Preparing to Submit

Advice for ACPs and ACP Educational Supervisors

ACPs and ACP Educational Supervisors should plan for the final sign-off of the portfolio to be complete at least 2 weeks before the application window opens. This gives time for last minute items to be completed and refinements to be made. Don't leave it until the night before! Providing there has been good supervision and regular contact between ACP and supervisor, this should be a seamless, painless process.

Both the ACP and ACP ES should ensure the requirements of the curriculum and credentialing regulations have been met in their entirety, and all mandated evidence identified in the checklist in section 5.2.2 of the curriculum document (and included as appendix 1 and 2 below) is present.

ACP Educational Supervisor

It will probably take a minimum of 4 hours to review the portfolio in detail – checking all of the evidence and completing the resolution comments - so plan ahead. The following questions may be useful to consider when reviewing the portfolio:

1. Have all academic certificates and transcripts been uploaded to the files area and are they clearly labelled? Has the Academic Credentialing Declaration been completed appropriately (for academic programmes not accredited by the NHSE Centre for Advancing Practice)? If in doubt about the suitability of the academic qualification for credentialing, please seek further advice from the College.

2. Has the ACP linked one piece of evidence to the 'mandated evidence for credential' section of each SLO/KC? This will either be the specified mandated item of evidence indicated in the checklist (appendix 1 and 2) or, if nothing is specified, the piece of evidence that best demonstrates the specific key capability. Has the ACP selected an appropriate form of evidence - relevant case, adequate performance, etc.? Does this evidence really assure you that they meet this key capability? If not, work with them to identify the best piece of evidence. If there is more than one item in the mandated evidence section, work with them to remove the additional items. Please note that it is acceptable for the mandated evidence sections of the KCs within SLO6 to contain more than one WBA as this SLO covers all core and additional procedures. However, the ACP must select only one assessment for each procedure.

3. Has the ACP provided evidence for each section of the clinical syllabus, and is it appropriate? The clinical syllabus defines the scope of presentations or clinical conditions that an EM-ACP may encounter in the ED and, therefore, some evidence will be expected in each section to confirm complete coverage across the breadth of the syllabus. Can you then sign-off in the Final ESR that the syllabus is complete?

4. Have you completed resolution comments for all KCs in every SLO? Resolution comments should focus on whether the evidence linked to 'mandated evidence for credential' really does fulfil that KC, and how, but should also provide some commentary on the other evidence and on observed practise in the department. For example, for *SLO4 KC2: be able to assess, investigate and manage low energy injuries in stable adult patients*, the resolution comment might say "*the MiniCEX for the 35-year-old man who had a sports injury with ACL rupture shows appropriate examination technique and*

onward referral as an independent practitioner. The other WBAs for Colles fracture and minor head injury without LOC show application of appropriate guidelines and x-rays. In working alongside X I have continued to see focused assessments with an emphasis on using clinical decision rules and ensuring good explanations and safety netting". Just stating that "the ACP evidence meets this KC" is not sufficiently detailed.

5. Are all mandatory consultant workplace-based assessments present and linked to the correct sections of the curriculum? Have they been completed by the right level of assessor and using the right tool (see appendix 1 and 2)?

6. Is there evidence of teaching in SLO9? Does this cover more than one type of learner? Is there a teaching assessment tool, and is there reflection from the tACP?

7. Is the QIP/audit good enough? Is the role of the ACP in the audit or QIP clear? Is there evidence of leadership and implementation of actions completed, including evaluation of the impact of those actions, data, reflection and learning? Has a QIAT form been completed and is there evidence of participation in QI in every ESR? If an audit has been undertaken, are there recommendations and actions with a re-audit (this is one of the common areas of difficulty)? Can you read this section and be assured that the tACP understands what quality improvement is?

8. Is there evidence that the tACP has been involved in research? Is a GCP certificate present? Does the evidence from the tACP Advanced Practice degree demonstrate some of these capabilities in SLO10?

9. Is there evidence of leadership in the form of responses to complaints, investigations of incidents, business plans, managing rotas or other similar leadership tasks? Has the tACP reflected and included demonstration of their own activity? Is there feedback and assessments on these tasks?

