foot Hyperosmolar hyperglycaemic state Pituitary disorders Thyroid emergencies
Environmental emergencies			EnvC 1 EnvC 2 EnvC 3	Heat stroke and heat exhaustion Drug-related hyperthermias Hypothermia and frost bite

			EnvC4	Decompression sickness
			EnvC5	Near-drowning
			EnvC6	Radiation exposure and safety
			EnvC7	Industrial chemical incidents
			EnvC8	Bites and envenomations typical for the UK
			EnvC9	High altitude emergencies - cerebral and pulmonary oedema
			EnvC10	Acid attacks
Gastroenterology and hepatology	GP1	Abdominal and loin pain	GC1	Alcohol related liver disease including withdrawal
	GP2	Abdominal swelling or mass		
	GP3	Ascites	GC2	Decompensated cirrhosis
	GP4	Constipation	GC4	Functional bowel disorders
	GP5	Diarrhoea	GC5	Gastrointestinal infections
	GP6	Haematemesis and melaena	GC6	Hepatitis
	GP7	Jaundice	GC7	Inflammatory bowel disease
	GP8	Anal pain and rectal bleeding	GC8	Peptic ulcer disease
	GP9	Nausea and vomiting		
	GP10	Dysphagia		
Haematology	HP1	Anaemia	HC1	Anti-coagulant reversal
	HP2	Bruising and spontaneous bleeding	HC2	DIC
			HC3	Haemophilia
	HP3	Massive haemorrhage	HC4	ITP
			HC5	Leukaemia
			HC6	Lymphoma
			HC7	Marrow failure
			HC8	Sickle cell disease/crisis
			HC9	Transfusion reactions
Infectious diseases	IP1	Fever	IC1	Influenza
	IP2	Pyrexia in travellers	IC2	Infection in immunocompromised patients
	IP3	Sepsis		
	IP4	Needlestick injury / exposure to blood borne viruses	IC3	Infestations
			IC5	Notifiable diseases
			IC6	

				Pyrexia of unknown origin – different age groups
			IC7	Malaria
			IC8	HIV infection
Maxillofacial / dental	MaP1	Dental pain	MaC1	Dental abscess
	MaP2	Facial swelling	MaC2	Facial wounds
	MaP3	Avulsed or fractured teeth	MaC3	Post extraction complications
	MaP4	Facial bone injury	MaC4	TMJ dislocation
Mental Health	MHP1	Aggressive or disturbed behaviour	MHC1	Alcohol and substance misuse
	MHP2	Anxiety / panic	MHC2	Depression
	MHP3	Physical symptoms unexplained by organic disease	MHC3	Eating disorders
			MHC4	Personality disorders
			MHC5	Acute psychosis including bipolar, schizophrenia
	MHP4	Self-harm		
	MHP5	Refusal of treatment	MHC6	Somatic symptom disorders
			MHC7	Stress disorders
			MHC8	Suicide
Musculoskeletal (non-traumatic)	MuP1	Acute back pain	MuC1	Cauda equina syndrome
	MuP2	Limb pain and swelling	MuC2	Crystal related Arthropathies
	MuP3	Neck pain	MuC3	Septic arthritis
	MuP4	Joint swelling	MuC4	Limb pain and swelling: bursitis and tendonitis in the upper and lower limb, including ruptured biceps, Achilles tendonitis, plantar fasciitis, metatarsalgia, carpal tunnel and other entrapment neuropathies plus sinister causes bone tumour, stress fracture
	MuP5	Acute hot swollen joint	MuC5	Spinal pain and radiculopathy
			MuC6	Risks of rheumatological disease modifying drugs
			MuC7	Spinal infections
Nephrology	NepP1	Electrolyte disorders	NepC 1	Acute kidney injury
	NepP2	Oliguria	NepC 2	Drugs and the kidney

			NepC 3	Electrolyte disorders
			NepC 4	Fluid balance disorders
			NepC 5	Renal replacement therapy
Neurology	NeuP1	Acute confusion	NeuC 1	Botulism
	NeuP2	Headache	NeuC 2	Cerebral venous sinus thrombosis
	NeuP3	Seizures / status epilepticus	NeuC 4	Functional illness
	NeuP4	Speech disturbance	NeuC 5	Guillain-Barre
	NeuP5	Hemiparesis / hemiplegia	NeuC 6	Meningitis and Encephalitis
	NeuP6	Gait abnormality		
	NeuP7	Visual disturbance	NeuC 7	Multiple Sclerosis
	NeuP8	Weakness / paralysis	NeuC 8	Myasthenia Gravis
	NeuP9	Dizziness and vertigo	NeuC 9	Parkinson's Disease and other movement disorders, epileptic and non-epileptic
			NeuC 10	Peripheral neuropathy (acute)
			NeuC 11	Subarachnoid haemorrhage
			NeuC 12	Stroke and TIA
			NeuC 13	Tetanus
			NeuC 14	Tumours involving the brain and spinal cord
			NeuC 15	VP shunts
			NeuC 16	Wernicke’s Encephalopathy
Obstetrics and Gynaecology	ObP1	Pelvic pain	ObC1	Ante-partum haemorrhage
	ObP2	Vaginal bleeding	ObC2	Bleeding in early pregnancy
	ObP3	Pregnancy		
	ObP4	Genital injury / assault	ObC3	Exposure to infections during pregnancy, e.g.
	ObP5	Vaginal discharge		

