Royal College of Emergency Medicine

The Royal College of Emergency Medicine

Emergency Medicine Advanced Clinical Practitioner Curriculum 2022

Adult

First edition September 2022

Second edition April 2025

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1. Introduction

1.1 Governance and strategic support

The Royal College of Emergency Medicine (RCEM) EM-ACP curriculum (Adult) 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 Academic 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 comprises of Fellows, credentialed ACPs, and consultant practitioners selected through an open application process.

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[1] platform was adjusted to support implementation of the curriculum.

1.1.2 Development of the curriculum

This is the second edition of the (RCEM) EM-ACP curriculum (Adult). This edition has been developed following feedback from trainers, trainee ACPs and experienced ACPs, and has been refined to meet the needs of the service, the training programme and the professional scope of practice. However, the standard, breadth of practice and requirements for credentialing remain unchanged.

The second edition of the curriculum provides additional information, clarification or guidance on:

- new academic requirement from 2026
- core procedures that may be assessed using simulation
- assessors permitted to complete WBAs for core and additional procedures
- annual requirements for credentialing
- using simulation for assessment
- currency of mandated consultant assessments
- foundation skills entrustment level
- mandated evidence for credentialing
- ACP Educational Supervisor eligibility criteria.

[1] Renamed risr/advance in November 2022

1.2 How to use this curriculum

The curriculum defines what is required to be a credentialed Emergency Medicine 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 NHS and why EM-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**[2].

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.

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. Entrustment decisions are defined in the same language and scale for EM-ACPs as they are for medical trainees. 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**. Entrustment Level 2b 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

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

is defined as 'Supervisor 'on call' from home for queries, able to provide direction via phone, and able to attend the bedside if required to provide direct supervision'.

EM-ACP specific **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 as a joint decision for each SLO by the faculty in the faculty group meetings. 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 (WBAs) 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**[3] 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

[3] Regulations for Credentialing

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; 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 EDs 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 emergency department, knowing when to ask for help and with the supervisor within the hospital for queries and able to provide prompt direction or assistance. In the context of entrustment levels, the term 'supervisor' relates to a senior decision maker who would normally be an experienced doctor at ST4 or above.

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**[4]. Additional guidance and advice on the credentialing process is 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 time they credential, 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 in 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.

[4] Regulations for Credentialing

RCEM Specialty Learning Outcomes (SLOs) for credentialed EM-ACPs

SLO	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
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 practitioner's 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, ePortfolio 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 whole-time equivalent.

2.3.2 Academic training

EM-ACPs will have undertaken an accredited educational programme in advanced clinical practice and gained a full Master's degree in Advanced Clinical Practice from

a UK Higher Education Institute (HEI). This is in line with the NHSE digital badge requirements.

Please note: Up to and including the Autumn 2025 credentialling window, RCEM will accept a level 7 PGDip award (minimum 120 credits) in advanced clinical practice as evidence of academic attainment. However, it should be noted that this ***will not*** be in line with NHSE digital badge requirements.

The advanced clinical practice programme must contain modules covering the topics of:

- History taking and physical assessment
- Clinical decision making and diagnostics
- Independent prescribing.

The programme may not have modules with the specific titles listed above, but they must meet the learning outcomes specified by the College. All modules must be at level 7.

A level 6 prescribing qualification will be accepted if obtained prior to commencing the tACP programme. All prescribing modules completed *during* the tACP programme must be at level 7.

It is the responsibility of the applicant to ensure that the required RCEM EM-ACP curriculum learning outcomes identified in the academic declaration are met by the learning outcomes specified by the HEI. The applicant will demonstrate this by mapping the HEI learning outcomes to the RCEM-required learning outcomes within the Academic Credentialing Declaration form on risr/advance.

If the tACP has attained a Master's degree in Advanced Clinical Practice that has been accredited by the NHSE Centre for Advancing Practice, completion of the academic declaration is not required. A list of NHSE accredited programmes can be found on the Centre for Advancing Practice website.

2.3.3 Independent prescribing

An independent prescribing qualification must be held at submission for credentialing. Independent provider status on the professional register of the appropriate regulator must be demonstrated.

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 in advanced clinical practice in an emergency department before submission is 3 years, working 30 hours per week direct clinical contact (or pro-rata). Any other activity (non-clinical time) will be additional to this, e.g. time for study, QI, etc.

