Royal College *of* Emergency Medicine

Wales Emergency Care - Advanced Clinical Practitioner Steering Group Recommendations
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Contents

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Purpose

This is a Good Practice Guide to promote and support the development of Emergency Care - Advanced Clinical Practitioners (EC-ACP) roles in Wales. The document fosters the principles of workforce transformation described in recent national policy, "A Healthier Wales" (Welsh Government 2019).

With the appropriate investment, these practitioners can provide a motivated and sustainable contribution to the emergency care workforce, and support the attainment of workforce stability (RCEM 2018). This guide aims to assist all staff involved in emergency care delivery and workforce planning.

Background

The role of the Emergency Care- Advanced Clinical Practitioner (EC- ACP) in Wales was first introduced in 2012. Over the past few years it has been demonstrated that ACPs can provide safe and effective delivery of Emergency Medicine in the UK for patients who present to Emergency Departments with a wide range of pathologies, at all levels of acuity. ACPs can form a valuable part of your substantive, sustainable and permanent workforce. There are also experienced EC-ACPs in Wales working at a senior clinical decision maker level, such as at the Princess of Wales Hospital Emergency Department at Bridgend.

It has become apparent through communication with Welsh Trainee ACPs (tACPs), EC-ACPs and their Educational Supervisors (ES) that there is significant variation in the way that ACPs have been introduced and supported. There are examples of good practice and accounts from which we can learn.

The purpose of this document is to summarise RCEM EC-ACP guidance for ease of reference, dispel myths and to communicate the recommendations of the Wales, Emergency Care - Advanced Clinical Practitioner Steering Group.

What is an EC-ACP?

The EC-ACP works as part of the multidisciplinary team in emergency care settings. They make an important contribution to the delivery of care, education, service improvement and research within EM. EC-ACPs may work in the adult area, the children's area or throughout the department dependent upon the route of specialisation.

EC-ACPs are able to look after patients with a wide range of pathologies from the life-threatening to the self-limiting.

Although the standard of practice they are expected to attain at the end of their training is equivalent to the EM trainee at the end of ST3, it is recognised that some senior EC-ACPs may work within a broader scope of practice.

EC-ACPs have mainly developed from a nursing or paramedical background, although RCEM have recently opened the portfolio to pharmacists and physiotherapists. Traditionally, these individuals will have significant experience in their respected field and will have undertaken a level 7 programme in advanced practice.

Following completion of this programme they then commence the RCEM Portfolio. The completion of the portfolio requires a significant commitment to the education and supervision of the tACP. There are a number of areas in the UK where these individuals have undertaken the level 7 programme and completed the RCEM portfolio simultaneously. There is currently a Health Education England funding pilot of this type running in the South West of England. In Wales, a group of experienced ACPs are working with Agored Cymru to achieve a similar programme.

This level 7 EC-ACP programme of education is being designed to support the population of the RCEM portfolio. It will be modular and vocationally based. It will have similarities to the All Wales Level 7 Autonomous Management of Minor Injuries Programme, as it is being built around this highly successful model.

Planning an EC-ACP Workforce

When developing workforce plans, it should be considered that it is unlikely that large numbers of credentialed EC-ACPs will be available for direct recruitment for many years. Therefore, EDs will be required to develop business plans to support the introduction, education and supervision of ACP cohorts. The development of this sustainable and permanent professional group is a significant commitment and requires careful planning.

To achieve the broad scope of competence detailed in the ACP curriculum, Both EC-ACP and Trainee ACP (tACP) should work predominantly in the Emergency Department and should have regular exposure to all areas of the department.

Business cases should give recognition to the cost of the initial advanced practice training and on-going education and supervision. The business case considerations should include:

- Budget for mandatory courses and continuing professional development including: Advanced Life Support; Advanced Trauma Life Support/European Trauma Course; Advanced Paediatric Life Support/Paediatric Advanced Life Support; Non-Medical Prescribing and Non-Medical Authorisation of Blood Products.

- ACP rosters should be an 80/20 clinical/SPA split (30 hours clinical/ 7.5hours SPA).

- EC-ACPs are experienced clinicians from a background of professions and often have extended roles outside of their clinical commitments. As such EC-ACPs should have 10 days of professional leave annually in addition to their SPA time. It should also be recognised that these commitments have a positive benefit to the department. (RCEM 2021a)

- RCEM recommends that trainee ACPs are funded at Band 7 progressing to band 8a with demonstration of competence.

- There should also be recognition of the time required for consultants (and experienced EC-ACPs/consultant practitioners where appropriate) to provide educational supervision and clinical supervision.

- RCEM recommends that consultants are allocated 0.25PA per tACP and senior EC-ACPs/ consultant practitioners also 0.25PA (this should be considered for ongoing supervision of experienced ACPs and not just trainees).

- The time for existing consultant workforce to attend training related to the credentialing of ACPs.

- tACPs will require supernumerary training and supervision until deemed competent. The tACP will need to be additional to your normal staffing for a period of time.

