NHS Education for Scotland

Credential Rural and Remote Health (Unscheduled and Urgent Care) Curriculum

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Contents

1. Introduction

1.1 Purpose of the credential

The purpose of the Rural and Remote Health curriculum is to provide a supportive training framework for General Practitioners (GP) on the General Medical Council (GMC) Register, and other doctors such as non-training grade doctors practising or wishing to practise in rural and remote contexts to provide unscheduled and urgent care in rural and remote hospitals and at the interface with the community.

The Credential in Rural and Remote Health (Unscheduled and Urgent Care) will address a service and patient safety need for General Practitioners and other doctors in non-training grade positions working in these contexts to extend and enhance skills that are not covered in specialty training. In doing so, the credential will support more flexible career development, facilitating credential holders to change career direction or enhance their skills and expertise in the provision of unscheduled and urgent care at the interface between primary and secondary care in remote and rural contexts.

1.2 Need for the credential

The definition of Rural and Remote Health varies between sources but is generally accepted to cover areas where there is low population density at significant distance from the nearest hospital, resulting in potential delayed access to secondary care when compared to densely populated cities. All four UK nations have rural communities.

Practising medicine in rural and remote areas is challenging. When compared with their urban counterparts, doctors practising in these locations may be described as “extended generalists” [1]. They provide a wider range of clinical service, sustain a heavier workload and carry a higher level of clinical responsibility, in relative professional isolation[2]. Recruitment and retention in rural and remote areas is challenging, with impact on both rural General Practices, and the staffing of smaller District/Rural General Hospitals (<100 beds) by doctors who possess the extended spectrum of emergency and inpatient clinical skills and competencies to deliver safe care without the wider specialty support available in larger hospitals. This is necessary because Acute and Emergency Medicine Consultants may not practice within these smaller hospitals. In particular, there is a need to ensure adequate training for doctors practising in small, remote community hospitals known as “No Bypass Units” – these differ from small rural units close to General Hospital support which are bypassed by ambulances in the event of major illness or trauma[3]. It is also essential that these doctors are adequately trained in the identification, preparation for and transfer of critically unwell patients where more specialist input is required.

[1] Roger Strasser, Ian Couper, John Wynn-Jones, James Rourke, A. Bruce Chater & Steve Reid (2016) Education for rural practice in rural practice, Education for Primary Care, 27:1, 10-14, DOI: 10.1080/14739879.2015.1128684

[2] Hogenbirk JC, Wang F, Pong RW, et al. Nature of rural medical practice in Canada: an analysis of the 2001 national family physician survey. Sudbury: Centre for Rural and Northern Health Research, Laurentian University; 2004.

[3] *Fraser* F, Demello G, Nicoll P, MacVicar R, Pacitti E, Needham G (2012) Scottish GP Rural Acute Care Competencies and Educational needs, Remote and Rural Healthcare Education Alliance, NHS Education for Scotland. Available: http://www.rrheal.scot.nhs.uk/media/174875/final%20acute%20care%20competencies%20and%20education%20needs%20poster.pd

Although bespoke posts (such as “Rural Practitioner/Emergency Medical Practitioner/Rural Emergency Physician”) [4] [5] have emerged as a pragmatic response to service need, there is currently no shared underpinning competency framework. While appointees commonly have a General Practitioner background, their clinical training and skill levels often vary significantly.

The credential will provide a consistent approach to the training of the “extended generalist” required to provide unscheduled and urgent care in rural and remote hospitals and at the interface with the community.

The Credential in Rural and Remote Health (Unscheduled and Urgent Care) aims to fully align with the key principles of the UK Shape of Training Review.

1.3 Scope of practice

The Credential in Rural and Remote Health will support doctors by providing the competences required to recognise, stabilise and manage an acutely unwell patient, for up to 24 hours if evacuation is necessary, as well as the management of appropriate inpatient cases. While the credential covers the skills required to package and transfer unwell patients to larger hospitals where necessary, it is also recognised that appropriately considered patients, often as a result of personal preference, will spend their entire in-patient stay in small rural hospitals, under the care of extended generalists.

Holders of the credential in Rural and Remote Health will be able to undertake clinical roles in small hospitals in a rural and remote context that are in addition to the usual scope of practice of a General Practitioner, including:

- Act as senior decision maker in acute and emergency presentations
- Perform a range of emergency care practical skills
- Interpret a range of emergency diagnostic tests
- Diagnose, assess, and manage a range of acute medical, surgical, trauma, paediatric and psychiatric conditions
- Manage the in-patient care of patients suitable to be cared for in small rural hospitals
- Contribute to the safe transfer and retrieval of acutely ill patients who require next level care, alongside specialist retrieval teams

Holders of the Credential in Rural and Remote Health (Unscheduled and Urgent Care) will not have a scope of practice equivalent to doctors on the specialist register for other GMC-approved curricula; rather, it is a generalist credential of core emergency skills capable of being delivered in a non-specialist rural and remote environment.

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[4] http://www.scotlanddeanery.nhs.scot/your-development/gp-fellowships/

[5] The Welsh NHS Confederation. Rural Health and Care Services in Wales. April 2018. Available: https://www.nhsconfed.org/-/media/Confederation/Files/Wales-Confed/Rural-Health-and-Care-Services-in-Wales.pdf

1.4 Entry requirements for learner route

General Practitioners

The entry point for this credential will most commonly be doctors on the GP Register (or equivalent) who already work (or wish to work) in rural and remote settings. They are already required to display a wide range of knowledge, skills, behaviours and attributes, reflecting the broad nature of General Practice. The credential curriculum will add further breadth and depth. They will develop expertise in a range of practical procedures and be adept at the management of complex situations in hospitals, and at the interface between primary and secondary care. These core areas will ensure that doctors can provide safe care whilst working on a range of challenging and diverse clinical situations, balancing acute and routine service provision, in a rural and remote context.

The indicative entry criteria for General Practitioners are as follows:

1. The doctor has some experience of unscheduled or urgent care.
2. The doctor can demonstrate that they have existing appropriate competencies relating to urgent care provision.
3. The doctor has their employer's recommendation and support in their application to be considered for credential training. The doctor will apply to the Credential Development Body, NHS Education for Scotland who will assess the application.

Staff and Associate Specialist Doctors

The entry point for the credential will also include doctors practising in non-training grade positions in rural and remote contexts with appropriate experience and existing competencies (e.g., Staff and Associate Specialist doctors).

The indicative entry criteria for SAS grade doctors are as follows:

1. The doctor has relevant experience of working in a discipline or branch of medicine where they are involved in unscheduled or urgent care.
2. The doctor can demonstrate that they have existing appropriate competencies relating to urgent care provision.
3. The doctor has their employer's recommendation and support in their application to be considered for credential training. It is expected that the doctor will apply to the Credential Development Body, NHS Education for Scotland who will assess the application.

Doctors on the Specialist Register

While the focus of this credential is at the interface between General Practice and Rural and Remote small hospitals, it is recognised that some smaller hospitals may be staffed in part by doctors on the Specialist Register, and that their scope of practice may differ from their specialty postgraduate training. The Credential in Rural and Remote Health (Unscheduled and Urgent Care) may therefore also be applicable for some doctors on the specialist register who work in this context.

The indicative entry criteria for these doctors are as follows:

1. The doctor has specialty training that has unselected acute care as part of the curriculum e.g., Acute Care Common Stem training.

2. The doctor can demonstrate that they have existing competencies involved in urgent care provision.
3. The doctor has their employer's recommendation and support in their application to be considered for the credential training programme.

It is anticipated that this initial credential could provide a framework for further credentials that help the profession to adapt to the future needs of rural and remote patients and maintain consistent standards across the UK.

For details of the application process for the credential learner route please see the Credential User Guide document.

1.5 High level outcomes

The overall outcome of training in this credential is to provide the competencies required to recognise, stabilise and manage an acutely unwell patient, for up to 24 hours if evacuation is necessary, as well as the management of appropriate inpatient cases.

The credential is underpinned by three generic and nine clinical Capabilities in Practice (CiPs) and upon completion of these CiPs the credential holder will have appropriate knowledge, skills and behaviours required to:

- Resuscitate, stabilise, and treat acutely unwell patients, liaising with specialist and primary care teams as necessary in a rural and remote context.
- Recognise, investigate, initiate, and continue the management of common acute health problems presenting to rural and remote small hospitals, drawing upon the expertise of specialists and other professions as necessary.
- Provide inpatient care to an appropriate cohort of cases.

1.6 Delivery of training, assessment and critical progression

Aligned with "Excellence by Design", the Rural and Remote Health credential curriculum is outcomes-based. Progression will therefore depend on capability rather than time. Attainment of the competencies may accordingly be achieved at different times depending on clinical placements as well as pre-credential experience and training. For example, doctors embarking on the credential may already have acquired breadth and depth of experience and competencies in rural and remote contexts. Recognising the heterogeneity of credential entrants, it is estimated that the curriculum may take up to 2 years to complete.

The curriculum will be assessed by a portfolio of evidence and completion of work-based assessments:

- Some of the outcomes may require a period of time in a different centre (e.g., secondary/tertiary hospital) in order to develop or maintain skills under supervision and see cases that may not be commonly encountered in their local area.
- Some outcomes may be achieved via simulation with experienced supervisors.
- Some outcomes may be achieved using Technology Enhanced Learning such as supported peer group case-based discussion.

Two methods for achieving competency levels are proposed:

1. Simulated: Demonstration of appropriate management/applied knowledge in a practical scenario and/or discussion of a clinical case.
2. Applied clinical practice: Demonstration of appropriate management/applied knowledge in the clinical environment.

Doctors undertaking the credential will have named Educational Supervisor support and can use flexible means of obtaining such continued support, with a strong preference for socially distanced and remote technology. Formative assessment tools will be used when clinically appropriate to help guide the needs of the learner as they progress through placements and learn to perform novel procedures.

Excellence by design defines critical progression points as those at which a learner transitions to higher levels of professional responsibility, often associated with an increase in potential risk to patients or those in training. The credential has two critical progression points:

1. Progression points between the first- and second-year learning programme. The evidence submitted by the learner will be reviewed by the rural and remote credential panel with an outcome documented. See page 48 for outcomes. The curriculum acknowledges that learners should progressively undertake an increasing number of unsupervised clinical tasks and procedures and the panel on review of the Educational Supervisors report and submitted evidence if the learner is making satisfactory progress towards safe and independent practice.

2. The second critical progression point in the credential marks the end of training. On completion of the credential the learners are expected to have:
    - Met the level descriptors described in each Capability in Practice (section 3.2) and be entrusted to act unsupervised (see section 5.3) **and**
    - Obtained simulated or applied clinical competencies for all the procedures (section 3.3).

1.7 Key interdependencies between the curriculum and other training programmes

The curricular competency framework has been developed in collaboration with existing rural and emergency health practitioners and is an evolution of the Acute Care General Practitioner Rural Fellowship competencies, originally developed and delivered by NHS Education for Scotland. It has been subject to iterative review and wide discussion with key stakeholders across the UK.

1.8 Quality Assurance

The Rural and Remote credential has been designed to meet the stipulations of the UK Shape of Training Review and its delivery will be overseen by NHS Education for Scotland (NES). The implementation of this outcome and capability-based curriculum aligns with current and projected trends in the care requirements of rural and remote populations.

NES, who have robust governance processes for the delivery and assessment of training, will maintain and support the credential.

1.9 Recognition of current practice for recognition route

Doctors currently working within the scope of the credential and wishing to be recognised as credential holders will where possible submit evidence rather than complete further training in the workplace. This approach is both flexible and proportionate for doctors delivering service and likely to be educational and clinical supervisors for the credential.