This clinical contact is defined as direct clinical care and not, for example, the tACP providing supervision to others, or departmental shift coordination and leadership. It will take 3 years (whole-time equivalent) to develop the experience, maturity and judgement to perform at the expected level of a credentialed EM-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 SLOs 1-4, 7, 8 and 12, and level 3 in SLOs 9-11 before credentialing. SLO6 has varying levels of entrustment depending on the procedural skill.

tACPs can credential working part time, providing they have time in clinical practice *equivalent* to 30 hours a week for 3 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 clinical syllabus presentation/condition.

Mandated assessments must all be within 3 years at point of submission. If these are not within timescale, they will need to be repeated.

Other assessments which are older than 3 years may be submitted as evidence but reflection on progress since the assessment was completed will be required.

The final FEGS and ESR must be completed within 3 months of submission, and both must be based on current capability as observed in the clinical workspace. tACPs should therefore be in active practice for the 3 months immediately prior to submission.

The final MSF cycle must be undertaken within 6 months of submission.

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 curricula concurrently, it is anticipated that the tACP will require a minimum of 4 years, 30 hours clinical contact per week (or pro-rata). Given the magnitude of the evidence required, it may be more appropriate to credential in adults first, and then in children at a later date. This may also allow focused experience in one patient group before consolidation in the second age group, which can further support the learning process. The regulations deal with the issue of complementary evidence in the adult and children's portfolios 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), irrespective of the level or context of their capabilities (HEE, 2017[5]). EM-ACPs should ensure that they always practice within

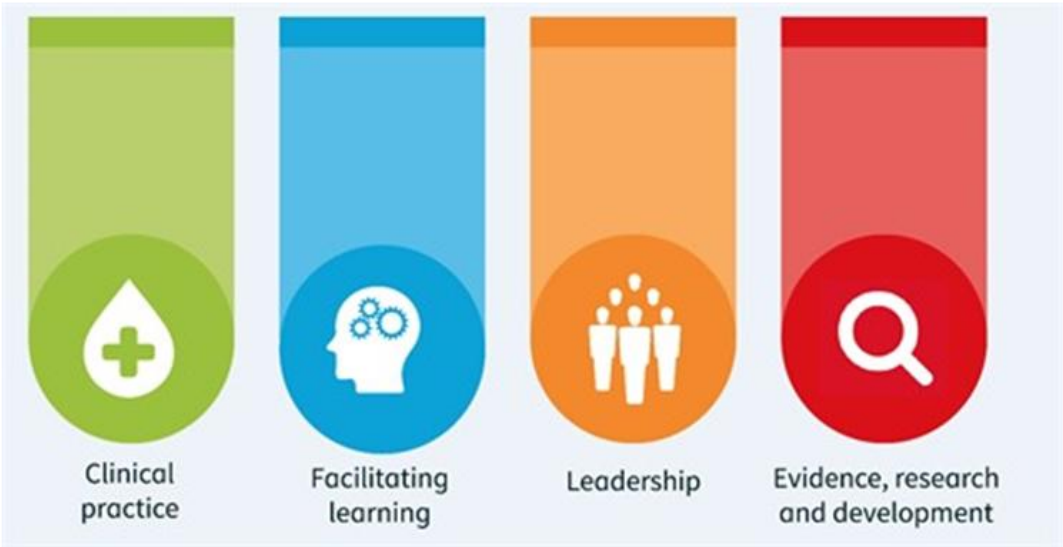
[5] https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf

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 four pillars of advanced practice, which also includes leadership and management, education, and research and quality improvement (defined by NHS England, 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 for the Royal College of Emergency Medicine.

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

<table>
<tr><th colspan="2">NHS Advanced practice framework pillars</th></tr>
<tr><td colspan="2"> 
</td></tr>
<tr><th colspan="2">Generic professional capabilities framework: domains</th></tr>
<tr><td>Domain 1</td><td>Professional values and behaviours</td></tr>
<tr><td>Domain 2</td><td>Professional skills</td></tr>
<tr><td>Domain 3</td><td>Professional knowledge</td></tr>
<tr><td>Domain 4</td><td>Capabilities in health promotion and illness prevention</td></tr>
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<tr><td>Domain 6</td><td>Capabilities in patient safety and quality improvement</td></tr>
<tr><td>Domain 7</td><td>Capabilities in safeguarding vulnerable groups</td></tr>
<tr><td>Domain 8</td><td>Capabilities in education and training</td></tr>
<tr><td>Domain 9</td><td>Capabilities in research and scholarship</td></tr>
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The domains within the General Medical Council's **Generic Professional Capabilities Framework**[6] 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 11 RCEM Adult ACP Specialty Learning Outcomes, seven of which are patient-facing and 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 adult SLOs are listed below. The EM-ACP 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.