	ObP6 ObP7	Foreign bodies Patient in labour	chickenpox ObC4 Ectopic pregnancy ObC5 Genital injury / Female Genital Mutilation ObC6 HELLP ObC7 Heavy menstrual bleeding ObC8 Hyperemesis Gravidaram ObC9 Maternal collapse ObC10 Post-partum haemorrhage ObC11 Pre-eclampsia/ eclampsia ObC12 Pelvic infection ObC13 Post-menopausal bleeding ObC14 Prescribing in pregnancy ObC15 Rhesus D prophylaxis
			ObC16 Sepsis in and following pregnancy ObC17 Thrombosis during and following pregnancy ObC18 Trauma in pregnancy ObC19 OHSS
Oncological Emergencies	OncP1	Acute presentations of undiagnosed cancer that may present to the ED (including weight loss, dysphagia, pain etc)	OncC1 Complications related to local tumour progression e.g. acute cord compression, upper airway obstruction, pericardial and pleural effusions, SVC compression syndrome, raised intracranial pressure OncC2 Complications relating to cancer treatment including - neutropenic sepsis, anaemia and thrombocytopenia and immunotherapy

			OncC3 Biochemical complications of malignancy- hypercalcaemia, SIADH, adrenocortical insufficiency
Ophthalmology	OptP1 OptP2 OptP3 OptP4 OptP5	Diplopia Eye trauma including foreign bodies Painful eye Red eye Sudden visual loss	OptC1 OptC2 OptC3 OptC5 OptC6	Acute glaucoma Cranial nerve palsy Orbital and per-orbital preseptal or peri-orbital cellulitis Inflammatory eye disease Temporal arteritis
Pain and sedation			PC1 PC2 PC3 PC4	Analgesics Non-pharmacological methods of pain management Pain assessment Sedation
Palliative and end of life care	PalP1	Advanced malignancy and end stage chronic disease	PalC1 PalC2 PalC3 PalC4	Advanced care planning Anticipatory medications End stage organ failure Pain management
			PalC5 PalC6 PalC7	Physical symptoms other than pain Psychosocial concerns including spiritual care and care of the family The dying patient
Pharmacology and poisoning	PhP1 PhP2 PhP3	Medication side effects/interactions Overdose Accidental Poisoning	PhC1 PhC2 PhC3 PhC4 PhC5	Overdose of prescription and non-prescription medications including legal and non-legal drugs Poisoning – carbon monoxide, cyanide, organo-phosphate Toxidromes Use of antidotes Batteries, household chemicals, poisonous plants

Respiratory	ResP1	Chest pain	ResC 1	Asthma
	ResP2	Breathlessness	ResC 3	COPD
	ResP3	Haemoptysis	ResC 4	Foreign body inhalation
	ResP4	Cough	ResC 5	Pertussis
			ResC 6	Pleural effusion
			ResC 7	Pneumonia
			ResC 8	Pneumothorax
			ResC 9	Pulmonary Aspiration
			ResC 10	Pulmonary embolus
Sexual health	SeP1	Genital discharge	SeC2	Sexual assault
	SeP2	Genital lesions	SeC3	Sexually transmitted infections
	SeP3	Emergency contraception		
	SeP4	Post-exposure prophylaxis		
Surgical emergencies	SuP1	Abdominal pain	SuC1	Ano-rectal abscesses
	SuP2	Abdominal swelling / mass	SuC2	Appendicitis
	SuP3	Constipation	SuC3	Biliary colic
	SuP4	Diarrhoea	SuC4	Bowel obstruction
	SuP5	GI bleeding	SuC5	Breast abscess
	SuP6	Anal / rectal pain	SuC6	Cholangitis
	SuP7	Nausea / vomiting	SuC7	Cholecystitis
			SuC8	Diverticular disease
			SuC9	Haemorrhoid disease
			SuC1 0	Hernias
			SuC1 1	Intussusception
			SuC1 2	Ischaemic bowel
			SuC1 3	Lower gastrointestinal and rectal bleeding
			SuC1 4	Pancreatitis
			SuC1 5	Viscus perforation
			SuC1 6	Volvulus

Trauma	TP1 TP2 TP3 TP4 TP5 TP6 TP7 TP8 TP9 TP10	Head injury Spinal injury Chest and lung injury Major vascular injury Abdominal injury Pelvic injury Limb and joint injury Burns Inhalational injury Wounds	TC1 TC2 TC3 TC4 TC5 TC6 TC7	Compartment syndrome Limb and joint injury including bony, musculo-tendinous and complications Electrical burns Salter- Harris classification Infection - paronychia, pulp space, flexor sheath nail bed, amputations etc. Animal bites including human Injury to bladder, urethra, testes or penis
Urology	UP1 UP2 UP3 UP4 UP5 UP6	Dysuria Injury to bladder, urethra, testes or penis Urinary retention Testicular pain/swelling Loin pain Haematuria	UC1 UC2 UC3 UC4 UC5 UC6 UC7	Epididymo-orchitis Renal stone disease Phimosis / Paraphimosis Priapism Testicular torsion Prostatitis UTI / Pyelonephritis
Vascular			VC1 VC2 VC3	Acute limb ischaemia Aortic aneurysmal disease DVT
Other clinical presentations			XC1 XC2 XC3 XC4	Major Incident Management PHEM Safeguarding in adults Domestic abuse

4. Programme of learning

4.1 Learning and teaching

The organisation and delivery of EM-ACP training is currently a local Trust responsibility. The Royal College of Emergency Medicine recommends collaboration within regions and networks for formal teaching opportunities as well as shared events with medical trainees where possible. Regions in England will benefit from liaison with their Regional Advanced Practice Faculty Lead. Throughout the UK, a number of Emergency Medicine Schools have identified an ACP TPD to lead on this work.