The recognition route is an entirely new process for acknowledging a doctor's knowledge, skills, and experience against a number of credential specific capabilities in practice (CiPs) and procedural skills. Doctors who can demonstrate they meet the outcomes of a GMC (General Medical Council) credential can be awarded the credential by providing evidence instead of completing the credential training pathway.

Please see the Curriculum Specific Guidance document for details recognition route.

1.10 Routes for a credential award

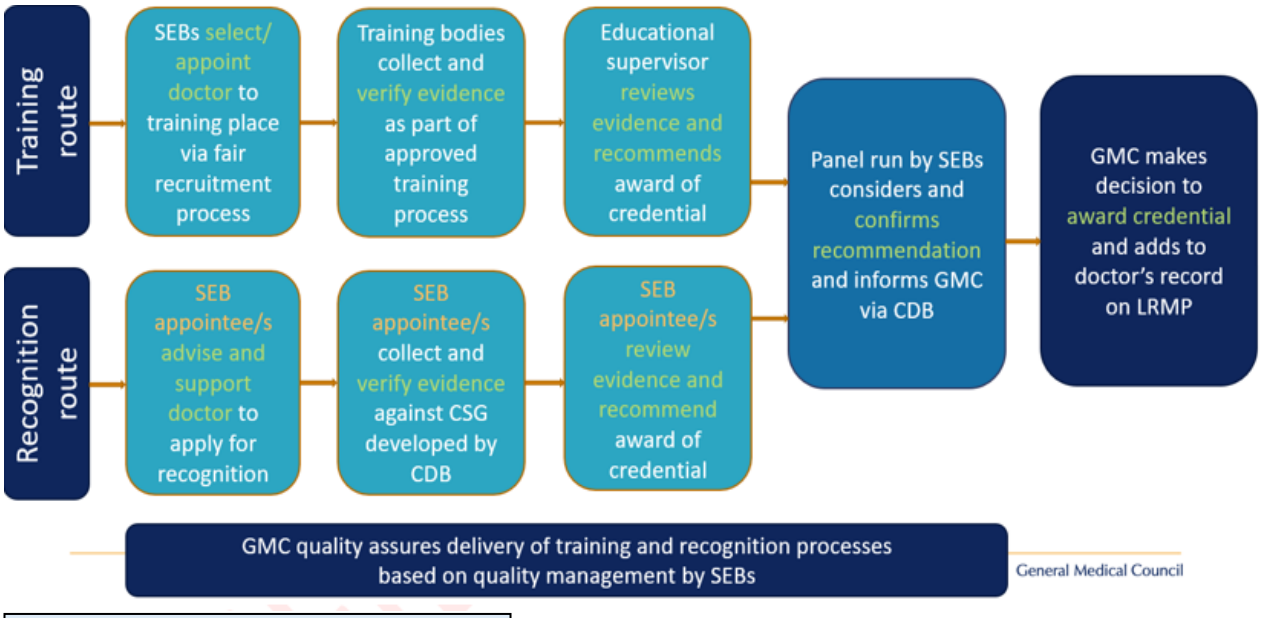
There are two routes for securing an award of a Credential in Rural and Remote Health (Unscheduled and Urgent Care):

1. Learner route.
2. Recognition route.

In order to ensure that consistent standards are applied for doctors gaining the credential via either the training or recognition route:

1. The recognition route is aligned with the training route.
2. An e-portfolio will be used to collate evidence, which will be linked to each Capability in Practice (CiP) and procedural skill.
3. The same signoff panels will be used for both training and recognition route.

The figure below outlines the two routes to an award of the GMC credential.



Key:
SEB – Statutory Education Body
CDB – Credential Development Body
LRMP – List of Registered Medical Practitioners
CSG – Credential Specific Guidance

1.11 Maintenance of the credential

Maintenance of the awarded credential and subsequent inclusion on the GMC List of Medical Practitioners (LRMP) will be based on extant processes such as appraisal and revalidation triangulated with local clinical governance systems.

2. Structure of training

2.1 General Professional Capabilities and Good Medical Practice

The Generic Professional Capabilities (GPC) framework[6] describes the fundamental, career-long, generic capabilities required of every doctor. It provides a consistent approach across all postgraduate medical curricula. It prioritises several themes, such as patient safety, quality improvement, safeguarding vulnerable groups, health promotion, leadership, team-working and other fundamental aspects of professional behaviour and practice.

Good medical practice (GMP)[7] is embedded at the heart of the GPC framework. In describing the principles, duties and responsibilities of doctors, the GPC framework articulates GMP as a series of achievable educational outcome to enable curriculum design and assessment. The GPC framework describes nine domains (*see figure 1*) with associated descriptors outlining the 'minimum common regulatory requirement' of

[6] Generic Professional Capabilities Framework 2017
[7] Good Medical Practice – professional standards Updated April 2019

professional behaviour and performance for those completing a CCT. Although not leading to a CCT, the GMC-regulated Credential in Rural and Remote Health defines an expectation that credential learners will meet a similar standard.

Figure 1: Domains of the generic professional capabilities framework

The focus of the credential is the attainment of high-level outcomes, as recommended for the new style of curriculum, and these have been separated into 3 generic and 9 clinical capabilities. The High-Level Outcomes (*see figure 2*) for the credential are aligned with the GMC's Generic Professional Capabilities Framework and underpinned by Good Medical Practice. The 9 domains of the GPC are directly identifiable in the credential content of learning and in turn each Capability in Practice (CiP) is mapped to assessment blueprints.

Domain 1 – Professional Values and Behaviours

- demonstrate situational awareness
- demonstrate awareness of their own limitations and understanding when and who to refer on to or seek professional advice from
- maintain their professional development and ensure their skills are kept up to date

Domains 2 & 3 – Professional Skills and Knowledge

- perform specific emergency care clinical competencies and manage an appropriate cohort of inpatient cases detailed further in the Competency Framework

Domain 4 – Capabilities in Health Promotion (and Illness Prevention)

- understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient
- understand and demonstrate the basic principles of person-centred care
- assess mental health and wellbeing

Domain 5 – Capabilities in Leadership and Team Working

- practice both independently and as a team leader
- safely lead the resuscitation of an acutely unwell patient while demonstrating situational and team awareness

Domain 6 – Capabilities in Patient Safety (and Quality Improvement)

- raise safety concerns and act upon them appropriately
- demonstrate effective interprofessional and multidisciplinary team working
- reflect on personal behaviour and practice

Domain 7 – Capabilities in Safeguarding Vulnerable Groups

- apply the mental capacity legislation in clinical practice, to protect the safety of individuals and society
- identify, assess and manage suicide risk
- recognise and take responsibility for safeguarding children, young people and vulnerable adults, using appropriate systems for identifying, sharing information, recording and raising concerns, obtaining advice and taking action

Domain 8 – Capabilities in Education and Training

- understand that the safety of patients must come first and that the needs of education must be considered in this context
- use simulation or technology-enhanced learning appropriately in protecting patients from harm
- promote and participate in interprofessional learning
- give timely and constructive feedback on learning activities and opportunities

Domain 9 – Capabilities in Research and Scholarship

- keep up to date with current research and best practice in the individual's specific area of practice, through appropriate continuing professional development activities and their own independent study and reflection
- practise in line with the latest evidence
- understand the role of evidence in clinical practice and demonstrate shared decision making with patients

Figure 2: High-Level Outcomes for the GMC-regulated Credential in Rural and Remote Health

2.2 Length of training

The Rural and Remote Health credential curriculum is outcomes-based, and progression will therefore depend on capability rather than time. Attainment of the competencies may accordingly be achieved at different times depending on pre-credential experience, training, and learning. For example, doctors embarking on the credential may already have acquired breadth and depth of experience and competencies in rural and remote

contexts. Recognising the heterogeneity of credential entrants, the indicative time for completion of training could take up to 2 years.

2.3 Previous experience and impact on training time

Doctors entering credential training will undertake an initial capability assessment to align training to their learning needs. Learning needs will vary according to previous experience. The following key criteria will apply:

- The indicative training time is up to 2 years.
- Doctors on the GP register will be able to display a wide range of knowledge, skills, behaviours and attributes, reflecting the broad nature of General Practice.
- Doctors practising in non-training grade positions will be expected to demonstrate appropriate experience and existing competencies attributed to rural and remote practice and/or emergency patient care. Typically, this will include recent experience of working in a rural and remote context for a period of at least 1 year.
- If a doctor considers that they already have achieved the capabilities in practice and are currently practising at the level laid out in the curriculum, consideration may be given to the accelerated award of the credential. This would normally involve them providing evidence of how they meet the capabilities in practice to the UK Rural and Remote Credential Panel. The Credential Panel may conclude either that further training is required within the credential pathway, or that sufficient evidence has been provided and that the Doctor should be recognised as holding the Credential. The Credential Panel will aim to review such applications in as timely a manner as possible.

2.4 Outcome-based training

The Rural and Remote Health credential curriculum is outcomes-based, and progression will therefore depend on capability and focus on the quality of the outcomes rather than on the means by which it was achieved. An outcomes-based framework avoids prescribing outputs or inputs unless they are fundamental to upholding the training standards overall. This flexible approach is fundamental as it allows the rural practitioner to shape their training based on the needs of the rural community in which they work.

The curriculum will be assessed by a portfolio of evidence. The training standards provide the framework not just for the delivery of the vocational training program but also focus on the quality of the processes.

The role of the learner is to seek high-quality training opportunities relevant to the credential capabilities. The role of the UK Rural and Remote Credential Panel is to measure and monitor the attainment outcomes against each capability in practice (CiP) and the processes used to reach them.

2.5 Location of training

The credential will focus on experiential workplace learning. This is essential for remote and rural practitioners as it provides context specific learning as well as minimising the need for unnecessary travel.

The Coronavirus pandemic has redefined the way in which education and training can be planned and delivered, accelerating the use of technology to support remote and socially distanced learning. These instructional methods are of relevance in remote and rural health since there is an ongoing need to minimise unnecessary travel for training. This credential will embrace the advantages that technology-enhanced learning can bring.

Although most of the learning will be locality-based and embrace technology-enhanced learning opportunities, some outcomes may require a period of time in a different centre. For example:

- Time in secondary or tertiary hospital in order to develop or maintain skills under specialist supervision.
- Time in secondary or tertiary hospital in order to see cases that may not be commonly encountered in their local area.
- Some outcomes may be achieved via simulation with experienced supervisors.

Doctors undertaking the credential will have named supervisor support and can use flexible means of obtaining such continued support, with a strong preference for socially distanced and remote technology.

3. Content of learning

3.1 Context

The practice of medicine in rural and remote acute contexts requires the generic and specialty knowledge, skills, behaviours, and procedural skills to manage patients presenting with a wide range of unselected symptoms and conditions. It involves particular emphasis on diagnostic reasoning, managing uncertainty, dealing with comorbidities, and recognising when another specialty opinion or care is required.

This credential focuses on the capabilities, knowledge, skills, and behaviours required for a rural and remote doctor to be able to:

- Resuscitate, stabilise, and treat acutely unwell patients for up to 24 hours if evacuation is necessary, liaising with specialist as required.
- Recognise, investigate, initiate, and continue the management of common acute health problems presenting to rural and remote small hospitals, drawing upon the expertise of specialists and other professions as necessary.
- Provide ongoing inpatient care to an appropriate cohort of cases.