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.

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

	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:** 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 the 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, 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 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 and 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: **KC1.** be able to understand how to apply clinical guidelines **KC2.** be able to understand how to use diagnostic tests in ruling in or excluding 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.** be able to support the medical, nursing and administrative team in answering clinical questions **KC5.** be able to make safe decisions for discharge, with appropriate advice for management beyond the ED, including when taking over other clinicians' patients **KC6.** be able to 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:** 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 resus 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: **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:** 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 for patients in all areas of the ED and of variable acuity.

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 competence in each of these foundation skills. This would normally take 3 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 tACP builds to acquire core and additional skills. These foundation skills can be assessed by trained assessors suitable for each procedure, e.g. practice educator. All tACPs, irrespective 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, whichever area they work in. Assessment will be by consultant DOPS[7], 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 can be carried out safely and independently by the tACP and must therefore be achieved by DOPS and those which may be covered by CbD (plus DOPS in a simulation situation 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.

[7] 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 consultant assessments

SLO 6: Deliver key procedural skills	
Foundation ACP Procedures to entrustment level 4 Overall ACP Educational Supervisor sign-off (using **ACP Adult Foundation Sign-off** ePortfolio form) If new skills, there may be evidence of local individual skills sign-off using DOPS (by trained assessors suitable for each procedure) but this is not mandated for submission	Within 3 months of commencing 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 Assessed by Consultant[8] DOPS Real patient except for those marked **^** which can be in a simulation situation (1:1) but must still be Consultant 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

[8] 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 consultant assessments

Additional ACP Procedures to minimum entrustment level 1 and can be assessed by Consultant[9] CbD. If the ACP is expected to perform these in practice, they must be at entrustment level 2b as evidenced by Consultant DOPS on a real patient. Those marked **^** can be in a simulation situation (1:1) but must still be assessed by Consultant DOPS to entrustment level 2b (or CbD entrustment level 1)	• 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:** 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:** 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 ACP ES), the tACP will be able to explain the procedure, understand complications involved, and diagnostic value for relevant procedures

[9] 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 consultant assessments

	Entrustment level 1: Direct supervisor observation/involvement, able to provide immediate direction/assistance
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 with patients **KC7.** be able to negotiate or manage complicated or troubling interactions with colleagues **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:** 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:** Supervisor within hospital for queries, able to provide prompt direction or assistance, and tACP knows reliably when to ask for help

Descriptors	• 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, particularly 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 manage data appropriately

SLO 10: Participate in research and manage 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 legislation • 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 team-working** **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:** 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 team-working** **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 needs 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 by use of online resources.

Unlike medical trainees, this knowledge is not assessed in an examination. 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

System / specialty	Clinical presentations		Conditions / issues	
Ear, nose and throat	EP1	ENT foreign bodies	EC2	Epiglottitis
	EP2	ENT injuries	EC3	Glandular Fever
	EP3	Epistaxis	EC4	LMN facial nerve palsy
	EP4	Hearing loss	EC5	Meniere's Disease
	EP5	Painful ear	EC6	Nasal fractures
	EP6	Sore throat	EC7	Otitis externa
	EP7	Vertigo	EC8	Otitis media
			EC9	Pharyngitis
			EC10	Post-tonsillectomy bleed
			EC11	Tonsillitis
			EC12	T racheostomy emergencies
			EC13	Quinsy
			EC14	Salivary gland disease
			EC15	Vestibular neuritis
Elderly care	ElP1	Delirium	ElC1	Comprehensive geriatric assessment
	ElP2	Deterioration in mobility	ElC2	Acute confusion
	ElP3	Falls	ElC3	Ceiling of care and end-of-life care
	ElP4	Fragility fractures	ElC4	Dementia – cognitive impairment
	ElP5	Frailty (adults only)	ElC5	Fragility fractures
	ElP6	Hypothermia	ElC6	Mobility
	ElP7	Incontinence	ElC7	Osteoporosis
	ElP8	Increasing care needs	ElC8	Pharmacology considerations in the older patient
	ElP9	Memory loss		
	ElP10	Unsteadiness / balance disturbance		
Endocrinology	EnP1	Addisonian Crisis	EnC1	Adrenal disorders
	EnP2	Hyperglycaemia	EnC2	Diabetic ketoacidosis
	EnP3	Hypoglycaemia	EnC3	Diabetes mellitus and complications including diabetic foot
			EnC4	Hyperosmolar hyperglycaemic state
			EnC5	Pituitary disorders
			EnC6	Thyroid emergencies
Environmental emergencies			EnvC1	Heat stroke and heat exhaustion
			EnvC2	Drug-related hyperthermias
			EnvC3	Hypothermia and frost bite
			EnvC4	Decompression sickness
			EnvC5	Near-drowning
			EnvC6	Radiation exposure and safety