4.2 Progression

Progression through the RCEM ACP curriculum will be determined by the local faculty. The College strongly recommends a process for independent review of progression of the tACP similar to the ARCP process for medical trainees. This **annual review** allows the local organisation to plan and to provide additional support if required. Whilst there is no formal requirement within credentialing for an outcome to be stated from such a process, a document summarising the progress made in the last 12 months is expected within the portfolio.

The minimum requirement for credentialing is three of each of the following at yearly intervals:

- Educational Supervisor Report (ESR) confirming the progress being made on evidence collection, entrustment decisions, coverage of the syllabus and breadth of knowledge
- Faculty Educational Governance Statement (FEGS)
- Multi-Source Feedback (MSF) for each year of training (minimum of three in total) with appropriate numbers of consultant faculty contributions.

4.3 The training environment

This curriculum should be used to help design training programmes locally that ensure all tACPs can develop their capabilities in a variety of settings and situations. It is designed to ensure that there is flexibility in training, meeting service needs as well as supporting each individual tACP's learning and development plan. The standards that apply to medical training are relevant for this ACP programme and follow the **HEE Quality Framework**[6]:

Theme 1: Learning environment and culture

S1.1 The learning environment is safe for patients and supportive for learners and educators. The culture is caring, compassionate and provides a good standard of care and experience for patients, carers and families. tACPs are provided with opportunities to deliver care to patients in their role in an appropriately supervised environment.

S1.2 The learning environment and organisational culture values and supports education and training, so that learners are able to achieve the learning

[6] https://nshcs.hee.nhs.uk/publications/health-education-england-hee-quality-framework-from-2021/

outcomes required by their curriculum. tACPs are enabled to access assessments and receive constructive feedback on their progression.

Theme 2: Educational governance and leadership

S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against the standards, demonstrating accountability and responding when standards are not being met. The training programme for tACPs is incorporated into the departmental programme with regular review of the tACP progress and access to learning.

S2.2 The educational and clinical governance systems are integrated, allowing organisations to address concerns about patient safety, the standard of care, and the standard of education and training. tACPs are encouraged to participate in local faculty group meetings as well as clinical governance meetings and are enabled to contribute to initiatives around safety and quality.

S2.3 The educational governance system makes sure that education and training is fair and is based on the principles of equality and diversity. All relevant staff are enabled to develop themselves and apply for ACP training.

Theme 3: Supporting learners

S3.1 Learners receive educational and pastoral support to be able to achieve the learning outcomes required by their curriculum. tACPs have named clinical and educational supervisors who meet the required RCEM standards.

Theme 4: Supporting educators

S4.1 Educators are selected, inducted, trained, and appraised to reflect their education and training responsibilities. ACP Educational Supervisors are expected to have attended the RCEM specific training if they are to sign off the credentialing application.

S4.2 Educators receive the support, resources and time to meet their education and training responsibilities. ACP supervisors should receive appropriate time (0.25 PA per ACP) in their job plan for educational supervision.

Theme 5: Delivering programmes and curricula

S5.1 Local training providers seek to develop new and innovative methods of education delivery including multi-professional approaches

S5.2 Timetables, rotas and workload enable the tACP to meet curriculum requirements including sufficient non-clinical time to meet the ACP key capabilities in the supporting SLOs

Theme 6: Developing a sustainable workforce

S6.1 Employers work across networks to ensure the curriculum can be delivered at the breadth and depth required

S6.2 Programmes provide information and advice to support career planning decisions including new and innovative ways of working

4.4 Teaching and learning methods

The curriculum can be delivered through a variety of learning situations:

4.4.1 **Clinical experience** should be used as an opportunity to undertake WPBAs and reflection. Every patient seen in the ED or urgent treatment centre, SDEC unit, CDU or acute assessment unit provides a learning opportunity which will be enhanced by following the patient through the course of their illness. The experience of the evolution of patients' problems over time is a critical part of both the diagnostic process as well as management. Patients seen should provide the basis for critical reading and reflection on clinical problems. Every time a tACP observes another clinician seeing a patient or their relatives there is an opportunity for learning. To ensure patient safety, tACPs should be appropriately supervised for their level of capability and entrustment.

4.4.2 **Learning with peers**: working alongside, discussion cases, small group teaching.

4.4.3 **Simulation**: as some presentations and procedures are relatively infrequent, simulation is a valuable tool to allow learning opportunities and also for the formative assessment of competence.

Simulation used for assessment: Where a summative DOPS for a procedure is required, this must be with a real patient other than for those indicated in SLO6. Where a simulation scenario is used for a clinical presentation assessment, only the tACP 'leading' the scenario can be summatively assessed, although other participants may have formative assessment and feedback recorded, both for clinical and non-technical skills.

4.4.4 **Courses (external or internal)**

- Mandatory life support courses: ALS, ATLS/ETC and Paediatric Basic Life Support (Trust)
- Management and leadership
- Vascular access
- Human factors
- Critical thinking
- Paediatric sedation
- Procedural skills including emergency thoracotomy, emergency caesarean section, surgical airway
- Resuscitation team leadership
- Dealing with challenging situations in the workplace.