To achieve the credential the learner will be expected to demonstrate the capabilities described by the Capabilities in Practice (CiPs) outlined in this document. Each CiP has a knowledge, skills and behaviours descriptor that underpins the capability.

Each CiP is mapped to the GMC's Generic Professional Capability and is accompanied by suggested methods of formative assessment that may support progress towards achieving the CiP.

Sign off will require clinical and educational supervisors to make entrustment decisions on the level of supervision required for each CiP or underlying activity at each stage. More

detail is provided in the programme of assessment section of the credential (see section 5.3).

3.2 Capabilities in practice (CiPs) – linked with presentations and conditions

A remote and rural practitioner, working in unscheduled and urgent care settings, will be expected to deal with a wide range of unselected acute presentations. Any attempt to list all presentations and conditions would be extensive, but inevitably incomplete.

There are 3 generic and 9 clinical CiPs. The approach taken is to match each clinical CiP to key clinical presentations and conditions with a general descriptor of the knowledge, skill and behaviours required for each capability. The presentations and conditions have been presented in an ABCDE structure, which is a recognised structure of assessment in urgent care settings.

Generic CiP 1: Able to work as a rural and remote practitioner within the NHS system	
Descriptor	**The Credential holder will be able to:** **Knowledge:** • Recognise the importance of the multi-disciplinary team in delivery of care in a rural and remote setting • Recognise the relationship between rural and remote communities and healthcare needs of the patient in terms of local capabilities and transport requirements/risks • Have a working knowledge of locality-based specialist referral pathways • Have a working knowledge of digital systems that allow for remote advice from specialist colleagues **Skills** • Demonstrate the ability to undertake the role of the generalist outside the scope of specialist supervision • Utilise the expertise of the whole multi-disciplinary team as appropriate, ensuring when delegating responsibility appropriate supervision is maintained • Apply knowledge of the locality-based emergency and specialist service options in the of planning treatment for patients seen in the rural and remote setting • Be able to access remote specialist advice making use of digital technology including ECG and common x-ray interpretation • Communicate accurately, clearly, promptly and comprehensively with relevant colleagues by means appropriate to the urgency of the situation, especially when responsibility for the patient care is being transferred. **Behaviour:** • Recognise one's own limitations and know when and where to seek specialist help for the patient • Recognise the importance of networking and peer support for maintaining patient safety as well as one's own resilience • Show willingness to participate in safety improvement strategies

Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Communication and interpersonal skills • Dealing with complexity and uncertainty **Domain 3 – Professional knowledge** • Professional requirements • National legislative requirements **Domain 4 – Capabilities in health promotion (and illness prevention)** • Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care • Demonstrate effective and interprofessional and multidisciplinary team working **Domain 7 – Capabilities in Safeguarding Vulnerable Groups** • National legislative requirements **Domain 8 – Capabilities in Education and training** • Use simulation or technology-enhance learning appropriately protecting patients • Promote and participate in interprofessional learning **Domain 9 - Capability in research and scholarship** • Keep up to date with current best practice and practice in line with latest evidence • Locate and use clinical guidelines appropriately

Generic CiP 2: Adapting practice to Urgent Care Setting	
Descriptors	**The Credential holder will be able to:** **Knowledge** • Describe factors that indicate need for rapid assessment of a patient • Describe the range of monitoring available in urgent care • Describe the range of patient investigations in urgent care setting and its application to patient care • Describe issues that can compromise patient safety • Knowledge of the adult and paediatric pain ladder

	Skills:
	• Identify the presence of life-threatening illness and the appropriate pathway for the management of the acutely unwell patient
	• Formulate a strategy for monitoring patients in an urgent care setting
	• Use and develop risk stratification tools to identify the best place for initial and ongoing management of patients
	• Assess, stabilise and manage an acutely unwell medical patient
	• Interpret and act on common investigations relevant to urgent care
	  ○ Radiology (interpretation of CXR, abdominal, spinal and limb radiographs)
	  ○ Blood results (haematology, biochemistry, d-dimer, troponin, arterial blood gases)
	  ○ ECG (ability to recognise and interpret abnormal rhythms/ ST changes)
	  ○ Capnography (ability to interpret and act on abnormal capnography trace)
	• Determine the most appropriate place ongoing patient management
	• Identify patients who are in the terminal phase of their life on presentation to prevent unnecessary harm to the patient and unnecessary use of resources
	• Prescribe pain medication in the urgent care setting (adult and paediatric)
	• Assess fluid balance and prescribe fluids and blood products appropriately
	• Demonstrate appropriate use of vasoactive and inotropic drugs
	
	Behaviours:
	• Recognise the patient whose care needs are best met in a specialist care setting
	• Early dialogue and onward referral of patients, involving retrieval services as appropriate

Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2- Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; humane interventions; prescribing medicines safety; using medical devices safely; infection control)

	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)** • Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care • Demonstrate effective and interprofessional and multidisciplinary team working • Reflect on personal behaviour and practice **Domain 7 – Capabilities in Safeguarding Vulnerable Groups**

Generic CiP 3: Facilitate effective handover of patient to specialist services	
Descriptors	**The Credential holder will be able to:** **Knowledge:** • Discuss the factors that influence effective handover to another service/hospital • Describe the local Emergency Retrieval Service for paediatric and adult patients • Describe the benefits of telemedicine advice from retrieval healthcare colleagues **Skills:** • Recognise the critically unwell patient and early referral to emergency retrieval service • Demonstrate effective handover to another healthcare provider • Work with retrieval teams in the stabilisation of the patient for transfer for specialist care **Behaviours:** • Recognise that effective communication and handover plays a significant role in patient safety • Recognise the need for early communication with Emergency Retrieval Services
Evidence to inform decision	• Mini-CEX • *ACAT* • *CbD* • MSF • MCR • ESR

GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrate awareness of their own limitations and understanding when and who to refer on to or seek professional advice from **Domain 2 – Professional Skills** • Communication and interpersonal skills • Dealing with complexity and uncertainty **Domain 3 – Professional knowledge** • Professional requirements • National legislative requirements **Domain 4 – Capabilities in health promotion (and illness prevention)** • Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care Demonstrate effective and interprofessional and multidisciplinary team working

Clinical CiP 1: Recognise and appropriately manage acute paediatric presentations	
Descriptors	**The Credential holder will be able to:** **Knowledge** • Describe the diagnosis and management of symptoms and conditions presenting in childhood with understanding of age-appropriate algorithms e.g., weight-based shock energy level • Understand the indications, pharmacology, contraindications, dose calculation and route of drug/fluid administration in children. • Know that some of the presenting symptoms could be manifestations of nonaccidental injury • Understand child protection procedures and process for seeking help with regards child welfare issues **Skills** • Demonstrate a structured approach to examination of a child • Demonstrate that the approach to managing a child differs from that of an adult • Demonstrate an ability to alter consultation practice for children presenting in an urgent care setting • Be able to prescribe drugs and fluids safely for children • Identify presentations that require safeguarding assessments **Behaviours:** • Recognise the patient whose care needs are best met in a specialist care setting • Early dialogue and onward referral of patients, involving retrieval services as appropriate • Identify presentations that require safeguarding assessments

<table>
<tr><td colspan="3">Link knowledge, skills and behaviours to acute paediatric presentations and conditions:</td></tr>
<tr><td rowspan="4">The range of conditions considered is intended to be indicative rather than a full listing</td><td>Airway</td><td>Stridor: laryngo-tracheobronchitis (croup)
Tonsillitis
Foreign body inhalation/ingestion</td></tr>
<tr><td>Breathing</td><td>Bronchiolitis
Paediatric asthma
Apnoeic episode</td></tr>
<tr><td>Circulation</td><td>Gastro-enteritis/dehydration
Childhood sepsis</td></tr>
<tr><td>Disability</td><td>Accidental poisoning and self-harm
Floppy child
Febrile seizure
Status epilepticus
Meningitis
Paediatric Diabetic Ketoacidosis
Limb/joint pain and a limping child</td></tr>
<tr><td></td><td>Exposure</td><td>Fever - undifferentiated
Rash – non-blanching and other
Identification and management of child safeguarding issues</td></tr>
<tr><td>Evidence to inform decision</td><td colspan="2">• Mini-CEX
• ACAT
• CbD
• MSF
• MCR
• ESR</td></tr>
<tr><td>GPCs</td><td colspan="2">Domain 1 – Professional Values and Behaviours
• Demonstrate situational awareness
• Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from
• Maintain professional development and ensure skills are kept up to date
Domain 2 – Professional Skills
• Practical skills
• Communication and interpersonal skills
• Dealing with complexity and uncertainty
• Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control)
Domain 3 – Professional knowledge
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• Patient safety
• Demonstrate effective and interprofessional and multidisciplinary team working
Domain 7 – Capabilities in Safeguarding Vulnerable Groups
• National legislative requirements</td></tr>
</table>

	• Recognise and take responsibility for safeguarding children and young people

Clinical CiP 2: Management of time-critical presentations/conditions (Medical and Surgical)			
Descriptors	**The Credential holder will be able to:** **Knowledge** Describe the principles underpinning immediate management of acutely unwell patient Describe the clinical features and immediate management of emergency and time critical conditions **Skills:** Manage an acutely unwell patient with respect to ABCDE approach Apply a triage tool in order to prioritise patient care Demonstrate leadership in a complex clinical setting **Behaviours:** • Understand the limitations of providing care in rural and remote settings and the need for early dialogue and/or referral to specialist centres		
Link knowledge, skills and behaviours to time critical presentations and conditions:			
The range of conditions considered is intended to be indicative rather than a full listing	**Airway**	Angioedema Anaphylaxis Stridor Threatened airway due to reduced consciousness	
	Breathing	Dyspnoea-undifferentiated Asthma COPD Respiratory failure Pneumothorax	Pulmonary embolism Pneumonia Left ventricular failure/pulmonary oedema
	Circulation	Abnormal pulse - arrhythmias	
		Abnormal blood pressure	Shock – Hypovolemic Septic Anaphylactic Cardiogenic Addisonian crisis
		Chest pain	Acute coronary syndrome - including thrombolysis Thoracic aortic aneurysm dissection
		bleeding	Manage major haemorrhage Gastrointestinal bleeding Haematuria Vaginal bleeding –antepartum haemorrhage Epistaxis Post tonsillectomy bleed Dental bleeding Bleeding on anticoagulant

	Disability	Abnormal conscious level	Reduced conscious level – undifferentiated Drug overdose Stoke including thrombolysis Seizure Acute confusion Encephalitis/meningitis Encephalopathy
		Headache	Meningitis Sub-arachnoid haemorrhage Intra-cranial bleed
		Abnormal blood glucose	Diabetic ketoacidosis Hyperosmolar hyperosmotic state Hypoglycaemia
		Abdominal pain	Acute abdomen Aortic dissection Pancreatic Intestinal obstruction Bowel obstruction Ischaemic bowel Pyelonephritis Renal colic Acute cholecystitis Acute diverticulitis Appendicitis Ectopic pregnancy
	Exposure	Abnormal temperature	Hypothermia Hyperthermia – drug induced
		Limb abnormality	Acute limb ischemia Deep venous thrombosis Cellulitis Necrotising fasciitis
		Genital pain	Testicular torsion
Evidence to inform decision	• Mini-CEX • ACAT • CbD		• MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3– Professional Knowledge** • Professional requirements **Domain 4 – Capabilities in health promotion (and illness prevention)**		

	• Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care • Demonstrate effective and interprofessional and multidisciplinary team working **Domain 7 – Capabilities in Safeguarding Vulnerable Groups**