- Trainees should be in a tACP post whilst carrying out their level 7 education programme and clinical competency progression (RCEM recommends 30 hours of clinical time per week).

Education

The curriculum will be delivered through a variety of learning modalities ranging from formal teaching programmes to experiential learning. A regional teaching programme in Wales is in place that is mapped to the RCEM curriculum. An education level 7 transferable clinically based qualification is under development in Wales that fulfils the RCEM ACP Curriculum.

It is recommended that tACPs undertake short placements (4-6 weeks) in acute medicine, anaesthetics, critical care and paediatrics. These placements will assist with specific competency/ portfolio development. There should be clear guidance provided to the tACP and placement supervisor regarding which competencies will be targeted during these placements.

In addition, the tACP/ EC-ACP should actively seek out further opportunities in the work place such as:

• Case presentations

• M&M meetings

• Journal clubs

• Research and quality improvement projects

• Lectures and small group teaching

• Clinical skills - use of simulation

• Critical appraisal exercises

• Joint specialty meetings

• Life support courses

• Participation in management meetings

Credentialing

The Royal College of Emergency Medicine recommends that all ACPs credential. The benefits of ACP achieving credentialing are as follows:

- The EC-ACP would be confirmed as having reached a nationally recognised standard of competence, as evidenced by WPBAs completed by consultants and supervisors in Emergency Medicine.

- An EC-ACP with a RCEM approved credentialed portfolio would be recognised as they move geographical boundaries.

- A statement of competence would be possible which would detail what an EC-ACP is competent to do within a defined scope of practice.

- The learning environment in the ED for junior doctors and other learners will be strengthened by credentialed EC-ACPs resulting in patient safety benefits.

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

Supervision

Supervision is key to the success of EC-ACP development. The RCEM recommends that educational supervisors should be allocated at least 0.25 educational PAs per week per EC-ACP (1 hour) in order to deliver this standard of supervision.

At least one individual involved in assessing trainees and established EC-ACPs at the Health Board must have completed the RCEM mandatory EC- ACP supervisor training. Details are available on the RCEM website.

In addition, the College recommends consultant practitioners and senior EC- ACPs acting as clinical supervisors should also be allocated 1 hour per week, per EC-ACP/ tACP. This is to support the development of the practitioner as they enhance their existing professional knowledge, skills and behaviours in their journey towards autonomous practice in emergency care.

Each department must ensure that the practitioners (tACPs/EC-ACPs) have access to:

- On-line learning facilities and libraries.

- 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 recording of clinical findings, they should be allocated the role on the EPR consistent with their training level.

- Adequate accommodation for trainers and practitioners in which to prepare their work.

- A private area where confidential activities such as assessment, appraisal, counselling, studying and mentoring can occur.

- A secure storage facility for confidential training records.

- A reference library where practitioners have ready access to bench books (or electronic equivalent) and where they can access information at any time.

- IT equipment so that they can carry out basic tasks on computers 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– this may be provided by integration with the FY2, core ACCS EM, middle grade or HST/senior middle grade training.

- An appropriate area for rest periods whilst on duty.

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

Educational supervisor

A Fellow of the RCEM and a substantive consultant in emergency medicine who is selected and appropriately trained, meeting the General Medical Council (GMC) framework standards, and who is responsible for the overall supervision and management of a EC-ACP's educational progress during training. The educational supervisor is responsible for agreeing and ensuring the trainee's educational agreement is fulfilled and for completing the structured training report (STR) each year.

Clinical supervisor

A trainer, usually a consultant but may be a consultant practitioner or senior advanced clinical practitioner, who is selected and appropriately trained to be responsible for overseeing a specified EC-ACP's clinical work and providing constructive feedback during their training.

Annual Review of Competency Progression (ARCP)

Each tACP and ACP should have ARCPs. This facilitates a year review of the quality and safety of patient care they are offering, and provides the opportunity to assess their progress against the ACP curriculum

Professional identity

Healthcare professionals may choose to enter EC-ACP training from a variety of backgrounds. The College believes that the professional training for nursing or paramedic professions provides a foundation most likely to support advanced training and practice that will then lead to successful credentialing with the RCEM.

We would recommend that EC-ACPs are given titles such as Trainee, Junior and Senior as they progress. This helps to define their level of independence and will support safe progression, particularly in the early years. This is important to avoid them being pulled into nursing duties or non-practitioner roles when the staffing is insufficient.

We would recommend that trainee EC-ACPs are employed solely in that role. Departments have employed trainee EC-ACPs in dual roles, such as Senior Sister 50% and Trainee EC-ACP 50%, and subsequently found trainees struggle to progress and will not achieve the 30 hours clinical time a week recommended for credentialing.

Management structure

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

ACPs will need to have professional accountability detailed within their job description. This may be for example, to the Director of Nursing for nurses or to the Director of Therapies if the ACP is registered with the Health and Care Professions Council (HCPC) for paramedics. This will allow for professional contribution to the revalidation process.