10. Is there a clear patient log? Are there sufficient patients of the correct case mix and, if not, have you explained why?

11. Is there an MSF, ESR (or STR prior to transition) and FEGS in the timeline for each year of training (minimum 3 of each completed at regular intervals)? If not, have you explained why?

12. Have you completed the ACP Foundation Sign-off form, Final ESR and Final FEGS?

ACP

Please allow yourself plenty of time to complete a final review of your portfolio – this will take you longer than you think. Make sure you book your final meeting with your ACP Educational Supervisor at least 2 weeks prior to the date the application window opens.

You may find the following questions helpful to consider when reviewing your portfolio:

1. Have you included all the mandatory evidence identified in the checklist in section 5.2.2 of the curriculum document (and included as appendix 1 and 2 below)?

2. Have you provided all academic certificates and transcripts, and are they clearly labelled so the Panel can locate them easily? Has the Academic Credentialing Declaration been completed (for academic programmes not accredited by the NHSE Centre for Advancing

Practice) so that it clearly demonstrates all RCEM-required learning outcomes have been achieved?

3. Have you linked the most appropriate piece of evidence to the 'mandated evidence for credential' section of each SLO/KC? For some, this will be the specified mandated item of evidence identified in the checklist (see appendix 1 and 2); for others, the piece of evidence that best demonstrates the specific key capability. Does it really tell the story of the KC as written, and does it adequately demonstrate capability?
4. Have you completed a Curriculum and Syllabus Comment (CSC) for every KC?
5. Are all your requests for WBAs (tickets) completed and reflected upon?
6. Have you provided evidence for each section of the clinical syllabus?
7. Have you delinked formative evidence that is no longer relevant and could detract from the remainder of your portfolio, especially if there are too many learning points?
8. Where there are mandatory consultant assessments with learning points, have you included reflection and evidence of taking the actions noted on the forms?
9. Are all documents named appropriately so that they can be easily located in the files area or timeline? Have all items been saved as PDF files (unless otherwise indicated) before being attached to a WBA or other event?

Submitting your credentialing application

1. Make sure you know when the credentialing application window in which you intend to submit is due to open. There are two application windows each year – in Spring and Autumn - and opening and closing dates can be found on the ACP credentialing page of the RCEM website.

   Please note: there is a separate, later application window for 'limited resubmissions', giving extra time to obtain the additional evidence required. Please ensure you submit within the correct window.

2. Once the application window opens, complete the online registration form via the link on the ACP credentialing page of the RCEM website, and pay the appropriate fee (the fee structure can be found on the same webpage).

3. When completing the online registration, you must be confident that you will have uploaded all evidence to your ePortfolio before the application window closes, as any evidence submitted after the closing date will not be considered (except in exceptional circumstances and at the sole discretion of the Chair of the ACP Credentialing Panel).

   Please note: you may continue to upload further evidence after you have completed the registration form, until the window closes.

Appendix 1: credentialing checklist (adult)

Mandated evidence required (adult credential)	
Assessments	
Type	**2022 ACP curriculum**
Foundation Skills - entrustment level 4 **ACP Adult Foundation Sign-off** (ePortfolio form) confirming capability by the ACP Educational Supervisor **AND** **Foundation DOPS** by trained assessors suitable for each procedure ***if required locally for procedures new to the tACP*** (not mandated for submission)	**Foundation Skills** • 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 Procedural Skills - entrustment level 3 **Consultant[1] DOPS** ***** DOPS by Consultant ***or*** another appropriate assessor **^** may be in a simulation situation (1:1) but still requires Consultant DOPS	**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)
Additional Procedures **Consultant CbD -** entrustment level 1 **OR** **Consultant DOPS** - entrustment level 2b for those procedures that the ACP is expected to perform in	**Additional Procedures** • 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