System / specialty	Clinical presentations		Conditions / issues	
			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	GC2	Decompensated cirrhosis
	GP3	Ascites	GC4	Functional bowel disorders
	GP4	Constipation	GC5	Gastrointestinal infections
	GP5	Diarrhoea	GC6	Hepatitis
	GP6	Haematemesis and melaena	GC7	Inflammatory bowel disease
	GP7	Jaundice	GC8	Peptic ulcer disease
	GP8	Anal pain and rectal bleeding		
	GP9	Nausea and vomiting		
	GP10	Dysphagia		
Haematology	HP1	Anaemia	HC1	Anti-coagulant reversal
	HP2	Bruising and spontaneous bleeding	HC2	DIC
	HP3	Massive haemorrhage	HC3	Haemophilia
			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	IC3	Infestations
	IP4	Needlestick injury / exposure to blood borne viruses	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		

System / specialty	Clinical presentations		Conditions / issues	
	MaP4	Facial bone injury	MaC3	Post extraction complications
			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	MHC6	Somatic symptom disorders
	MHP5	Refusal of treatment	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 of 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	NepC1	Acute kidney injury
	NepP2	Oliguria	NepC2	Drugs and the kidney
			NepC3	Electrolyte disorders
			NepC4	Fluid balance disorders
			NepC5	Renal replacement therapy
Neurology	NeuP1	Acute confusion	NeuC1	Botulism
	NeuP2	Headache	NeuC2	Cerebral venous sinus thrombosis
	NeuP3	Seizures / status epilepticus	NeuC4	Functional illness
	NeuP4	Speech disturbance	NeuC5	Guillain-Barre

System / specialty	Clinical presentations		Conditions / issues	
	NeuP5	Hemiparesis / hemiplegia	NeuC6	Meningitis and Encephalitis
	NeuP6	Gait abnormality	NeuC7	Multiple Sclerosis
	NeuP7	Visual disturbance	NeuC8	Myasthenia Gravis
	NeuP8	Weakness / paralysis	NeuC9	Parkinson's Disease and other movement disorders, epileptic and non-epileptic
	NeuP9	Dizziness and vertigo	NeuC10	Peripheral neuropathy (acute)
			NeuC11	Subarachnoid haemorrhage
			NeuC12	Stroke and TIA
			NeuC13	Tetanus
			NeuC14	Tumours involving the brain and spinal cord
			NeuC15	VP shunts
			NeuC16	Wernicke's Encephalopathy
Obstetrics and Gynaecology	ObP1	Pelvic pain	ObC1	Ante-partum haemorrhage
	ObP2	Vaginal bleeding	ObC2	Bleeding in early pregnancy
	ObP3	Pregnancy	ObC3	Exposure to infections during pregnancy, e.g. chickenpox
	ObP4	Genital injury / assault	ObC4	Ectopic pregnancy
	ObP5	Vaginal discharge	ObC5	Genital injury / Female Genital Mutilation
	ObP6	Foreign bodies	ObC6	HELLP
	ObP7	Patient in labour	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

System / specialty	Clinical presentations		Conditions / issues	
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	Diplopia	OptC1	Acute glaucoma
	OptP2	Eye trauma including foreign bodies	OptC2	Cranial nerve palsy
	OptP3	Painful eye	OptC3	Orbital and periorbital (preseptal) cellulitis
	OptP4	Red eye	OptC5	Inflammatory eye disease
	OptP5	Sudden visual loss	OptC6	Temporal arteritis
Pain and sedation			PC1	Analgesics
			PC2	Non-pharmacological methods of pain management
			PC3	Pain assessment
			PC4	Sedation
Palliative and end of life care	PalP1	Advanced malignancy and end stage chronic disease	PalC1	Advanced care planning
			PalC2	Anticipatory medications
			PalC3	End stage organ failure
			PalC4	Pain management
			PalC5	Physical symptoms other than pain
			PalC6	Psychosocial concerns including spiritual care and care of the family
			PalC7	The dying patient
Pharmacology and poisoning	PhP1	Medication side effects / interactions	PhC1	Overdose of prescription and non-prescription medications including legal and non-legal drugs
	PhP2	Overdose		
	PhP3	Accidental poisoning		