Clinical CiP 3: Assessment and initial management of the trauma patient		
Descriptors	**The Credential holder will be able to:** **Knowledge:** • Describe the principles underpinning the initial management of the trauma patient • Understand the need for early dialogue and referral to trauma centre • Describe the initial management of soft tissue injury and fractures • Describe the symptoms and signs of inhalation of noxious chemicals • Classify burns and be aware of features requiring referral to specialist services **Skills:** • Demonstrate a structured approach in the initial assessment and management of a trauma patient • Demonstrate a structured approach in the assessment and management of a neck injury including - cervical spine immobilisation and log roll • Demonstrate a structured approach in the assessment and management of soft tissue injuries • Demonstrate a structured approach in the assessment and management of fractures • Assess the severity of inhalation of noxious substances **Behaviours:** • Assess the need for urgent referral to trauma centre for specialist care	
Link knowledge, skills, and behaviours to the systematic approach to the diagnosis and management of:		
The range of conditions considered is intended to be indicative	**Airway**	Airway obstruction
	Breathing	Pneumothorax – traumatic Haemothorax Flail segment Pulmonary contusion Inhalation of noxious substances – smoke/carbon monoxide

rather than a full listing	**Circulation**	Haemorrhagic shock Spinal shock
	Disability	Head injury Spinal injury
	Exposure	Limb injury and different types of fracture Wound Burns Temperature control Electrocution
Evidence to inform decision	• Mini-CEX • ACAT • CbD	• MSF • MCR • ESR
GPCs	Domain 1 – Professional Values and Behaviours • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date Domain 2 – Professional Skills • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) Domain 3– Professional Knowledge • Professional requirements Domain 5 – Capabilities in Leadership and Team Working • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness Domain 6 – Capabilities in Patient Safety (and Quality Improvement) • Patient safety • Demonstrate effective and interprofessional and multidisciplinary team working.	

Clinical CiP 4: Ability to assess and appropriately manage core Ear, Nose, and Throat (ENT) presentations	
Descriptors	**The Credential holder will be able to Knowledge:** • State the common causes of ear pain • State the common causes of a sore throat and outline necessary investigations • Describe the symptoms of stridor and impending airway obstruction **Skills:** • Undertake a full ear examination • Perform a full examination of neck and throat, recognising when the airway is at risk • Assess the severity of stridor and croup • Manage epistaxis

	• Know when antibiotics are indicated • Remove readily accessible foreign bodies from nasal cavities and external ear canals and know when to refer for specialist care **Behaviour:** • Recognise ENT emergencies, including airway compromise ensuring early dialogue/referral to ENT specialists • Know when to refer to ENT for continued care
Link knowledge, skills and behaviours to the systematic approach to the diagnosis and management of:	
The range of conditions considered is intended to be indicative rather than a full listing	Otitis media and externa Viral and bacterial tonsillitis Peri-tonsillar abscess Epistaxis Post-tonsillar bleed Stridor – croup Food bolus
Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3– Professional Knowledge** • Professional requirements **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Demonstrate effective and interprofessional and multidisciplinary team working

Clinical CIP 5: Ability to evaluate and appropriately manage the patient presenting with acute eye problems	
Descriptors	**The Credential holder will be able to:** **Knowledge:** • State the common causes of a painful red eye • State the common causes of sudden visual loss/disturbance **Skills:** • Perform full examination including visual acuity, ocular movements, visual fields and related cranial nerves • Demonstrate the use of a slit lamp, fundoscopy and lid eversion • Demonstrate the removal of a foreign body • Demonstrate the indications for and application of fluorescein • Be able to assess and manage common causes of an acute red eye **Behaviours:** • Know when to refer a patient with an eye problem for a specialist ophthalmology opinion
Link knowledge, skills and behaviours to common ophthalmology presentations:	
The range of conditions considered is intended to be indicative rather than a full listing	Red eye Sudden visual disturbance Orbital cellulitis Foreign body and chemical splash
Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3– Professional Knowledge** • Professional requirements **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness

	Domain 6 – Capabilities in Patient Safety (and Quality Improvement) • Patient safety • Demonstrate effective and interprofessional and multidisciplinary team working.

Clinical CIP 6: Ability to assess and manage appropriately core obstetric and gynaecology presentations	
Descriptors	**The Credential holder will be able to:** **Knowledge:** • State the early complications of pregnancy and the presentation of ectopic pregnancy • State the causes for vaginal bleeding in different age groups: pre-menopausal, post-menopausal and pregnant women • State the common causes of pelvic pain • Describe when to refer to a surgeon, gynaecologist, or GUM specialist **Skills:** • Early identification of ectopic pregnancy • Discuss the management of a patient who has vaginal bleeding early in pregnancy • Perform a full pelvic examination and arrange appropriate initial investigations of a patient with acute pelvic pain or make a referral for specialist assessment **Behaviour:** • Use chaperones appropriately • Recognise the need for specialist care
Link knowledge, skills and behaviours to common obstetric and gynaecology presentations:	
The range of conditions considered is intended to be indicative rather than a full listing	Spontaneous or threatened miscarriage Ectopic pregnancy Pelvic pain - undifferentiated
Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR

GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3– Professional Knowledge** • Professional requirements **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care • Demonstrate effective and interprofessional and multidisciplinary team working **Domain 7 – Capabilities in Safeguarding Vulnerable Groups** • Recognise and take responsibility for safeguarding young people and vulnerable adults

Clinical CiP 7: Evaluate and appropriately manage the patient with acute psychiatric presentation including overdose	
Descriptor	**The Credential holder will be able to:** **Knowledge:** • Outline the risk factors for self-harm and suicide • Outline the powers that enable assessment and treatment as defined in applicable legislation • State the important symptoms, signs, and tests to establish the type of poisoning • Recognise the importance of accessing TOXBASE **Skills:** • Take a psychiatric history and be familiar with scoring tools used to assess risk of self-harm • Assess the acutely poisoned patient and identify those requiring intervention for the management of an overdose • Recognise and manage aggression appropriately **Behaviours:** • Liaise promptly with psychiatric services if in doubt of suicidal risk or high risk of repeat self-harm and suicide

	• Recognise when to refer to psychiatric services for a specialist opinion • Know when to contact secondary/tertiary referral centre for ongoing management for the manifestations of an overdose
Link knowledge, skills and behaviours to:	
The range of conditions considered is intended to be indicative rather than a full listing	Aggressive patient Alcohol abuse/withdrawal Suicidal ideation Self-harm and overdose Emergency detention
Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3 – Professional knowledge** • Professional requirements • National legislative requirements **Domain 4 – Capabilities in health promotion (and illness prevention)** • Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient • Person-centred care • Assess mental health and wellbeing **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Demonstrate effective and interprofessional and multidisciplinary team working **Domain 7 – Capabilities in Safeguarding Vulnerable Groups** • National legislative requirements • Apply mental capacity legislation in clinical practice to protect the safety of individuals and society

	• Recognise and take responsibility for vulnerable people, using appropriate systems for identifying, sharing information, recording and raising concerns, obtaining advice and taking action

Clinical CIP 8: Evaluation and management of the older person		
Descriptor	**The Credential holder will be able to:** **Knowledge:** • State the common factors in the frail elderly that need to be considered when prescribing for this group of patients e.g. renal impairment, falls risk • Demonstrate a practical understanding of legislation relating to capacity and how this is assessed • Use appropriate the tools to aid the differentiation and management of delirium and dementia in an urgent care setting • Describe the factors which affect an end-of-life decision and the communication with patient, family, and staff **Skills:** • Facilitate treatment escalation planning, especially in the frail population • Perform an assessment of cognition (including acute, chronic, and rapidly deteriorating) and mental capacity • Recognise, diagnose, and manage a state of delirium • Assess, diagnose, and manage older people who present with dementia • Manage the care of the elderly patient considering the anatomical and physiological changes associated with age • Identify issues associated with polypharmacy and how this may play a role in the urgent care presentation • Identify patients with limited reversibility of their medical condition, discuss end of life, undertake advance care planning conversations, and determine palliative care needs **Behaviours:** • Ensure continuity and coordination of patient care through the appropriate transfer of information demonstrating safe and effective handover • Ensure that all clinicians involved in the care of complex patients receive adequate communication to ensure safe and effective discharge • Apply legal and ethical principles to patients lacking mental capacity in an emergency situation	
Link knowledge, skills and behaviours to:		
The range of conditions considered is intended to be indicative	Delirium Pressure sores and skin ulceration Urinary retention Constipation, diarrhoea, faecal impaction Immobility and functional decline	Falls, fractures and other injuries Syncope, pre-syncope, dizziness Hypothermia Infections and sepsis Acute surgical presentation

rather than a full listing	
Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3 – Professional knowledge** • Professional requirements • National legislative requirements **Domain 4 – Capabilities in health promotion (and illness prevention)** • Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient • Person-centred care • Mental health and wellbeing **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader • Safely lead the resuscitation of an acutely unwell patient demonstrating situational and team awareness **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care • Demonstrate effective and interprofessional and multidisciplinary team working **Domain 7 – Capabilities in Safeguarding Vulnerable Groups** • National legislative requirements • Apply mental capacity legislation in clinical practice to protect the safety of individuals and society • Recognise and take responsibility for vulnerable people, using appropriate systems for identifying, sharing information, recording and raising concerns, obtaining advice and taking action

Clinical CiP 9: Management of patients requiring palliative and end of life care	
Descriptor	**The Credential holder will be able to:** **Knowledge:** • Describe different disease trajectories and prognostic indicators and the signs that a patient is dying • Describe the factors which affect an end-of-life decision and communication with patient, family, and staff

	• Describe the roles of the multi-disciplinary team involved in end-of-life care • Knowledge of major cultural & religious practices relevant to the care of dying people **Skills:** • Deliver effective control of symptoms including pain, agitation, excessive respiratory secretions, nausea & vomiting, breathlessness and bowel dysfunction • Communicate honestly and sensitively with the patient (and family/carers) about the benefits and disadvantages of treatment, and appropriate management plan, allowing the patient to guide the conversation • Lead a discussion about cardiopulmonary resuscitation with patient, carers, family, and colleagues appropriately and sensitively ensuring patients interests are paramount • Discuss and complete an advanced care plan with the patient, carers and family. **Behaviour:** • Refers to specialist palliative care services when appropriate
Link knowledge, skills and behaviours to:	
The range of conditions considered is intended to be indicative rather than a full listing	Symptom management Pressure sores and skin ulceration Constipation, diarrhoea, faecal impaction Immobility and functional decline
Evidence to inform decision	• Mini-CEX • ACAT • CbD • MSF • MCR • ESR
GPCs	**Domain 1 – Professional Values and Behaviours** • Demonstrate situational awareness • Demonstrates awareness of their own limitations and understanding when and who to refer on to or seek professional advice from • Maintain professional development and ensure skills are kept up to date **Domain 2 – Professional Skills** • Practical skills • Communication and interpersonal skills • Dealing with complexity and uncertainty • Clinical skills (history taking, diagnostic and medical management; consent; interventions; prescribing medicines safety; using medical devices safely; infection control) **Domain 3 – Professional knowledge** • Professional requirements • National legislative requirements **Domain 4 – Capabilities in health promotion (and illness prevention)**

	• Understand and demonstrate the relationship of the Rural and Remote environment with the healthcare needs of the patient • Assess mental health and wellbeing **Domain 5 – Capabilities in Leadership and Team Working** • Practice both independently and as a team leader **Domain 6 – Capabilities in Patient Safety (and Quality Improvement)** • Patient safety • Person-centred care • Demonstrate effective and interprofessional and multidisciplinary team working **Domain 7 – Capabilities in Safeguarding Vulnerable Groups** • National legislative requirements • Recognise and take responsibility for vulnerable people, using appropriate systems for identifying, sharing information, recording and raising concerns, obtaining advice and taking action

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3.3 Resuscitation capabilities and practical procedures

Resuscitation capability

Holders of the credential in Rural and Remote Health will be expected to act as the senior decision maker in acute and emergency presentations and be able to resuscitate, stabilise and treat acutely unwell patients. They will be expected to provide leadership of a cardiac arrest and trauma team.