[1] Associate Specialist or Senior Specialty Doctors who meet the eligibility criteria to be an ACP Educational Supervisor as defined in the ACP Credentialing Regulations may complete any assessment which stipulates a consultant assessor is required

practice) **^** may be in a simulation situation (1:1) but must still be assessed by Consultant DOPS to entrustment level 2b (if required locally) or CbD entrustment level 1	• Procedural sedation in adults • Resuscitative thoracotomy**^** • Lateral canthotomy • Emergency delivery**^**
MiniCEX / CbD – entrustment level 2b **Consultant assessor**	**Resus:** 5 MiniCEX / CbD 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 MiniCEX / CbD focusing on: • GI / abdominal • GU • O&G • Neurology • Endocrinology • Respiratory • Cardiology • Psychiatry • Frail elderly
	Ambulatory EM: 6 MiniCEX / CbD focusing on: • Eyes • ENT • Dermatology • Wounds • Trauma • MSK non traumatic
MiniCEX / CBD - entrustment level 2a **Trained assessor**	3 additional MiniCEX / CbD (by trained assessor) for items within the **resus** domain of the clinical syllabus not previously assessed by Consultant MiniCEX / CbD above
MiniCEX / CBD - entrustment level 2a **Trained assessor**	Minimum of 30 additional MiniCEX / CbD spread across the clinical syllabus
ACAT	3 ACATs in total, with at least one focusing on SLOs 3 and 4 (resus/high acuity patients[2]) and one covering the KCs in SLO2

[2] Resus/high acuity patients are defined as those patients determined to be critically ill or significantly injured (identified by a high NEWS2/PEWS score, acuity 1 or 2 Manchester Triage, or requiring immediate intervention and resuscitation)

ESLE	3 ESLEs in total. All four domains of the ESLE (management and supervision, teamwork and cooperation, decision making and situational awareness) must be covered between the three ESLEs.
QIAT	At least one QIAT based on a completed project, and evidence of participation in each ESR (required annually)
Complaint response assessment	
Incident investigation assessment	
One other management task assessment	
Teaching observation assessment	Evidence of observed delivery of education with reflection and feedback from participants
MSF	Minimum of three MSFs (one per year, completed at least 8 months apart) each with a minimum of 12 respondents, including 2 consultants. The final MSF must be completed within 6 months of submission.
Clinical Syllabus	
Final Educational Supervisor Report (ESR)	ACP Educational Supervisor sign-off within the Final ESR confirming coverage of the entire clinical syllabus with evidence presented for each syllabus item.
Educational meetings and progression	
Educational Supervisor Report (ESR)	Completed annually by the ACP ES (minimum of 3 in total, including the Final ESR which must be completed within 3 months of submission)
Faculty Educational Governance Statement (FEGS)	Completed annually by the ACP ES with faculty contribution. Minimum of 3 in total, including the Final FEGS which must be completed within 3 months of submission.
Annual Trust appraisal	
Annual Record of Progress (ARP)	Either the RCEM Annual Record of Progress (ARP) form (on risr/advance) completed by the ACP ES and others involved in the ACP programme, or similar locally devised document. **Please note:** If the ACP's progress towards credentialing is discussed in the Trust appraisal, an additional record of progress is not required but the appraisal document must detail progress towards credentialing as well as the personal development and professional aspects addressed in appraisal.

Courses	
Life support	ALS, ATLS (or ETC) valid at date of submission Paediatric Basic Life Support (Trust Training) valid at date of submission
GCP	NIHR online module competed within 2 years of submission
Safeguarding	Safeguarding children level 3 (completed within 3 years of submission) Safeguarding adults level 2 (completed within 3 years of submission)

Appendix 2: credentialing checklist (children)

Mandated evidence required (children credential)	
Assessments	
Type	**2022 ACP curriculum**
Foundation Skills - entrustment level 4 **ACP Children Foundation Sign-off** (ePortfolio form) confirming capability by the ACP Educational Supervisor **AND** **Foundation DOPS** by trained assessors suitable for each procedure ***if required locally for procedures new to the tACP*** (not mandated for submission)	**Foundation Skills** • 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 • Aseptic technique
Core Procedural Skills - entrustment level 3 **Consultant[3] DOPS** ***** DOPS by Consultant ***or*** another appropriate assessor **^** may be in a simulation situation (1:1) but still requires Consultant DOPS	**Core Procedural Skills** • Manipulation of fracture/dislocation • Plastering***** • Vascular access in emergency – IO***^** • ED management of life-threatening haemorrhage**^**
Additional Procedures **Consultant CbD -** entrustment level 1 **OR** **Consultant DOPS** - entrustment level 2b for those procedures that the	**Additional Procedures** • Urethral catheterisation (male and female) • Chest drain: Seldinger and open technique • Establish invasive monitoring CVP • Establish invasive monitoring arterial line • Vascular access in emergency – femoral vein • POCUS vascular access • Lumbar puncture