EC-ACP clinical rotas

EC-ACPs are a permanent workforce and not rotational trainees. Rota developers should be mindful of this fact and consider EC-ACPs wellbeing. Rotas should not have excessive night and weekend commitments. EC-ACPs should not be seen as the sole solution to out of hour's clinical cover. ACPs rotas should be balanced and sustainable.

EC-ACPs should have input into their work schedule and rota as well as an active role in assisting the department in improving rotas and working conditions in general. It is a recommendation of the forum that the ACP rota is managed by a Lead ACP with experience of managing a rota in line with the specifics of Agenda for Change contract. Where the rota includes night shifts the rota should be a forward rotating design, working patterns should progress from day to night shifts.

They should ensure adequate recovery time (EMTA 2020) this is to facilitate sustainable working lives and longevity in the role.

The ACP rota should be shared with other rota leads in the department in a constructive and measured way to instigate a consistent approach to feedback.

The ACP Forum suggests a working pattern based on Agenda for Change. Full time this is 37.5 hrs a week, or 150 hours a month. (RCEM 2021a)

Radiology

To enable safe and effective practice, ACPs will require access to appropriate investigative and therapeutic interventions to adequately perform their role within the ED. ACPs meet professional requirements to be eligible to be a referrer as defined by the Royal College of Radiologists, but many ACPs across Wales report difficulty in obtaining authorisation to refer for many radiological investigations.

It has been reported that in some areas "workaround" arrangements have developed where EC-ACP are having to asking medical practitioners to countersign or sign for radiological investigations, for patients they are not involved with, and have not examined. This is contrary to IR(ME)R legislation. It is not a safe and effective practice and could lead to "Never Events".

It is recommended that ACPs employed within Health Boards across Wales who are deemed competent by their employer to assess and manage the whole spectrum of undifferentiated emergency care patients, be authorised to discuss and request appropriate ionising radiology investigations. As such, approval should be granted by employing Health Boards for a scheme of work that will assist the Health Boards to meet its objectives of providing high quality, timely and safe Emergency Care.

Please refer to RCEM guidance "Radiology Requesting Protocol for Extended and Advanced Clinical Practitioners in the Emergency Department", for further guidance in this matter. (RCEM 2021b)

Recommendations

The EC-ACP Steering Group recommends the following:

1.   When introducing EC-ACPs services, the organisation should identify the requirement for EC-ACPS as part of their workforce plan.

2.   A comprehensive business case with appropriate financial commitment must be developed prior to the introduction of ACPs.

3.   tACPs and EC-ACPs should be supported in the credentialing process to ensure, patient safety, standardised practice and effective governance. This should include:

   a.   a minimum of two tACPs appointed to commence training at any point in time

   b.   dedicated study leave budget should be allocated to EC-ACP cohorts to fulfil continuing professional development

   c.   tCAPs being appointed in dedicated tACP roles.

   d.   Educational Supervisors will have dedicated time in the job plan (1hr per week per tACP/ EC-ACP).

   e.   EC-ACPs will have a 80/20 Clinical/SPA split (i.e. 30hrs clinical / 7.5 hrs SPA)

   f.   tACP/EC-ACPs should be supported to attend relevant regional and other training. High priority should be given to release all for regional teaching days.

4.   All tACPs cases should be reviewed prior to discharge, until competence is demonstrated.

5.   tACPs should undertake short placements in acute medicine, anaesthetics, critical care and paediatrics.

6.   tACPs should be employed at band 7 and at minimum band 8a for credentialed ACP or those with an equivalent level of competence.

7.   Recognition should be given to experienced EC-ACPs who have been allocated senior/ supervisory roles or other additional senior responsibilities. This would necessitate an appropriate level of remuneration commensurate with Agenda for Change principles.

8.   tACPs /ACPs should have ARCPs to monitor progress.

9.   tACPs/EC-ACPs should be considered as an integral part of the department's clinician rota as opposed to nursing roster.

10. tACPs/EC-ACPs must have clear lines of managerial accountability. They should report to the ED Clinical Lead/ Director in relation to clinical issues. For day to day management (e.g. rosters and sickness) reporting lines should be via the same management arrangement for that of the clinician rota. Professionally the ACPs will be accountable to the relevant senior professional (e.g. Director of Nursing or Director of Allied Health Professionals).

11. As with all other professional staff groups, tACPs/EC-ACPs should be clearly identified via their title and uniform as a clinician. This will ensure clear and rapid identification and to promote public safety and confidence. There is no provision for the identification of tACPs/ EC-ACPs within the All Wales Uniform Policy.

12. Radiology referral protocols should reflect the full scope of the ACP. Relying on "workaround" countersignatures in unsafe and inefficient.

13. Organisations should give consideration to ensure retention of experienced EC-ACPs that will have developed high levels of competence and become senior clinical decision makers, supervisors and leaders. These senior professionals may be given increased responsibilities in areas such as education, management/leadership, governance, research and quality improvement. Such roles can assist EM consultants in the delivery of the service. Some organisations have developed consultant practitioner roles to recognise this progression.

References

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