Although the Rural and Remote Health Credential curriculum is outcomes-based and focused on the quality of the outcomes rather than on the means by which it was achieved, credential holders will be expected to be able to lead a multi-disciplinary team in the management of life-threatening cardiac and respiratory conditions including peri-arrest and arrest situations.

Procedure	Completion of credential
Advanced cardiopulmonary resuscitation (CPR)	Lead the management of cardiac arrest and peri-arrest in adults and children. Lead trauma resuscitation

ABCDE practical procedures

All learners are expected to develop the skill set required to be able to cover an emergency, out of hours rota and to have an in-depth knowledge of the relevant disease processes, potential treatment options and skills to enable comprehensive patient care from referral to completion of the patient episode.

There are several procedural skills in which a learner must become proficient. It is essential the learner, in consultation with their employer, identifies the urgent care practical procedures they may be expected to perform. Sites that require credential

holders to perform these procedures for service reasons will need to put in place mechanisms to provide training and assure competence for independent practice. Learners must be able to outline the indications for these procedures and recognise the importance of valid consent, aseptic technique, safe use of analgesia and local anaesthetics, minimisation of patient discomfort, and requesting for help when appropriate. For all practical procedures the learner must be able to recognise complications and respond appropriately if they arise, including calling for help from colleagues in other specialties when necessary.

Learners should ideally receive training in procedural skills in a clinical skills lab before performing these procedures clinically, but this is not mandatory. Assessment of procedural skills will be made using the direct observation of procedural skills (DOPS) tool on simulated or actual patients. Attainment of the skill will be competency based, not numbers based. The table below sets out the minimum competency level expected for each of the practical procedures on completion of the credential.

Credential holders are expected to maintain procedural competences achieved during training and should be supported by employers to undertake refresher training in procedural skills in a simulated environment if required.

The procedural skills required in each locality may differ due to the provision of the service by other clinicians e.g., anaesthetists. It was agreed that credential holders should be proficient in procedure that they will be expected to carry out and have simulated competencies for those skills they are less likely to use.

Procedure		**Completion of credential**
Airway	Treat airway obstruction secondary to reduced consciousness following foreign body inhalation	Management of adult airways to include basic manoeuvres through to advanced techniques of subglottic airway devices Ability to undertake failed airway drill Ability to perform a surgical airway Ability to perform airway manoeuvres/use airway adjuncts Ability to correctly introduce a laryngeal mask Awareness/consideration of endotracheal intubation Ability to manage obstruction
	Basic airway management including bag mask ventilation	
	Advanced airway management	
	Care of tracheostomy tube	
Breathing	Arterial blood gas sampling and delivery of appropriate oxygen therapy	Ability to perform ABG sampling and interpret the results in relationship to common pathologies Ability to adjust treatment based on interpretation of results
	Bag mask ventilation	Be able to demonstrate safe techniques in invasive and non-invasive ventilation in the management of acute ventilatory failure with the use of simple devices such as bag valve mask through to acceptable
	Set up non-invasive ventilation or CPAP and deal with complications	

		emergency mechanical ventilation strategies Competent to preform unsupervised Ability to set up basic ventilator
	Ventilation with capnography	
	Intercostal drain insertion[a]	Be able to perform surgical or non-surgical techniques in the management of ventilatory failure caused by air or fluid in pleural cavity
Circulation	Intraosseous access to circulation for resuscitation	Competent to perform unsupervised in adults and children
	Pacing -pharmacological -external	Demonstrate procedural skills in management of cardiovascular collapse from arrythmia through pharmaceutical management, external or internal cardiac pacing intervention depending on the severity and cause
Disability	Spinal immobilisation	Competent to perform unsupervised
	Log roll	Competent to perform unsupervised
	Lumbar puncture	Competent to perform unsupervised
Exposure	Demonstrate the application of recognised splints in the management of both pelvic and long bone fractures	Competent to perform unsupervised
	Joint dislocation reduction techniques alongside appropriate analgesia and sedation techniques	Competent to perform Mandible/Shoulder/elbow/digit/hip/patella/ankle dislocation reduction techniques unsupervised
	Wound management	Competent to perform unsupervised
	Local anaesthetic techniques	Competent to perform unsupervised
	Plaster cast application	Competent to perform unsupervised
	Demonstration of the management of both medical and traumatic epistaxis using recognised techniques and equipment in both upright patient and supine patient	Competent to perform unsupervised
	Removal of foreign body from ear/nose/eye	Competent to perform unsupervised
	Peripheral nerve blocks	Competent to perform unsupervised

[a]*Pleural procedures should be undertaken in line with the British Thoracic Society guidelines. These state that thoracic ultrasound guidance is strongly recommended for all pleural procedures for pleural fluid, also that the marking of a site using thoracic ultrasound for subsequent remote aspiration or chest drain insertion is not recommended, except for large effusions. Ultrasound guidance should be provided by an appropriately trained pleural-trained ultrasound practitioner*.

4. Teaching methods

4.1 Teaching and learning methods

It is anticipated that most doctors seeking to gain a credential in remote and rural health will be already practising in a rural context and participating in patient care at the interface between primary and specialist care. The credential will also be open to other doctors seeking employment that encompasses clinical roles in small hospitals in a rural context that are in addition to their usual scope of practice, such as acting as a senior decision maker in acute and emergency presentations.

Responsibility for seeking training opportunities to meet the credential requirements rests with the learner and their employer. The GMC's Promoting Excellence[8] sets out the requirements for the management and delivery of postgraduate medical education and training. The Gold Guide[9] provides further guidance on the management and expectations of training, although not all its processes apply to credential learners.

Training is generally expected to be experiential and most of the learning will take place in the learner's place of work. There will be some aspects of training that cannot be met in the locality and the learner will be required to undertake blocks of supervised time in specialist centres or units. Experiential and formal training will take advantage of existing and developed learning packages and opportunities.

The curriculum will be delivered through a variety of learning experiences and will allow learners to achieve the capabilities described through a variety of learning methods. There will be a balance of different modes of learning from experiential learning 'on the job' to more formal courses. The proportion of time allocated to different learning methods will vary depending on the previous experience of the learner. Training should be constructed to enable learners to experience the full range of educational and training opportunities available and there will be robust arrangements for quality assurance in place to ensure consistent implementation of the curriculum.

When training the learner will have appropriate clinical supervision and an appropriate educational supervisor. The clinical supervisor and educational supervisor may at points be the same person.

4.2 Work-based experiential learning

Training is expected to be on the most part work-based experiential learning, supported by the employer. It is expected that the employer and employee (learner) will undertake an initial needs assessment taking into consideration the roles and responsibilities of the post with locality work-based training opportunities identified.

The content of work-based experiential learning includes active participation in:

- Apprentice model - A major component of training is achieved by the apprentice system with the learner undertaking an increasing number of unsupervised clinical tasks and procedures. Credential attachments with gradual reduction in supervision according to capability as judged by trainer/supervisors.

[8] GMC. Promoting Excellence: standards for medical education and training. July 2015

[9] The Gold Guide - 9th Edition. August 2022

- Reviewing patients with consultants - It is important that learners have an opportunity to present a proportion of the patients to a consultant for senior review in order to obtain immediate feedback into their performance (supplemented by an appropriate WPBA such as an ACAT, Mini-CEX or CbD). This may be accomplished when working on a take shift along with a consultant or on a post-take ward round with a consultant.
- Direct patient care - Every patient seen, in an emergency care setting or on the ward provides a learning opportunity, which will be enhanced by following the patient through the course of their illness. Patients seen should provide the basis for critical reading and reflection on clinical problems. A log of cases encountered with learner reflection will inform the credential process.
- Out of hours (OOH) and emergency provision - on call work should be a positive learning opportunity and the level of supervision will be determined by the employer based on the nature of the OOH work and the experience of the clinician (learner).

The degree of responsibility undertaken by the learner will be increased as competency increases. The employer should ensure there is appropriate level of supervision throughout the training with increasing independence and responsibility as capabilities in practice are achieved.

4.3 Optional work-based experiential learning

The Rural and Remote Health credential seeks to mitigate existing tensions that may occur where doctors in rural and remote locations are practising at a level that exceeds their license. Whilst the credential covers the core capabilities required for rural practice at the interface between hospital and community care there may be locality specific job requirements that are out with the scope of the credential process. In this instance it would be the responsibility of the learner along with their employer to seek additional training opportunities to ensure the clinician is fit for purpose.

4.4 Formal teaching

Formal teaching attendance can be used as evidence against credential curriculum requirements. Evidence may include:

- Grand round attendance (with the option for virtual grand round attendance linking various rural sites)
- Journal clubs
- Case presentations
- Lectures and small group teaching
- Clinical skills demonstrations and teaching
- Mortality and morbidity meetings
- Conference attendance
- Peer directed learning events supported by technology

4.5 Independent self-directed learning

Learners will use this time in a variety of ways depending upon their stage of learning. Suggested activities include:

- Reading, including web-based material such as e-Learning for Healthcare (e-LfH)
- Maintenance of personal portfolio (self-assessment, reflective learning, personal development plan)
- Audit, quality improvement and research projects
- Reading journals and articles
- Achieving personal learning goals beyond the essential, core curriculum.

4.6 Formal study courses

Time and funding for formal courses is encouraged, subject to local conditions of service. Such courses may involve the use of simulation at a rural and remote boot-camp styled event.

Although the Rural and Remote Health Credential curriculum is outcomes-based and focused on the quality of the outcomes rather than on the means by which it was achieved, credential holders will be expected to be able to demonstrate resuscitation skills commensurate with the level required at accredited resuscitation skills courses.

4.7 Technology-enhanced learning

The Coronavirus pandemic has redefined the way in which education and training can be planned and delivered, accelerating the use of technology to support remote and socially distanced learning. These instructional methods are of relevance in remote and rural health since there is an ongoing need to deliver training near to home and minimise unnecessary travel. This credential will embrace the educational and public health advantages that technology-enhanced learning can bring.

Technology-enhanced learning opportunities will allow:

- Networking opportunities across rural sites allowing peer directed learning.
- Formal small group learning sessions delivered by specialists at a distance from the rural site.
- Grand round sessions hosted by different rural sites.
- Flexible and healthy development and training culture for doctors in rural and remote areas.
- Flexible means of obtaining such continued support, including distant support from educational supervisor.

4.8 Simulation

In rural and remote areas some clinical presentations and procedures are relatively infrequent, therefore simulation may be utilised for both learning and assessment of competence**.** Where simulation is used for assessment, only the person leading the scenario can be provided with a summative assessment, although other participants may have formative assessment and feedback.

Simulation training including non-technical skills/human factors and clinical scenarios should be carried out as part of the credential programme with training or refresher training for procedural skills where necessary.

There are many scenarios in remote and rural healthcare where simulation can play a useful role in supporting delivery of this credential and each centre delivering the training is encouraged to incorporate these techniques wherever possible. Simulation could also take the form of 'boot-camp' styled events.

4.9 Learning experiences

The delivery of the credential curriculum and assessments should enable learners to meet the capabilities required for the expert generalist at the interface between primary and secondary care.