[3] Associate Specialist or Senior Specialty Doctors who meet the eligibility criteria to be an ACP Educational Supervisor as defined in the ACP Credentialing Regulations may complete any assessment which stipulates a consultant assessor is required

ACP is expected to perform in practice)	• Procedural sedation in children • Airway management including iGEL/LMA without drugs • Pleural aspiration of air
MiniCEX / CbD – entrustment level 2b **Consultant assessor**	**Resus:** 5 MiniCEX / CbD focusing on: • Significant trauma in resus room (as team leader) • Respiratory condition • Shocked child • Cardiac arrest (as team leader) • Other condition treated in resus
	Majors / trolley area: 9 MiniCEX / CbD focusing on: • GI / abdominal • GU • O&G • Neurology • Endocrinology • Respiratory • Cardiology • Psychiatry • Social situation – vulnerable child
	Ambulatory EM: 6 MiniCEX / CbD focusing on: • Eyes • ENT • Dermatology • Wounds • Trauma • MSK non traumatic
MiniCEX / CBD - entrustment level 2a **Trained assessor**	3 additional MiniCEX / CbD (by trained assessor) for items within the **resus** domain of the clinical syllabus not previously assessed by Consultant MiniCEX / CbD above
MiniCEX / CBD - entrustment level 2a **Trained assessor**	Minimum of 30 additional MiniCEX / CbD spread across the clinical syllabus
ACAT	3 ACATs in total, with at least one focusing on SLOs 3 and 4 (resus/high acuity patients[4]) and one covering the KCs in SLO2
ESLE	3 ESLEs in total. All four domains of the ESLE (management and supervision, teamwork and cooperation, decision making and situational awareness) must be covered between the three ESLEs.

[4] Resus/high acuity patients are defined as those patients determined to be critically ill or significantly injured (identified by a high NEWS2/PEWS score, acuity 1 or 2 Manchester Triage, or requiring immediate intervention and resuscitation)

QIAT	At least one QIAT based on a completed project, and evidence of participation in each ESR (required annually)
Complaint response assessment	
Incident investigation assessment	
One other management task assessment	
Teaching observation assessment	Evidence of observed delivery of education with reflection and feedback from participants
MSF	Minimum of three MSFs (one per year, completed at least 8 months apart) each with a minimum of 12 respondents, including 2 consultants. The final MSF must be completed within 6 months of submission.
Clinical Syllabus	
Final Educational Supervisor Report (ESR)	Sign-off confirmed on Final ESR by ACP Educational Supervisor
Educational meetings and progression	
Educational Supervisor Report (ESR)	Completed annually by the ACP ES (minimum of 3 in total, including the Final ESR which must be completed within 3 months of submission)
Faculty Educational Governance Statement (FEGS)	Completed annually by the ACP ES with faculty contribution. Minimum of 3 in total, including the Final FEGS which must be completed within 3 months of submission.
Annual Trust appraisal	
Annual Record of Progress (ARP)	Either the RCEM Annual Record of Progress (ARP) form (on risr/advance) completed by the ACP ES and others involved in the ACP programme, or similar locally devised document. **Please note:** If the ACP's progress towards credentialing is discussed in the Trust appraisal, an additional record of progress is not required but the appraisal document must detail progress towards credentialing as well as the personal development and professional aspects addressed in appraisal.
Courses	
Life support	APLS (or EPALS), ATLS (or ETC) valid at date of submission Adult Basic Life Support (Trust Training) valid at date of submission
GCP	NIHR online module competed within 2 years of submission
Safeguarding	Safeguarding children level 3 (completed within 3 years of submission)