System / specialty	Clinical presentations		Conditions / issues	
			PhC2	Poisoning – carbon monoxide, cyanide, organo-phosphate
			PhC3	Toxidromes
			PhC4	Use of antidotes
			PhC5	Batteries, household chemicals, poisonous plants
Respiratory	ResP1	Chest pain	ResC1	Asthma
	ResP2	Breathlessness	ResC3	COPD
	ResP3	Haemoptysis	ResC4	Foreign body inhalation
	ResP4	Cough	ResC5	Pertussis
			ResC6	Pleural effusion
			ResC7	Pneumonia
			ResC8	Pneumothorax
			ResC9	Pulmonary Aspiration
			ResC10	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
			SuC10	Hernias
			SuC11	Intussusception
			SuC12	Ischaemic bowel
			SuC13	Lower gastrointestinal and rectal bleeding
			SuC14	Pancreatitis
			SuC15	Viscus perforation
			SuC16	Volvulus
Trauma	TP1	Head injury	TC1	Compartment syndrome
	TP2	Spinal injury	TC2	Limb and joint injury including bony, musculo-tendinous and complications
	TP3	Chest and lung injury		
	TP4	Major vascular injury		
	TP5	Abdominal injury	TC3	Electrical burns
	TP6	Pelvic injury	TC4	Salter- Harris classification

System / specialty	Clinical presentations		Conditions / issues	
	TP7 TP8 TP9 TP10	Limb and joint injury Burns Inhalational injury Wounds	TC5 TC6 TC7	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 Centre for Advancing 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 and routinely documented in the FEGS. In addition to the FEGS, which details the evaluation of the Faculty in the SLOs, the College mandates 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 provide additional support if required. Such a panel should be chaired by the lead for ACP training in the department and include the ACP ES (as well as any other RCEM ES) and the tACP.

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 *Annual Record of Progress* form on the ePortfolio platform is recommended for this purpose, although a similar locally devised document may be used. If an appraisal/personal development record is used instead of a separate credentialing progression form, it must explicitly reference the curriculum coverage, WBA completed and other elements of credentialing.

In addition to the annual review of progress/appraisal, there must be a minimum of 3 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. The Final ESR must be completed within 3 months of submission.
- **Faculty Educational Governance Statement (FEGS)** confirming the entrustment level for all relevant SLOs. The Final FEGS must be completed within 3 months of submission.
- **Multi-Source Feedback (MSF)**, each with at least 12 responses, of which 2 must be consultant faculty. Each MSF cycle must be undertaken no less than 8 months apart and the final MSF must be completed within 6 months of submission.

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**[10]:

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 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

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

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 completed 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:

- **Clinical experience** should be used as an opportunity to undertake WBAs 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.

- **Learning with peers**: working alongside, discussion cases, small group teaching.
- **Simulation**: as some presentations and procedures are relatively infrequent, simulation is a valuable tool to allow learning opportunities, and for the formative assessment of competence.

  Simulation used for assessment: Where a procedure requires a summative DOPS, this must be with a real patient, other than for those indicated otherwise in SLO6. Where a simulation scenario is used for a clinical presentation assessment, only the tACP leading the scenario can be formally assessed and have a formal mandated assessment, although other participants may have formative assessment and feedback recorded, both for clinical and non-technical skills. For SIM days, in which multiple presentations are covered, separate assessment forms must be used for each individual presentation, rather than one form for all.

- **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.

- **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.

- **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 resources as relevant
    - Reading journals
    - Working towards personal learning goals beyond the essential core curriculum.

- **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 falls 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.

All assessments should indicate the entrustment level achieved in that event.

For submission, there must be a consultant assessment[11] at the expected entrustment level for all mandated assessments (trained assessors are accepted where specified). These must be selected and linked to the mandatory evidence sections of the portfolio by the tACP.

At submission, there should be another 30 assessments at the expected level which cover the clinical syllabus, and may also be linked to KCs. These can be by a range of assessors including senior EM trainees and Trust doctors (ST4 equivalent and above), consultant and credentialed ACPs, and other practitioners.