Clinical and educational supervisors are encouraged to identify learner-centred educational opportunities in the course of clinical work, maximising the wide variety of learning opportunities in the workplace. These may include:

- Learning from practice: Learners will spend a large proportion of work-based experiential learning involved in supervised practice in Accident and Emergency and ward settings.
- Learning with peers: There are opportunities for learners to learn with and from their peers using digital platforms.
- Learning in formal situations: Morbidity and mortality meetings and Grand Rounds
- Personal study: Time should be provided during training for personal study.
- Specialist teaching input: Specialist teaching is essential. Using digital platforms there is an opportunity to have specialist teaching delivered to learners across different rural sites.

4.10 Audit and quality improvement projects

Assessment of audit or quality improvement projects is not included in the credential programme. Credential learners will however be expected to participate in audit or quality improvement projects that are taking place within the department in which they work.

5. Programme of assessment

5.1 Purpose of assessment

The assessment of learning is an essential component of any curriculum. The programme of assessment comprises an integrated framework of assessments in the workplace and global judgements made about the learner during the credential programme.

The purpose of the programme of assessment is to robustly evidence, ensure and clearly communicate the expected levels of performance and to demonstrate satisfactory completion of training as required by the curriculum. To achieve this, the programme of assessment aims to:

- Assess the learners' performance in the workplace.
- Enhance learning by providing formative assessment, enabling learners 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 learners and motivating them to ensure they receive suitable training and experience.
- Demonstrate learners have acquired the GPCs and meet the requirements of GMP.
- Ensure that learners possess the essential underlying knowledge required for their practice.
- Provide robust, summative evidence that learners are meeting the credential standards.
- Inform the annual review, facilitating discussion regarding progression through the credential and identifying any requirement for additional training.

5.2 Programme of assessment

The programme of assessment is comprised of several different types of assessment needed to meet the requirements of the curriculum. These together generate the evidence required for global judgements to be made about satisfactory learner performance, progression in, and completion of, the credential.

The programme of assessment refers to the integrated framework of formative work-based assessments and judgements made about a learner during their approved programme of training. There is no formal examination as part of credential process. Work-based assessment together with other portfolio evidence, contributes to the annual Educational Supervisor's Report. Central to the assessment framework is professional judgement. Assessors are responsible and accountable for these judgements, which in turn support structured feedback to learners. Assessment takes place throughout the credential programme to allow learners to continually gather evidence of learning and to provide formative feedback to the learner to aid progression.

All assessments, including those conducted in the workplace, are linked to the relevant curricular learning outcomes (e.g., through the blueprinting of assessment system to the stated curricular outcomes).

Learners have a personal responsibility to undertake regular self-assessment against the curricular requirements and in doing so, in consultation with their Educational Supervisor,

shape their training. Reflection and feedback should be an integral component to all work-based assessments. In order for learners to maximise benefit, reflection and feedback should take place as soon as possible after an event. Every clinical encounter can provide a unique opportunity for reflection and feedback and this process should occur frequently.

5.3 Assessment of CiPs and practical procedures

Assessment of CiPs and practical procedures involves looking across a range of key skills and behaviours to make global decisions about a learner's suitability to take on particular responsibilities or tasks.

Clinical Supervisors and others contributing to assessment will provide formative feedback to the learner on their performance throughout the training year. Towards the end of each training year, the learner will make a self-assessment of their progression for each CiP and practical procedure, and record this in the Portfolio with signposting to the evidence to support their rating. The Educational Supervisor (ES) will review the evidence in the Portfolio including workplace-based assessments, feedback received from Clinical Supervisors and the trainee's self-assessment and record their judgement on the trainee's performance in the Educational Supervisors Report, with commentary.

The ES will make an entrustment decision for each CiP and practical procedure and record the indicative level of supervision required with detailed comments to justify their entrustment decision. A scale shown in Table 1 will be used to assess the CiPs and practical procedures, reflecting the need for supervisors to make entrustment decisions about the ability of learners to take on the particular responsibilities or tasks described in the CiPs/practical procedure, and the level of supervision that they require, as appropriate to their stage of training.

Level	Descriptors	
1	Entrusted to act with direct supervision	The supervising doctor is physically present and immediately available to provide direct supervision
2	Entrusted to act with indirect/minimal supervision	The supervising doctor is not physically present within department but is available to provide advice and can attend physically if required to provide direct supervision
3	Entrusted to act unsupervised	The learner is working independently

Table 1: Level descriptors for the CiPs and practical procedures

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5.4 Critical progression points

A critical progression point is a point in a curriculum where a learner transitions to higher levels of professional responsibility or enters a new or specialist area of practice. These transitions are often associated with an increase in potential risk to patients, so they need to be carefully managed and decisions to progress need to be based on robust evidence of satisfactory performance.

Learners undertaking the credential will be entering training with different skills and knowledge. The majority will be doctors on the GP register who display a wide range of knowledge, skills, behaviours, and attributes, reflecting the broad nature of General Practice. The credential curriculum will add further breadth and depth. They will develop expertise in a range of practical procedures and be adept at the management of complex situations in hospitals, and at the interface between primary and secondary care. These core areas will ensure that doctors can provide safe care whilst working on a range of challenging and diverse clinical situations, balancing acute and routine service provision, in a rural and remote context.

The Rural and Remote Health Credential Curriculum is outcomes-based. Progression will therefore depend on capability rather than time. Attainment of the competencies may accordingly be achieved at different times depending on clinical placements as well as pre-credential experience and training.

Excellence by design defines critical progression points as those at which a learner transitions to higher levels of professional responsibility, often associated with an increase in potential risk to patients or those in training. The credential has two critical progression points:

1. The first critical progression point will be at the end of year 1. It is essential that the learner is working at level 3 entrustment for all three generic CiPs and clinical CiP 2 (the management of time-critical medical & surgical presentations) and lifesaving practical procedural skills (see User Guide Decision Aid for details).

2. The second critical progression point is at the end of year 2 when the trainee must be signed off as level 3 competent for all generic and clinical CiPs and practical procedures.

Transitions and the crossing of thresholds are about taking on new responsibilities with a higher degree of independence. Knowing whether a learner is ready to do so is complex. It requires a clear working knowledge of the responsibilities involved. These responsibilities are articulated for each procedural skill and capability in practice (CiPs) in the credential curriculum document. The workplace-based assessment approach prepares learners for thresholds in training. To that end, assessments in the workplace are also aligned to entrustment/independence.

The expectation of learners is detailed in the credential entrustment scale (see section 5.3). This ensures that the requirements are transparent and explicit for all – learners, trainers and the public. Making these expectations transparent for learners is one of the ways the assessment scheme is designed to foster self-regulating learners.

The outline grid below sets out the expected level of supervision and entrustment for the Clinical CiPs and the critical progression points for the programme.

Capability in Practice	Year 1	Critical Progression	Year 2	Critical Progression
Generic				
1. Able to work as a rural and remote Practitioners within NHS system	3			
2. Adapting practice to Urgent Care Settings	3			

3. Facilitate effective and safe handover of patients to specialist services	3			
Clinical				
1. Recognise and appropriately manage acute paediatric presentations	2 or 3		3	
2. Management of the time-critical presentation/condition (medical and surgical)	3		3	
3. Assessment and initial of the trauma patient	2 or 3		3	
4. Ability to evaluate and appropriately manage core ear, nose and throat (ENT) presentations	2 or 3		3	
5. Ability to evaluate and appropriately manage the patient presenting with acute eye problems	2 or 3		3	
6. Ability to assess and manage appropriately core obstetric and gynaecology presentations	2 or 3		3	
7.Evaluate and appropriately manage the patient with acute psychiatric presentation including overdose	2 or 3		3	
8.Management of patients requiring palliative and end of life care	2 or 3		3	
9. Evaluation and management of the older person	2 or 3		3	

Table 2: Critical Progression Points

5.5 Evidence of progression

The following methods of assessment will provide evidence of progression against each CiP and practical procedure.

Summative assessments	
Workplace-based assessments	• Direct Observation of Procedural Skills (DOPS) -summative
	• Portfolio – logbook of cases/ reflections
Formative workplace-based assessments	
Supervised Learning Events	• Acute Care Assessment Tool (ACAT) • Case-Based Discussion (CbD) • Mini-clinical Evaluation Exercise (Mini-CEX) • Direct Observation of Procedural Skills (DOPS) -formative
Global assessments	
• Multiple Clinician Report (MCR) – per placement • Educational Supervisor Report (ESR) – quarterly • Clinical Supervisor – End of Placement Report (CS-EPR)) • Multi-Source Feedback (MSF) – minimum one in twelve months	

Assessment should be recorded in the learner's Portfolio. These methods include feedback opportunities as an integral part of the programme of assessment.

5.5.1 Summative assessments

- Direct Observation of Procedural Skills (DOPS) – summative
  A learner can be regarded as competent to perform a procedure independently after they have been signed off as independent and able to deal with complications by the required number of appropriate assessors (summative assessment).

5.5.2 Formative assessments

- Acute Care Assessment Tool (ACAT)
  The ACAT is designed to assess and facilitate feedback on a doctor's performance during their practice on the acute take. Any doctor who has been responsible for the supervision of the acute take can be the assessor for an ACAT. This tool can also be used to assess other situations where a learner is interacting with a number of different patients (e.g., acute receiving or a ward round).

- Case-based Discussion (CbD)
  The CbD assesses the performance of a learner in their management of a patient to provide an indication of competence in areas such as clinical reasoning, decision-making and application of medical knowledge in relation to patient care. It also serves as a method to document conversations about, and presentations of, cases by learners. The CbD should focus on a written record such as written case notes.

- Mini-Clinical Evaluation Exercise (mini-CEX)
  This tool assesses part of a clinical encounter (history, physical examination, explanation and counselling) 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 learner is observed and receives immediate feedback to aid learning. The mini-CEX can be used at any time and in any setting when there is a learner and patient interaction, and an assessor is available.

- Direct Observation of Procedural Skills (DOPS)
  A DOPS is an assessment tool designed to evaluate the performance of a learner in undertaking a practical procedure, against a structured checklist. The learner receives immediate feedback to identify strengths and areas for development. DOPS can be undertaken as many times as the trainee and their supervisor feel is necessary (formative assessment).

5.5.3 Global assessments

- Multiple Clinician Report (MCR)
  The MCR captures the views of clinical supervisors based on observation of a learner's practice. The MCR feedback and comments received give valuable insight into how well the learner is performing, highlighting areas of excellence and areas of support required. MCR feedback will be available to the learner and contribute to the educational supervisor's report.

- Clinical Supervisor - End of Placement Report (CS-EPR)
  There will be some aspects of training that cannot be met in the locality and the learner will be required to undertake blocks of supervised time in specialist centres or unit.

  In order to ensure that assessments are conducted consistently and fairly, the knowledge, skills and attitudes for each Capability in Practice are outlined in detail (see section 3.2). The clinical supervisor overseeing the training is responsible for completing a clinical supervisor's report, using evidence collected by the learner and feedback provided in the form of MCR and MSF. The report will include the entrustment decision for the relevant learning outcome/Capability in Practice.

  The suggested evidence to inform entrustment decisions is listed for each Capability in Practice in the assessment blueprint. It is, however, critical that trainers appreciate that learners do not need to present every piece of evidence listed, the list is not exhaustive and other evidence may be equally valid.