4.4.5 **A programme of regular teaching** sessions to cohorts of medical trainees or tACPs (organised in each hospital or across a region) designed to cover aspects of the curriculum:

- Case presentations
- M&M meetings

- Journal clubs
- Research and audit projects
- Lectures and small group teaching
- Clinical skills - use of simulation
- Critical appraisal exercises
- Joint specialty meetings
- Life support courses
- Participation in management meetings
- Delivering teaching to peers, or junior colleagues/other professionals.

4.4.6 Independent self-directed learning

- **RCEMLearning:** content mapped to the Clinical Syllabus and SLOs and maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- Other eLearning sources as relevant
- Reading journals
- Working towards personal learning goals beyond the essential core curriculum.

4.4.7 Governance activity: audit, quality improvement and research projects within job planned protected non-clinical time

5. The Programme of Assessment and relevance for credentialing

5.1 The purpose of assessment

The purpose of the RCEM ACP Programme of Assessment fall into three broad categories:

Assurance:

- demonstrate EM-ACPs are competent across the breadth of the curriculum having acquired the knowledge and skills at the required standard
- mandatory workplace-based assessment as evidence that tACPs are meeting the curriculum standards during the training programme.

Regulating progression and targeting remediation:

- assess tACPs' actual performance in the workplace
- inform the progression meeting and identify any requirements for targeted or additional training or experience where necessary
- identify performance concerns and ultimately tACPs who should be advised to consider changes of career direction.

Fostering self-regulated learners:

- enhance learning by providing formative assessment, enabling tACPs to receive immediate feedback, understand their own performance and identify areas for development

- drive learning and enhance the training process by making it clear what is required of tACPs and motivating them to ensure they receive suitable training and experience
- identify and encourage excellence.

5.2 Types of assessment

The credentialed EM-ACP, by presenting a comprehensive suite of evidence, demonstrates their development into a reflective practitioner, committed to lifelong learning as well as meeting the required standards. The inclusion of assessments from the beginning of training helps to demonstrate the journey to capability. It is recognised that assessments completed in the first year or two of training will not meet the entrustment level required but will allow feedback to the tACP on how they can continue to develop their capability to reach that level. Therefore, it is expected that there will be a considerable number of formative type assessments, not meant to confirm capability but to enable ongoing development.

The mandatory consultant supervisor assessments (or by trained assessors in some cases) are expected to demonstrate the required entrustment level at the point of submission; the tACP is expected to select the most appropriate assessment as per the requirements below.

- The mandated assessments, demonstrating appropriate capability and entrustment has been reached, must be completed by an experienced supervisor – in most cases an Emergency Medicine Consultant
- The remaining assessments can be completed by a range of supervisors including senior EM trainees and Trust doctors (ST4 equivalent and above), consultant and credentialed ACPs and other practitioners. These assessments are designed to foster self-regulated learners.

5.2.1 Panel-based judgements

Faculty Educational Governance Statements (FEGS) provide regular, panel-based, information-rich, individualised judgements that inform each tACP's progression. The faculty will consider the tACP's workplace performance and provide a summative recommendation about whether a tACP has met the standard in the SLOs relevant to their experience as a tACP. This information is combined with other evidence in an **Educational Supervisor Report (ESR)** that is completed each year in preparation for credentialing. It is envisaged that the ESR is written by the ACP Educational Supervisor having reviewed the evidence collected and offering a judgement on progress and the standard reached, including the WPBAs and MSF, case load, critical incidents, reflections, logbooks, etc. These ESRs are reviewed at credentialing to ensure a progression and any suggestions on additional focus or activity are followed by the tACP.

5.2.2 The ACP credentialing assessment blueprint

The table below shows the mandatory assessments required for credentialing. There is no requirement for any assessment to be completed in a specific year of training although evidence older than five years is not appropriate. Any mandatory assessment must be within three years of submission, exceptionally a mandatory assessment that

is older can be accepted but must be accompanied by suitable reflection on the individual's development of capability since the assessment. A mandatory assessment submitted for credentialing must demonstrate the relevant level of entrustment has been met. An assessment completed at the beginning of training is unlikely to demonstrate the appropriate entrustment level has been achieved.

In addition to the mandatory assessments, a considerable amount of other evidence must be presented, including assessments where the relevant entrustment level is not met but which may provide an indication of the development of capability (formative). All sections of the clinical syllabus must have some evidence. In addition to the 48 mandatory consultant/named assessor assessments (listed below), it is expected that the clinical syllabus will have a minimum of 30 additional assessments, with the rest covered by eLearning and other evidence. This is the **minimum** number of assessments and many tACPs will find additional assessments helpful.

Within the syllabus, the **resus domain** must have an assessment for each of the eight clinical presentations, i.e. three further assessments in addition to the five listed below. These can be at entrustment level 2a. The additional three do not need to be by a consultant assessor.