As an assessor's capacity to recall in detail the tACP's performance is likely to significantly diminish over time, all DOPS and MiniCEX must be created by the tACP and sent to the assessor within one week of the patient being seen and completed by the assessor within 4-6 weeks of receipt. CBDs should also be created and sent to the assessor within one week, but completion will be permitted up to 6 months from receipt[12].

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 will be written by the ACP Educational Supervisor, having reviewed the evidence collected, and offers a judgement on progress and the standard reached, including the WBAs 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

For credentialing, a minimum of 48 mandatory consultant[13] assessments are required, consisting of:

- 20 MiniCEX or CBD mapping to 23 KCs
- 1 Foundation skills sign-off form
- 10 Core skills DOPS[14]
- 11 Additional skills DOPS or CbD
- 3 ESLEs
- 3 ACATs

[11] Associate Specialist or Senior Specialty Doctors who meet the eligibility criteria to be an ACP ES as defined in the ACP Credentialing Regulations may also complete consultant assessments
[12] This requirement applies to patients seen after 01 April 2024
[13] As for 11 above
[14] Trained assessors accepted where specified

The table below shows the details of the mandatory assessments and other evidence required for credentialing. There is no requirement for any assessment to be completed in a specific year of training although evidence older than 5 years is not appropriate. All *mandatory* assessments must be within 3 years of submission; older non-mandatory assessments can be accepted but must be accompanied by suitable reflection on the individual's development of capability since the assessment was first completed. 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 requisite 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 (by a trained assessor), 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 clinical syllabus, the **resus domain** must have an assessment for each of the 8 clinical presentations, i.e. 3 further assessments in addition to the 5 listed below. The additional 3 can be at entrustment level 2a and do not need to be by a consultant assessor.

Each clinical SLO is expected to have at least one mandated consultant assessment (MiniCEX or CbD) and, given there are 23 KCs with 20 mandated assessments, it is likely that the majority of KCs will have a mandated assessment. The additional 30 assessments (not mandated to be by a consultant) should be distributed across the clinical syllabus so that the majority of the 29 sections of the syllabus have an assessment, keeping in mind that each presentation within the resus domain must have an assessment.

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[15] DOPS** ***** DOPS by Consultant ***or*** another appropriate assessor **^** may be in a simulation situation (1:1) but will still require 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)

[15] 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

Additional Procedures **Consultant CbD -** entrustment level 1 **OR** **Consultant DOPS -** entrustment level 2b for those procedures that the ACP is expected to perform in 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 to entrustment level 1	**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 • 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[16]) 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
QIAT	At least one QIAT based on a completed project, and evidence of participation in QI 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 3 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.

[16] 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)

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 Programme Lead and others involved in the ACP programme, or similar locally devised document. **Please note:** If the tACP'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) and 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)

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. It is self-evident that for any practitioner undertaking any procedure or managing any case, it is unlikely that they will be operating at a level independent of supervision. Thus, a tACP is unlikely to reach entrustment level 3 the first time they undertake a procedure or manage a particular case.

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. 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. In the context of entrustment decisions, the term 'supervisor' relates to the senior clinician on the shop floor who would normally be an ST4 equivalent or more senior.

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 tACP)	Entrustment level (newly credentialed EM-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 regarding 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 WBAs (individual WBAs and reflections need not be reviewed by the training faculty at each FEG meeting but should be 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 regarding 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 should be completed by the ACP Educational Supervisor, but the faculty group discussion can be conducted in different ways according to local arrangements. 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 must provide reflection on each Key Capability and, where there are learning points on WBAs or other events, there should be evidence of reflection and action taken. Reflection should be written as level 7 writing – this should analyse events, and the evidence presented, and describe how the evidence demonstrates the development of their capability and progression to independent practice in that SLO/KC. The reflection should not simply list the items of evidence. The purpose is for the tACP to examine how they have demonstrated that they have reached the required level of entrustment.

Engagement in training is very important. The tACP is expected to show, by reflection and by seeking appropriate assessment opportunities, how they wish to develop beyond their current capabilities, and to describe how they will achieve that improvement.

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, etc. is all part of the valuable evidence that is expected. Whilst not every item of evidence needs substantial reflection, the demonstration of the desire to develop is a key part of the overall evidence required.