- Educational Supervisor Report (ESR)
  The educational supervisor will periodically (at least annually) draw together the results of a learner's educational activities to give an overview of their progress in a formal structured educational supervisor's report. The overall judgment of a learner will include a triangulated view of the doctor's performance, which will include their participation in educational activities, appraisals, the assessment process and recording of this in the e-portfolio. The educational supervisor's report can incorporate commentary or reports from longitudinal observations, such as from supervisors or formative assessments demonstrating progress over time.

- Multi-source feedback (MSF)
  This tool is a method of assessing generic skills such as communication, leadership, team working, reliability, across the domains of Good Medical Practice. This provides systematic collection and feedback of performance data on a learner, derived from a number of colleagues. 'Raters' are individuals with whom the learner works, and include doctors, administrative staff, and other allied professionals.

  The recommended mix of raters is:
  - 2-4 senior doctors across a range of specialties with who the learner works regularly
  - 2-4 doctors in training
  - 2-4 nurses
  - 2-4 allied health professionals
  - 2-4 other team members including clerical staff

  The learner will not see the individual responses by raters. Feedback is given to the learner by the educational supervisor.

5.5.4 Assessment blueprints

Table 3 shows the possible methods of assessment for each CiP and procedures. It is not expected that every method will be used for each capability and additional evidence may be used to help make a judgement on entrustment.

Although the credential has no tick list of evidence, it is important for the learner to show their development as a self-regulating learner by recording and reflecting on

evidence in each of the Capabilities**.** Engagement in training is very important and a marker of a learner who is seeking to develop beyond their current capabilities and is a key principle that underpins the ethos of assessment in the workplace.

Evidence / Capabilities	Mini-CEX	ACAT	CbD	DOPs	MSF	MCR	CS-ESR	ESR
Generic CiP 1: Able to work as a rural and remote practitioner within NHS system	X	X	X		X	X	X	X
Generic CiP 2: Adapt practice to Urgent Care Setting	X	X	X		X	X	X	X
Generic CiP 3: Facilitate effective handover of patient to specialist services	X	X	X		X	X	X	X
Clinical CiP 1: Recognise and appropriately manage acute paediatric presentations	X	X	X		X	X	X	X
Clinical CiP 2: Management of time- critical presentations/conditions (Medical and Surgical)	X	X	X		X	X	X	X
Clinical CiP 3: Assessment and initial management of the trauma patient	X	X	X		X	X	X	X
Clinical CiP 4: Ability to assess and appropriately manage core ENT presentations	X	X	X		X	X	X	X
Clinical CIP 5: Ability to evaluate and appropriately manage the patient presenting with acute eye problems	X	X	X		X	X	X	X
Clinical CIP 6: Ability to assess and manage appropriately core obstetric and gynaecology presentations	X	X	X		X	X	X	X
Clinical CiP 7: Evaluate and appropriately manage the patient with acute psychiatric presentation including overdose	X	X	X		X	X	X	X
Clinical CIP 8: Evaluation and management of the older person	X	X	X		X	X	X	X
Clinical CiP 9: Management of patients requiring palliative and end of life care	X	X	X		X	X		X
Resuscitation capability				X				
Practical procedures				X				

Table 3: Blueprint of workplace-based assessments to CiPs and procedural skills

5.5.5 Number of workplace-based assessments

There are no fixed numerical targets for any of the competencies related to the generic or specialist capabilities, but rather the learner should demonstrate attainment of high-level outcomes and have robust MCR, ESR and MSF to convey confidence in their clinical decision making and overall performance.

The timeline shown in table 4 illustrates how these assessments will be typically used at 12-month training period.

		Month of training											
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Formative assessment	Learner meets with named ES to identify learning needs	To be collected during placements			*	To be collected during placements			*	To be collected during placements			*
Summative DOPs													
Portfolio		To be kept during training											
CS- EPR		Recommended at the end of each placement											
MCR		Recommended at the end of each placement											
MSF		Recommended at the end of each placement											
Logbook review by ES													
Quarterly ES report													
End of year ES report													**

Table 4: Timeline of assessments

Note:

*Assessment tools will be used when clinically appropriate to help guide the educational needs of the learner as they progress through placements and learn to perform novel procedures. Generally, learners will be expected to submit a minimum of:

- One ACAT
- One CbD
- One Mini-CEX
- One DOPS

For each quarterly review as evidence of training progress

**Learner may be signed of at 12- or 24-month review dependant on progress against the credential curriculum.

5.6 Decision on progress

To ensure consistency of standards and impartiality in this new learning programme, the review of learners following the credential programme will be carried out by the UK Rural and Remote Credential Panel. The Credential Panel will meet at least twice a year to enable timely review of learners who have started training at different times and will be progressing at different rates.

The evidence to be reviewed by the Credential Panel should be collected in the learner's portfolio. This process will be used to integrate and systematically review evidence about a learner's performance and progress to facilitate decisions regarding progression through the credential programme, as well as identifying any requirements for targeted or additional training where necessary.

In accordance with GMC requirements, the Academy of Medical Royal Colleges, Colleges and Faculties have developed assessment strategies that are blueprinted against the curricula approved by the GMC and the requirements of the GMC's standards in Good Medical Practice.

It is up to the learner to ensure that the documentary evidence that is submitted is complete.

The purpose of the Credential Panel is to review the evidence and to assess competence and acquisition of required capabilities that inform a judgement of meeting credential specific requirements, which is captured as an outcome. The Credential Panel upon review of evidence submitted by the learner can award the following outcomes (see Appendix A):

Outcome	Descriptor
Outcome 1	Satisfactory progress - achieving progress and the development of credential competences at the expected rate and entry into second year of training.
Outcome 2	Development of specific credential competences still required – additional training time not required.
Outcome 3	Insufficient progress – additional training time required *.
Outcome 4	Released from credential programme - with or without specified capabilities **.
Outcome 5	Incomplete evidence presented – An assessment of progression cannot be made.
Outcome 6	Recommendation for completion of training - gained all required capabilities. Recommendation for credential award.
No review	There are circumstances when a Credential Panel is not able to recommend an outcome. For example, if the learner is absent due to statutory leave. In these cases, the Credential Panel will record the reason why no credential outcome could be recommended.

Table 5: Credential Panel review - learner route outcomes

The credential outcomes are based on Annual Review of Competency (ARCP) outcomes. For more information in relation to ARCP outcomes, please consult Gold Guide version 9.

*Conditional progress into the next stage of training: The UK Rural and Remote Credential Panel will make specific recommendations to the learner, their Educational Supervisor and

the Credential Development Body who will then work together to formulate an action plan to address deficiencies in performance. The action plan should be shared with the Credential Panel Board and progress will be re-assessed at next UK Rural and Remote Credential Panel review.

**Release from the programme: insufficient and sustained lack of progress despite usually having had additional training to address concerns.

For outcomes related to the recognition route please refer to the Credential Specific Guidance document.

5.7 Credential sign-off process

Recognising the heterogeneity of credential entrants, it is estimated that the curriculum may take up to 2 years to complete.

The second critical progression point in the credential marks the end of training and if all credential requirements are met the award of the credential is recommended.

On completion of the credential the learners are expected to have:

- Met the level descriptors described in each Capability in Practice (section 3.2) and be entrusted to act unsupervised (see section 5.3) **and**
- Obtained simulated or applied clinical competencies for all the procedures (section 3.3)

If the learner has met the credential requirements the UK Rural and Remote Credential Panel will recommend signoff and award of the credential.

6. Feedback, supervision, and appraisal

6.1 Feedback

Effective feedback is known to enhance learning and combining self-reflection[10] with feedback promotes deeper learning. Learners are encouraged to seek feedback, either informally, through verbal feedback at the end of a learning event, or formally through workplace-based assessments. The MCR and use of the CiP and GPC descriptors provide regular opportunities for detailed and specific feedback.

Opportunities for feedback will arise during workplace-based assessments, and through discussions with supervisors, trainers, assessors, and those within the wider multi-disciplinary team. Learner reflection is an important part of the feedback process and exploration of that reflection with the trainer should be a two-way dialogue.

Recognising the heterogeneity of credential entrants, learner's self-assessment is essential as it provides a regular opportunity for focused and structured reflection and development of self-directed goals for learning as well as developing these goals through dialogue with trainers.

[10] Improving feedback and reflection to improve learning. A practical guide for trainees and trainers

Constructive feedback is expected to include three elements:

1. A reflection on performance
2. Identification of the trainee's achievements, challenges and needs
3. An action plan

Opportunities for feedback include:

- Following Workplace Based Assessments - WPBA provides a structure for observing the individualised and contextualised application of learning. By incorporating feedback into WPBA and encouraging reflection it helps learners develop self-regulated learning skills. The WPBA programme is designed to be used throughout training, and so offers the opportunity for developmental feedback, and in doing so shape further learning.

  The learner's reflection, assessor's feedback and the learning and development plan will all be recorded on the appropriate WPBA form and should be stored in the personal portfolio as evidence of the learner's progress and engagement with the learning progress.

- Regular education and clinical supervisors' reviews - The educational supervisor will provide feedback in a structured Educational Supervisors Report (ESR) prior to progression review by the UK Rural and Remote Credential Panel, as well as through discussion with the learner at their quarterly review meetings.

  The clinical supervisor will usually be the clinician to whom a learner is directly responsible for their clinical work and there will be frequent contact between them. They will review the learner's practice throughout training and will provide constructive feedback in a variety of ways. These include:

  - Induction and end of placement review for each element of training
  - Formal meetings with the learner to discuss progress and learning needs
  - Oral and written feedback as part of workplace-based assessment
  - Formal end of post review in the form of the ESR and/or CS-EPR
  - Informal feedback on the learner's day-to-day clinical and professional work.

- Feedback from the wider team - Learners will receive ongoing informal feedback from other team members in a variety of roles during training and are also encouraged to seek patient feedback. They will also receive feedback from the wider team through WPBA and multisource feedback (MSF).

6.2 Supervision

Supervision is fundamental in the delivery of safe and effective training. It takes advantage of the experience, knowledge and skills of expert clinicians and ensures interaction between an experienced clinician and a learner. Supervision is designed to ensure the safety of the patient by encouraging safe and effective practice and professional conduct. The level of supervision will vary depending on the experience of the learner and the type of clinical exposure. As training progresses, the learner should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient.

Each learner must have access to a named clinical supervisor and a named educational supervisor. It is preferred that a learner has a single named educational supervisor for the duration of training. For this credential:

- The educational supervisor should be a clinician working in remote and rural context or have a detailed working knowledge of this area of practice.
- The clinical supervisor will change during the training and will usually be the clinician to whom a learner is directly responsible for that element of training.

The first year in the credential may be difficult for some learners, especially if they have come from a non-rural and remote background, or not previously been based in a rural practice or hospital. Supervisors are encouraged to offer advice, a mentor system, and a counselling service during the year.

The following principles should be acknowledged:

- The learner should meet with their clinical and educational supervisors at the start of their appointment, and again after four months. These meetings should be documented in the portfolio.
- The learner's practice must be supervised, and patient safety is of paramount importance. Such aspects are monitored by the clinical supervisor and documented in the portfolio. Formal mechanisms for feeding back any concerns raised by the clinical supervisor, to the learner, and the educational supervisor, should be in place.
- Learners must work with a level of clinical supervision commensurate with their clinical experience and level of competence. This is the responsibility of the relevant clinical supervisor after discussion with the learner's educational supervisor. In keeping with the principles of Good Medical Practice, learners should know that they must limit their clinical practice to within their level of clinical competence and seek help and support without hesitation.
- Learners should receive support to be able to achieve the requirements of the credential curriculum.
- Learners should feel that they are valued members of the healthcare team, receive appropriate and timely induction into the learning environment, named clinical and educational supervisors and understand their role and the context of their placement.