Consultant assessments required – Adults	
Type	**New curriculum**
Mini-CEX / CbD (consultant) – entrustment level 2b	**Resus:** 5 Mini-CEX / CbDs focusing on: • Significant trauma in resus room (as team leader) • Respiratory condition • Cardiology • Cardiac arrest (as team leader) • Other condition treated in resus
	Majors / trolley area: 9 Mini-CEX / CbDs focusing on: • GI / abdominal • GU • O&G • Neurology • Endocrinology • Respiratory • Cardiology • Psychiatry • Frail elderly
	Ambulatory EM: 6 Mini-CEX / CbDs focusing on: • Eyes • ENT • Dermatology • Wounds • Trauma • MSK non traumatic
DOPS foundation skills – entrustment level 3	One foundation skills form (within the ePortfolio) confirming capability by the ACP Educational Supervisor **OR** individual DOPs for: • Venepuncture and IV cannulation • Prepare and administer IV medications and injections, including infusion of blood products • Take blood cultures from peripheral sites • Injection of local anaesthetic to skin • Use a range of techniques for wound closure (simple dressing, suturing, skin adhesive, steri-strips)

	• Injection – subcutaneous and intramuscular • Perform a 12-lead ECG • Perform peak flow measurement • Urethral catheterisation (male and female) • Airway care including simple adjuncts • Aseptic technique
DOPS (consultant or another appropriate assessor*) - entrustment level 3 ^ by sim with 1:1 DOPS	10 DOPS for core procedural skills: • Arterial blood gas sampling* • Pleural aspiration of air • Manipulation of fracture/dislocation • Plastering* • Vascular access in emergency – IO*^ • External pacing^ • DC Cardioversion* • Non-invasive ventilation* • ED management of life-threatening haemorrhage • Airway management (including iGel/LMA without drugs)
CbD: entrustment level 1 **(or DOPS if entrustment level 2b required locally)**	• Chest drain: Seldinger and open technique • Establish invasive monitoring CVP • Establish invasive monitoring arterial line • Vascular access in emergency – femoral vein • POCUS Fascia iliaca block • POCUS vascular access • Lumbar puncture • Procedural sedation in adults • Resuscitative thoracotomy • Lateral canthotomy • Emergency delivery
ACAT	3 ACATs in total, at least one should focus on SLOs 3 and 4 (resus patients) and one should cover the KCs in SLO2.
ESLE	3 ESLEs in total All four domains of the ELSE (management and supervision, teamwork and cooperation, decision making and situational awareness) must be covered between the three ESLEs.

MSF	1 MSF per year with a minimum of 12 respondents (including 2 consultants) in each – 3 in total
Life support courses	• ALS, ATLS (or ETC) valid at date of submission • Paediatric Basic Life Support (Trust Training)
QI project	• One completed project with recommendations and report on actions • One final QIAT form for the project • Evidence of participation in QI on every ESR
Management experience	• Attendance and participation at meetings • One management task per year to include one complaint, one incident investigation and one other

5.3 Entrustment decisions

The transition to a credentialed EM-ACP is an important time. Not only does it signify the ACP is able to provide a defined standard of care, but it also conveys that the ACP is able to take on some responsibilities and a higher degree of independence. The judgement of the entrustment level requires a clear working knowledge of what the level means and the ability to predict how the ACP will respond when given a higher complexity of cases or additional clinical responsibility.

Key features of good judgement-based assessment are asking the right people and asking the right questions. The FEG panels are composed of staff who know the tACP well and know the responsibilities of the job well. Critically, the judgements are framed in terms of entrustment and independence. This aligns with the natural decision-making heuristics of clinician supervisors, and there is good empirical evidence that such 'construct aligned' judgements are significantly more dependable that judgements framed in terms of experience in the job or merit, e.g. poor, satisfactory, or good.

The RCEM entrustment scale for EM-ACPs is shown in the table below:

RCEM entrustment scale	
1	Direct supervisor observation/involvement, able to provide immediate direction/assistance
2a	Supervisor on the 'shop-floor' (e.g. ED, theatres, AMU, ICU), monitoring at regular intervals
2b	Supervisor within hospital for queries, able to provide prompt direction or assistance and tACP knows reliably when to ask for help

3	Supervisor 'on call' from home for queries, able to provide directions via phone and able to attend the bedside if required to provide direct supervision
4	Would be able to manage with no supervisor involvement (all tACPs practice with a consultant taking overall clinical responsibility)

The expectation of tACPs in each SLO are shown below. It should be noted that for credentialing, the EM-ACP is expected to reach entrustment level 2b in the clinical SLOs, although it is recognised that in the supporting SLOs the EM-ACP will be at entrustment level 3. A newly credentialed EM-ACP is not expected to be operating at entrustment level 4 in any SLO.

SLOs	Entrustment level (first year ACP)	Entrustment level (newly credentialed ACP)
Care for physiologically stable patients attending the ED across the full range complexity	1	2b
Answer clinical questions	1	2b
Resuscitate and stabilise	1	2b
Care for an injured patient	1	2b
Deliver key procedural skills	1	Varies depending on procedure
Deal with complex situations in the workplace	1	2b
Lead the ED shift	1	2b
Teach and supervise	2a	3
Participate in research	1	3
Patient safety and quality improvement	1	3
Lead manage and administer	1	2b

5.4 Faculty Educational Governance Statement (FEGS)

What is it?

This is a statement that summarises the collated views of the training faculty about the progress of a tACP and, specifically at the point of credentialing, their suitability for the award of the credential.

This judgement is based on the observation of the tACP in the workplace, on feedback from staff and patients and what faculty members have learned about the tACP's

performance from WPBAs (individual WPBAs and reflections need not be reviewed by the training faculty at each FEG meeting, but they are available for review if the faculty judges that they need more data to make their judgement). Within this statement, the strengths of the tACP are also summarised, as well as areas to develop, thus giving the opportunity to reflect and encourage excellence. The FEG panel can also offer suggestions as to how the tACP might address any on-going training needs, potentially making the FEGS an 'adaptive' or individualised assessment.