6.2 Procedural log

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

6.3 Other evidence

All sections of the clinical syllabus must have evidence against them. Where relevant, this may be a mandatory item or formative WBAs, eLearning, teaching delivered, case reports, conference elements, etc. For the clinical syllabus, one item of evidence may cover several presentations and conditions, but these should span no more than two areas/sections of the syllabus.

6.4 Patient logbook

As the curriculum is competence/capability based, adequate experience and patient contact must be demonstrated. It is expected that the EM-ACP will have had direct contact with a significant number of patients with a sufficient breadth of practice.

In order to gain sufficient experience to develop the standard of competence required, it is expected that the EM-ACP will have seen a minimum of 2100 adult patients by the end of the 3-year minimum (whole time equivalent) duration of training. This would likely be represented by around 700 adult patient contacts in the first year, rising to 1000 as the tACP gets more proficient. It is recognised that the more experienced tACP

may see less patients themselves as they are supervising others; an explanation for this would be expected in the tACP's reflection and from the supervisor.

It is recommended that the EM-ACP has a case mix that is made up of 20% resus/high acuity[17] cases, with 50% of the remaining cases being ones that are referred for ongoing or expert opinion, i.e. referred to an inpatient specialty. 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.

A patient logbook 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. This should be an anonymised list of patients with headings giving the presenting complaint and diagnosis, as well as gender, age and where treated. If the raw data shows where the tACP is the primary clinician and includes patients where the tACP took handover of care, this must be indicated. It is not essential to show the secondary handed over patients.

In addition to the raw, anonymised data, an annual breakdown of patient numbers and case mix must be provided, using the summary table templates available on the RCEM website.

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 successfully completed the RCEM training for ACP supervisors (2022 curriculum). Whilst Paediatricians who are working primarily

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

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 appropriate for adult-only tACPs. Paediatrician ACP Educational Supervisors must be Members of the RCPCH and have successfully completed 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 FY2 or ACCS EM training
- a private study area
- an appropriate rest area whilst on duty.

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

At least one individual involved in assessing tACPs within the local ED must have successfully completed the mandatory RCEM ACP supervisor training (2022 curriculum). Further information on how to access this training is available on the RCEM website.

7.3 Definitions of supervisors

ACP Educational Supervisor (ACP ES)

A trainer, usually a Fellow of RCEM and a substantive consultant in EM (but may also be an Associate Specialist or Senior Specialty Doctor employed in a substantive role in EM ***or***, for tACPs working in a children's ED, a Member of the RCPCH and employed as a substantive consultant in PEM) who is selected and appropriately trained in

accordance with the GMC's criteria for trainer recognition[18], to be responsible for the overall supervision and management of a tACP's educational progress during training. All ACP Educational Supervisors must meet the eligibility criteria described in the ACP credentialing regulations.

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 successfully completed RCEM ACP supervisor training (2022 curriculum) **within 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's 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 the tACP.

Educational Supervisor (RCEM ES)

A trainer who meets the criteria to be an ACP Educational Supervisor (above) and has been selected and appropriately trained in accordance with the GMC's criteria for trainer recognition[19], but has not yet completed RCEM ACP Supervisor training. They will be responsible for the supervision and management of a tACP's educational progress until an approved ACP Educational Supervisor can be assigned (no more than 12 months after the tACP has commenced training). Only an approved ACP Educational Supervisor can complete the foundation skills sign-off form, FEGS and ESR, and perform the final sign off of the portfolio. RCEM Educational Supervisors can continue to provide day-to-day educational and clinical supervision, including completion of the mandatory consultant assessments, once an ACP Educational Supervisor has been assigned to the tACP.

Clinical Supervisor (RCEM CS)

A trainer, usually a consultant, but may be a consultant practitioner or senior ACP, who is selected and appropriately trained (in accordance with the GMC's criteria for trainer recognition[20] or similar process) 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

[18]The GMC uses the Academy of Medical Educators' *Professional standards for medical, dental and veterinary educators* (2014) as the criteria against which all trainers in recognised roles must provide evidence of their ongoing professional development.
[19] As above
[20] As above

undergone training for their role. This may also be a consultant in another specialty who has undergone training to the GMC framework.

Supervisor

Within the context of the definition of entrustment, 'supervisor' refers to the senior clinician responsible for the department at the time. For much of the time, this will be a consultant in EM but, overnight and at weekends, this may well be an ST4 equivalent or more senior doctor and, on occasion in some departments, may be a consultant ACP or credentialed ACP. This is the individual to whom the tACP will turn to for advice or guidance and therefore is referenced in the entrustment statements.