The decision made by the faculty on the progress towards independence is seen as a benefit locally in supporting the tACP as they make progress on the training pathway. The clear descriptions of what is required should benefit both the tACP and the local department.

How is it done?

The FEGS can be completed in different ways according to local arrangements. However, the key feature of the FEGS is that it includes the views of the right people, i.e. those who know the tACP and know the responsibilities of the job. It must represent the collated views of the training faculty as to whether they believe a tACP has met the requirement for practice in each of the relevant SLOs at the level of independence required in their job role. The decision will relate to the Key Capabilities for each SLO that are relevant to the tACP's stage of training.

When is it done?

For tACPs a FEGS is required for each year of practice, culminating in submission for credentialing. The final FEGS should be completed within 3 months of the submission date. A minimum of 3 FEGS, each spaced approximately 12 months apart, is mandated for credentialing.

6. Other evidence required

6.1 Reflective practice

tACPs are expected to provide reflection on each item of evidence and, in addition, to provide evidence of reflective practice. Reflection should analyse their own capability – not just a description of the activity, but how the evidence demonstrates the development of their capability and progression to independent practice in that SLO. At each sign-off for key capabilities, the tACP is expected to reflect on why and how they have reached the relevant level of entrustment.

Engagement in training is very important and a marker of an ACP who is seeking to develop beyond their current capabilities is a key principle that underpins the ethos of assessment in the workplace.

In addition, the tACP is expected to reflect on eLearning, e.g. how this affects their daily practice; evidence of learning and a planned change in behaviour is expected. Reflection on teaching attended and delivered, meetings attended, projects undertaken, is all part of the valuable evidence that is expected.

6.2 Procedural log

In addition to the mandatory DOPS that are required, it is recommended that tACPs complete a reflective practice log within the portfolio demonstrating both experience and familiarity with procedures. These can also be used in reflective practice.

6.3 Other evidence

All sections of the clinical syllabus should have evidence against them. Where relevant, this may be a mandatory item or formative WPBAs, eLearning, teaching delivered, case reports, conference elements, etc. For the clinical syllabus one item of evidence may cover several elements of one section of the syllabus.

6.4 Patient log

In order to gain experience sufficient to develop the standard of competence required, it is expected that the EM-ACP has had direct contact with a significant number of patients with a sufficient breadth of practice. A patient log is required which demonstrates the breadth of conditions managed, and an adequate number where the EM-ACP has been the primary clinician caring for the patient. Guidance on the presentation of the patient log is available on the RCEM website. As the curriculum is competence/capability based, adequate experience and patient contact must be demonstrated.

It is recommended that the EM-ACP has a case mix that is made up of 20% resus cases, with 50% of the remaining cases being ones that are referred for ongoing or expert opinion. This provides evidence that the EM-ACP has been working in a multi-disciplinary team and can engage with other specialties for the benefit of patients.

If it recommended that the EM-ACP will have seen a minimum of 2100 adult patients by the end of the three-year minimum (whole time equivalent) training. This would likely be represented by around 700 adult patient contacts in the first year, rising to 1000 as the ACP gets more proficient. It is recognised that the more experienced ACP may see less patients themselves as they are supervising others; an explanation for this would be expected in the ACP's reflection and from the supervisor.

7. Departmental considerations

7.1 Supervision and feedback

Access to high quality, supportive and constructive feedback is essential for the professional development of the tACP. Personal reflection is an important part of the feedback process and exploration of that reflection with the trainer should ideally be a two-way dialogue.

Effective feedback is known to enhance learning and combining self-reflection with feedback promotes deeper learning.

All elements of work in training must be supervised with the level of supervision depending on the experience of the tACP, case mix and workload. The duties, working hours and supervision of tACPs must be consistent with the delivery of high-quality, safe patient care.

Initially there should be close supervision of the tACP with opportunities to discuss each case if required. As training progresses, the tACP is expected to work with increasing independence, consistent with safe and effective care for the patient. It is important to establish that the tACP's knowledge, skills, behaviours and professional conduct are developing appropriately.

The College recommends that Educational Supervisors should be allocated at least 0.25 educational PAs (1 hour) per week per tACP in order to deliver this standard of supervision.

ACP Educational Supervisors must have attended the RCEM training for ACP supervisors. Whilst Paediatricians who are working primarily as PEM consultants in a paediatric emergency department may apply to be an ACP Educational Supervisor for tACPs in the Children's department, this is unlikely to be required for adult-only tACPs. Paediatrician ACP Educational Supervisors must be Members of the RCPCH and attend the RCEM ACP supervisor training.

In addition, the College recommends Consultant Practitioners and Senior ACPs acting as Clinical Supervisors should also be allocated 1 hour per week, per tACP. This is to support the professional development of the tACP as they transition to autonomous practitioners working in the medical model.

7.2 Facilities

Each department must ensure tACPs have access to:

- on-line learning facilities and libraries
- an adequate induction to local policies, procedures and arrangements in the same way as junior doctors undergo local induction
- electronic patient records (EPR) on the same basis as medical staff to allow the tACP to record their clinical findings. They should be allocated the role on the electronic patient record (EPR) consistent with their training level.
- adequate accommodation for themselves and their trainers in which to prepare their audit, teaching, or quality management work
- a private area where confidential activities such as assessment, appraisal, counselling and mentoring can occur
- a secure storage facility for confidential training records
- a reference library where tACPs have ready access to bench books (or electronic equivalent) and where they can access information at any time
- IT equipment such that they can carry out basic tasks on computer including the preparation of audio-visual presentations. Access to the internet is recognised as an essential adjunct to learning.
- a suitably equipped teaching area and access to local training suitable for tACPs – this may be provided by integration with the FY2 or core ACCS EM training
- a private study area
- an appropriate rest area whilst on duty.

Trainee ACPs will always have a named Educational Supervisor and Clinical Supervisor responsible for overseeing their education.

At least one individual involved in assessing trainee and established ACPs within the local ED must have completed the mandatory RCEM ACP supervisor training. Dates are advertised on the RCEM website.

7.3 Definitions of supervisors

ACP Educational Supervisor

A Fellow of the Royal College of Emergency Medicine and a substantive consultant in Emergency Medicine who is selected and appropriately trained, meeting the GMC framework standards, and who is responsible for the overall supervision and management of a tACP's educational progress during training. The ACP Educational Supervisor is responsible for completing the Educational Supervisor Report (ESR) and Faculty Educational Governance Statement (FEGS) each year. The ACP educational supervisor must have attended the RCEM supervisor training a year before credentialing sign off for the ACP, and preferably in the tACP's first year of training.

The ACP Educational Supervisor has responsibility for confirming that the evidence required for credentialing is present and clearly visible and that, in their opinion, the tACP is ready for credentialing. They are expected to review the whole portfolio and to complete the sign-off of the portfolio to confirm they believe the evidence is complete.

This will also require them to have spoken to the entire faculty involved in training the tACP and to ensure that the standard of performance expected is understood and maintained, particularly during the tACP assessments.

The ACP Educational Supervisor has responsibility for the safety of the patients and the tACP. Therefore, the Educational Supervisor should discuss issues of clinical governance risk management and any report of untoward clinical incidents involving the tACP. The Educational Supervisor should be contacted if there are any concerns identified by any member of the extended faculty and clinical team regarding their tACP.

Other consultants in EM may act as educational supervisor and have oversight of educational progression for the early years. However only an approved ACP educational supervisor can perform final sign off and complete FEGS and ESRs.

Clinical Supervisor

A trainer, usually a consultant but may be a consultant practitioner or senior advanced clinical practitioner, who is selected and appropriately trained to be responsible for overseeing a specified tACP's clinical work and for providing constructive feedback during their training. The Clinical Supervisor must be familiar with the assessment tools, the standard required, and have undergone training for their role. This may be a consultant in another specialty who will also have undergone training to the GMC framework.

7.4 Assessors

Assessors may be medical doctors, or advanced clinical practitioners or other senior healthcare professionals. All assessors need to be aware of the standards required and have been trained in assessment. Assessors must be competent themselves in the area being assessed.

It should be noted that all mandatory consultant assessments must be completed by a substantive consultant in the appropriate specialty. In the majority of cases this will be a Fellow of the Royal College of Emergency Medicine.

It is essential that training in assessment is provided for trainers and ACPs in order to ensure that there is complete understanding of the assessment system, assessment methods, their purposes and use. Training will ensure a shared understanding and a consistency in the use of WPBAs and the application of standards. Opportunities for feedback to tACPs 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 progression meetings where relevant within a local programme.

7.5 Responsibility of the tACP

All tACPs should make the safety of patients their first priority. Furthermore, tACPs should not be practising in clinical scenarios which are beyond their experiences and competences without supervision. tACPs should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. tACPs will need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during training. tACPs should actively seek guidance from their trainers in order to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs.

It is the responsibility of tACPs to seek feedback following learning opportunities and WPBAs. tACPs should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, tACPs should formulate action plans with further learning goals in discussion with their trainers.

7.6 Appraisal

A formal process of discussion and review underpins training. This process ensures adequate supervision during training, provides continuity and is one of the main ways of providing feedback to tACPs. All educational meetings should be recorded in the ePortfolio for the purposes of credentialing. Whilst these meetings relate specifically to the progress made in the tACP training programme, it is acknowledged that the tACP's line manager may need to be involved and/or kept informed of this process.

These educational meetings may be in addition to the Personal Development Review (PDR) process that is a local professional requirement. Ideally the process would be in parallel or in conjunction.

tACPs will be undertaking an academic level 7 programme in Advanced Practice in conjunction with completing this curriculum. It is therefore advised that educational meetings involve feedback from their HEI clinical practice tutor. In this way, themes and work plans across both the ACP curriculum and the Master's programme can be drawn together to ensure a robust and effective plan for the year ahead can be developed.

The tACP, HEI clinical practice tutor and the Educational Supervisor should have a meeting at the beginning of each year. They should review the tACP's progress thus

far, agree learning objectives for the next year and identify learning opportunities. A personal development plan should be developed that highlights the experience needed, the evidence that will be gathered and any focused learning required.

8. Intended use of curriculum by trainers and ACPs

ACP Educational Supervisors and tACPs will be expected to have a good knowledge of the curriculum and should use it as a guide for their training programme and ACP discussions. The evidence collected by the tACP must demonstrate the depth, breadth and scope of practice and evidence that the tACP is working across all areas.

Each tACP will engage with the curriculum by maintaining their ePortfolio (hosted on the Kaizen platform). The tACP will use the curriculum to develop personal learning objectives and reflect on learning experiences.

The College recommends using the curriculum proactively, both to confirm coverage and identify areas to be covered by new evidence. This ensures more thoughtful learning and ensures cases are valuable learning experiences. The curriculum is also key to the planning of tutorials and assessments.