7.4 Assessors

Assessors may be medical doctors, Advanced Clinical Practitioners or other senior healthcare professionals. All assessors need to be aware of the standards required and 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 *medical* consultant in the appropriate specialty. In the majority of cases this will be an RCEM Fellow but, for children's credentialing submissions, this may also be a Member of the RCPCH who is employed in a substantive PEM consultant role. 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 also complete mandatory consultant assessments

It is essential that training in assessment is provided for trainers and tACPs 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 WBAs and the application of standards. Opportunities for feedback to tACPs about their performance will arise through the use of workplace-based assessment, 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 WBAs accordingly to enable their WBAs 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 WBAs according to their individual learning needs.

It is the responsibility of tACPs to seek feedback following learning opportunities and WBAs. 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 Responsibility of the ACP Educational Supervisor

It is expected that regular educational meetings will take place between the ACP ES and the tACP and that these meetings are 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.

Many tACPs will be undertaking their academic level 7 programme in Advanced Clinical Practice whilst 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 Masters programme can be drawn together to ensure that a robust and effective plan can be developed for the year ahead.

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.

7.7 Annual review

All professionals are required to undertake an annual review of their scope of work to ensure they are maintaining their professional standards. Organisations will have their own arrangements and processes to meet the professional regulation requirements. This process may be called appraisal, PDR, or be known under another similar title.

Credentialing also requires an annual review of progress – to facilitate the tACP in planning their learning and ensure evidence is being collated that will support the submission. RCEM recommends that this process is formal and is led by the consultant with responsibility for ACP development, together with the rest of the faculty (educational and clinical supervisors). The process ensures adequate supervision during training, provides continuity, and is one of the main ways of providing feedback to tACPs. This meeting should be recorded in the portfolio – ideally using the Annual Record of Progress (ARP) form. A locally devised form is also appropriate.

In some circumstances, the professional appraisal meeting may be combined with a review of progress where the documentation required by the employer/regulator can be submitted to the portfolio as the annual record of progress. The discussion must specifically look at progress towards credentialing.

8. Intended use of the 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 risr/advance 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

tACPs must provide evidence that covers the entire curriculum. For new tACPs who commence their evidence collection at the same time as undertaking their Masters, ensuring evidence meets the currency guidelines should be relatively easy. However, established ACPs who have been working as an EM-ACP prior to commencing the credentialing process, and who may have a significant amount of retrospective evidence, maintaining currency can be more challenging.

The following guidance on currency applies:

- All mandatory consultant/named assessor assessments *must* be completed within three years of submission and on the appropriate forms indicating entrustment level.
- All other supporting evidence for the KCs should be within 3 years but may be acceptable up to 5 years if accompanied by reflection on progression since.
- Evidence within the clinical syllabus must be within 5 years but there should be reflection on how their practice has developed if collected more than 3 years prior to submission.

tACPs may use evidence of their teaching to cover the curriculum and clinical syllabus. However, there must be evidence of clinical contact for the majority of the elements, and a suitable case mix and appropriate workload as evidence of that clinical experience.

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 (WBAs, 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 WBAs
- 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 credentialed 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. Acknowledgements

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Appendix 1: 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 – and should focus on clinical assessment and management, patient safety, decision making, team working, time management, record keeping and handover. It is very much a tool that helps look at behaviour across a function – managing a clinical area, managing a round in CDU, looking at working to support the streaming function - rather than the non-technical skills that are reviewed in an ESLE. The ACAT can be linked to a number of clinical syllabus items and is likely to provide evidence for KCs in SLO2, 7, 8 and 9.

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 a number of cases. It should focus mainly on non-technical skills, although naturally the clinical context is important, and decision making, for example, will be dependent on the clinical case. It is designed to take up to 2.5 hours in total – with 90-120 minutes of observation and up to 30 minutes of feedback and discussion. The tACP should be working as they would normally. Ideally, this would include them taking on some shop-floor leadership role or responsibility to enable the supervisor to observe all of the skills described in the ESLE

The ESLEs are particularly needed as evidence for SLOs 2, 7, 8 and 12 (leadership and complex situations) and for SLO9 (support, supervise and educate).

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 (MiniCEX): 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 MiniCEX can be used at any time and in any setting when there is a tACP and patient interaction and an assessor is available. The MiniCEX 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).