8.1 Currency

Established EM-ACPs will need to provide evidence that covers the entire curriculum. Naturally, some evidence may be retrospective. However, such evidence must be within five years with the majority within three years, and in the case of older evidence, there must be reflection on how their practice has developed since the evidence was collected.

Experienced EM-ACPs may use evidence of their teaching to cover the curriculum. However, there must be evidence of clinical contact for the majority of the presentations, and a suitable case mix and appropriate workload as evidence of that clinical experience.

It should be noted that, given the requirement to use RCEM forms for consultant assessments, and the time limit on currency of evidence, it will take time for established ACPs to ensure the full range of required evidence is collected and appropriate. Revisiting previously demonstrated competences requires appropriate reflection on the personal development and progression since that evidence was first collected.

8.2 Recording progress in the ePortfolio

Upon becoming a member of RCEM, tACPs will be given access to the ePortfolio. The ePortfolio allows evidence to be built up to inform decisions on a tACP's progress and provides tools to support the tACP's education and development.

The tACP's responsibilities are to:

- Keep their ePortfolio up-to-date
- Request assessments (WPBAs, MSF) and ensure they are recorded
- Maintain their personal development plan
- Record their reflections on learning and record their progress through the curriculum.

The supervisor's responsibilities are to:

- Provide guidance on the standard required
- Provide feedback to enable the tACP to meet that standard and to continue to develop professionally
- Communicate with the entire faculty to provide comprehensive feedback to the tACP
- Highlight areas of deficiency and make recommendations for improvement
- Agree the personal development plan and learning objectives for each year
- Regularly review the portfolio to ensure progress is being made
- Complete an Educational Supervisor Report (ESR) each year
- Complete some WPBAs
- Contribute to the MSF
- Ensure the FEGS entrustment decisions are recorded.

9. Continuing Professional Development (CPD) and revalidation

In line with professional requirements, all tACPs and established ACPs should engage in CPD and maintain a portfolio to ensure they meet the requirements for professional revalidation.

It should be noted that professional revalidation is required for the whole scope of practice but is not affected by credentialing. Revalidation will be with the relevant regulator of the individual practitioner. Evidence collected for revalidation may be useful for credentialing and vice versa but will require reflection on how it contributes to the evidence for credentialing.

10. Equality and diversity

The Royal College of Emergency Medicine complies, and ensures compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The College believes that equality of opportunity is fundamental to the many and varied ways in which individuals become involved with the College, either as members of staff and Officers; as advisers from the medical profession; as members of the Colleges' professional bodies or as ACPs and credentialing applicants.

11. Assessment methods

Acute Care Assessment Tool (ACAT) assesses the capability of a tACP across a range of patients over a period of time – typically 1-2 hours. The tool looks at clinical assessment, investigation and management of patients, patient safety, clinical judgement and time management. The ACAT can be linked to a number of clinical syllabus items and is usually either focused on the clinical KCs in SLO1 or SLOs 3 and 4. This tool also assesses SLOs 2 and 7.

Case Based Discussion (CbD): assesses the performance of a tACP in their management of a patient 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 tACPs. The CbD should focus on a written record such as a patient's written case notes. The CbD tool can be used for summative or formative assessment.

Direct observation of procedural skills (DOPS): assessment tool designed to evaluate the performance of a tACP in undertaking a practical procedure, against a structured checklist. The trainee receives immediate feedback to identify strengths and areas for development.

Extended Supervised Learning Event (ESLE): an extended event of observation in the workplace across cases. It covers interactions, decision making, management and leadership, as well as the tACP's individual caseload. It is therefore an assessment of the non-technical supporting SLOs (2,7,8,9,12) although the clinical patient characteristics may meet SLO 1,3 and 4 KCs. The event will characteristically be three hours in length, with around two hours of observation followed by one hour of feedback. The tACP will be observed during their usual work on shift, but the consultant observer will be supernumerary, i.e. not in the clinical numbers. tACPs are given a rating aligned to independence in each domain observed by the consultant supervisor. The purpose of doing so is to provide expert opinion on development against expectation and to generate learning outcomes for further work in the ED and future ESLEs.

Leadership assessment tool: designed to provide feedback and development of leadership skills as per the RCEM Leadership framework

Management assessment forms: a range of forms looking at specific management activities designed to provide feedback and development of management capabilities

Mini-clinical evaluation exercise (Mini-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 tACP receives immediate feedback to aid learning. The Mini-CEX can be used at any time and in any setting when there is a tACP and patient interaction and an assessor is available. The Mini-CEX can be used in a summative or formative manner.

Multi-source feedback (MSF): method of assessing generic skills such as communication, leadership, team working, reliability etc. This provides objective systematic collection and feedback of performance data on a tACP, derived from a minimum of 12 colleagues, which should include 2 consultants, line manager, senior nursing/AHP staff, junior doctors, junior nurses and support staff.

Quality Improvement Assessment Tool (QIAT): designed to assess a tACP's competence in completing a quality improvement project. The QIAT requires 3 main areas of content: a report of the project itself, an account of working with others, and reflection on leadership and learning.

Teaching Observation: designed to provide structured, formative feedback to tACPs on teaching competence. The Teaching Observation can be based on any formal teaching by the tACP, which has been observed by the assessor. The process should be trainee-led (identifying appropriate teaching sessions and assessors).

12. Acknowledgements

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