The role and responsibilities of supervisors have been defined by the GMC in their standards for medical education and training[11]. Educational and clinical supervisors need to be formally recognised by the GMC to carry out their roles.

6.2.1 Educational supervision

An educational supervisor must be appropriately trained for the role, familiar with the curriculum and have demonstrated an interest and ability in teaching, training, assessing and appraising. For this credential the educational supervisor should be a clinician working in remote and rural context or have a detailed working knowledge of this area of practice. They should have gained skills equivalent to courses such as Training the Trainer offered by an appropriate educational institution and must keep up to date with developments in training, including equality and diversity training. They must have appropriate access to teaching

[11] Promoting excellence: standards for medical education and training (gmc-uk.org)

resources and time for training allocated to their job plan (approx. 0.25 PA per learner).

The educational supervisor will:

- Ensure that the programme is appropriate for the learner's needs.
- Be responsible for the learner's educational agreement.
- Help the learner by reviewing their learning needs in the light of achieved goals.
- Carry out and/or collate assessments from clinical supervisors, trainers and other assessors.
- Have a good understanding of the credential curriculum and review the learner's portfolio of evidence against the curriculum.
- Give supportive feedback.
- Have a good understanding of what is acceptable progress and complete a supervisor's report at the appropriate times prior to the progression.
- Support the learner through any difficulty.
- Inform the clinical director, head of service or medical director and those responsible for training, of serious weaknesses in their learner's performance that have not been dealt with.
- Inform the learner the content of any information about them that is given to someone else.
- Ensure that all training opportunities meet the requirements of equality and diversity legislation.

The educational supervisor, when meeting with the learner, should discuss issues of clinical governance, risk management and the report of any untoward clinical incidents involving the learner. If the clinical supervisor should have any concerns about the performance of the trainee, or if issues of doctor or patient safety have arisen, these would be discussed with both the learner and the educational supervisor. In turn, the educational supervisor may consult with the learner and their Responsible Officer. These processes, which are integral to learner development, must not detract from the statutory duty of the employer to deliver effective clinical governance through its management systems.

6.2.2 Clinical supervision

Clinical supervisors are responsible for the day-to-day supervision in the clinical setting. Clinical supervisors integrate learning with service provision by enabling learners to learn by taking responsibility for patient management within the parameters of good clinical governance and safety. A learner may be allocated (for instance, if they are not working with their educational supervisor in a particular placement) a named clinical supervisor, who is responsible for reviewing the learner's training and progress during a particular placement.

Local education providers must ensure that clinical supervisors have adequate support and resources to undertake their training role. This will include training in equality and diversity.

The clinical supervisor is responsible for:

- Ensuring that their credential learners are never put in a situation where they are asked to work beyond their competence without appropriate support and supervision. Patient safety must always be paramount.
- Guaranteeing suitable induction to the department.
- Meeting with the learner at appropriate points in the training pathway to discuss what is expected, learning opportunities available and the learner's training needs.
- Agreeing how the learning objectives for this period of training will be met and confirming how formative feedback and summative judgements will be made.
- Ensuring that the clinical experience available to the learner is appropriate and properly supervised.
- Ensuring that all training opportunities meet the requirements of equality and diversity legislation.
- Monitoring, supporting, and assessing the learner's day-to-day clinical and professional work.
- Providing regular feedback on the learner's performance.
- Undertaking and facilitating WPBA.
- Contribute to MCR.
- Allowing the learner to give feedback on the experience, quality of training and supervision provided.
- Discussing serious concerns with the educational supervisor about a learner's performance, health, or conduct.
- Meeting with the learner to assess whether they have met the necessary outcomes and completing an end of post review form for each post.

6.2.3 Learners

Learners should make the safety of patients their priority and they should not be practising in clinical scenarios which are beyond their experiences and competencies without supervision. Learners should actively devise individual learning goals in discussion with their trainers and should subsequently identify the appropriate opportunities to achieve said learning goals. Learners would need to plan their WPBAs accordingly to enable their WPBAs to collectively provide a picture of their development during a training period. Learners should actively seek guidance from their trainers to identify the appropriate learning opportunities and plan the appropriate frequencies and types of WPBAs according to their individual learning needs. It is the responsibility of the learner to seek feedback following learning opportunities and WPBAs. Learners should self-reflect and self-evaluate regularly with the aid of feedback. Furthermore, trainees should formulate action plans with further learning goals in discussion with their trainers.

6.3 Review and Appraisal

All learners should undergo an annual appraisal as required for NHS professionals as part of the revalidation process. Appraisal should be conducted under the auspices of the parent specialty but must cover the full scope of practice and consider the learner's time training in the credential. In addition to the formal appraisal process, learners will

undertake regular and formal reviews of progress against the credential curriculum. This process ensures adequate supervision during training, provides continuity between different elements of training and different supervisors, and is one of the main ways of providing feedback to learners. Arranging a review is primarily the responsibility of the learner. A “typical” year of appraisals involving both clinical and educational supervisors as well as review of progress by the UK Rural and Remote Credential Panel is detailed below in table 6. All appraisals should be recorded in the portfolio.

Months / Review	Pre-start	1	2	3	4	5	6	7	8	9	10	11	12
Clinical Supervision		Ongoing review as part of clinical placements Clinical supervisor may change throughout the 12 months											
Educational Supervision		Meet to agree learning needs											End of year review
UK Rural and Remote Credential Panel	Agree meets entry requirements												Review of evidence and ESR *

Table 6: Review timetable

Note: * At the 12-month national panel review the credential learner will either commence year 2 of learning or be recommended for sign off and credential reward.

6.3.1 Educational supervisor: annual induction meeting

When learners start in a new indicative training year following a successful review, they must arrange a meeting with their educational supervisor. The induction appraisal is an essential starting point for negotiating educational goals and discussing learning opportunities, the assessment process and use of the portfolio. This forms the basis for the educational agreement between the educational supervisor and learner.

6.3.2 Clinical supervisor: induction meeting

When learners start a new element of training (for example, undertaking a period of training in a specialist unit), they must arrange a meeting with their clinical supervisor. Discussions should cover the educational objectives for the upcoming period of training.

6.3.3 Clinical supervisor: end of placement review

Towards the end of a period of training/placement, the learner and clinical supervisor will meet again. They will review results of assessments made during the period covered. This process will involve review of comments from colleagues who have observed the learner's performance in practice and/or in individual assessments. If the educational supervisor is different to the clinical supervisor, there should be a robust communication system to ensure a continuous, appropriate, and timely flow of evidence.

6.3.4 Educational Supervisor: quarterly review

A quarterly review with the educational supervisor is an opportunity to look at the learner's progress against the agreed educational objectives within the portfolio.

6.3.5 End of training year review

The results of educational activities for an indicative year of training in the credential will be drawn together and included in a formal structured Educational Supervisor's Report. This will cover the overall performance of the learner in all elements of training in the credential. The overall judgment of a learner, and the educational supervisor's recommendations of satisfactory progress, will be based on a triangulated view of the learner's performance. The outcome of the final appraisal discussion should be agreed by both the learner and the educational supervisor and recorded in the structured supervisor's report in the portfolio.

At the end of each training year, the UK Rural and Remote Credential Panel will review the evidence collected by the learner as well as well as the ESR. A decision on the learner's progress will be made. If the learner has been deemed to meet the curricular requirements, they will be recommended for signoff and credential award. See section 5.6 for Credential Panel outcomes.

7. Quality management

7.1 Quality assurance

The credential curriculum has been written with the intention that it meets the GMC's "Excellence by Design" standards.

Educational and clinical supervisors are expected to be formally recognised by the GMC to carry out their roles. The GMC criteria for trainer recognition comprise seven areas:

- Ensuring safe and effective patient care through training
- Establishing and maintaining an environment for learning
- Teaching and facilitating learning
- Enhancing learning through assessment
- Supporting and monitoring educational progress
- Guiding personal and professional development
- Continuing professional development as an educator.

The curriculum development references and embeds:

- Good Medical Practice
- Promoting Excellence: standards for medical education and training
- Improving feedback and reflection to improve learning. A practical guide for trainees and trainers
- The Gold Guide
- General Professional Capabilities Framework.

7.2 Credential-specific quality assurance activities

By engaging with stakeholders, learners and trainers, NHS Education for Scotland will normally carry out a review of the credential every 5 years, or more frequently if appropriate. The purpose of the review is to ensure the credential maintains relevance and reflects current practice and service requirements.

NHS Education Scotland as the statutory and awarding body has two distinct roles and as such two distinct governance lines:

1. Credential Development Body (CDB), which sits within the Centre for Remote and Rural Health. The centre sits within NHS Education for Scotland and leads on all remote and rural health policy and programmes. The centre is funded by the Scottish Government.
2. Credential Delivery Team (CDT), which sits within the NES Medical Directorate Training Programme Management Team, who deliver ARCP for all speciality training.

7.2.1 Quality Assurance responsibilities of Credential Development Body

- Data monitoring**:** NES will monitor use of the portfolio to understand use of assessments and other activities. This will only be to consider patterns of use, not to review the content of individual assessment forms etc.
- Advise on and support the management and delivery of the Credential to standards set by the GMC's Promoting Excellence.
- Surveys**:** Annual surveys to learners and trainers to track improvements or areas of the curriculum that are consistently problematic.
- Curriculum review process**:** By engaging with stakeholders, learners and trainers, the UK Rural and Remote Credential Panel with the assistance of the CDB will carry out a full-scale review of the credential every 5 years. The purpose of the review is to ensure the credential is relevant and reflects current practice.

  The Credential Development Body will:

1. Advise the Credential Delivery Team on the appropriate composition of panels.
2. In line with GMC guidance provide representation on the credential panel.
3. Provides guidance on indicative evidence that may demonstrate completion of the outcomes to meet the requirements of the credential via the recognition route.
4. Appoint an individual (Associate Postgraduate Dean – development):
   4.1 To work with the doctor seeking to be awarded the credential via the recognition route to identify and recommend the evidence that they would need in order to demonstrate their capabilities.

4.2 Provide advice to the Credential Panel on whether the doctor meets the recognition route outcomes.

7.2.2 Quality Assurance responsibilities of Credential Delivery Team

- Progression reviews: to ensure consistency of standards of the credential programme, a review of doctors following this programme will be carried out by the Credential Panel. The panel will meet at least twice a year.
- Oversee quality management and improvement in training posts related to the credential and act as a conduit of information sharing with trainees in other postgraduate training programmes to promote good practice. Conduct and analysis of annual trainee and trainer surveys.
- Evaluate strategies to reduce differential attainment in achieving credential outcomes and ultimate credential award.
- Receive and consider concerns raised regarding the learning environment, method of assessment or curriculum.
- Visits to training sites: the panel may choose to visit sites where credential learners are being trained. Such visits would include meetings with learners and trainers and review of facilities.

The Credential Delivery Team will:

1. Identify members and arrange panels, with advice from the CDB.
2. Determine appropriate processes and appoint panel chairs.
3. Be responsible for decisions about the operational management of sign-off panels, following the same principles used for annual review of competence progression (ARCP) panels.
4. In line with GMC guidance provide representation on the credential panel.
5. Take responsibility for delivery of training - this will involve approval of programmes and sites, where the credential training route is separate from existing postgraduate training programmes.
6. Manage any appeals process based on a panel recommendation.

7.2.3 UK Rural and Remote Credential Panel

To ensure consistency of standards and impartiality in this new programme, the review of learners following the credential programme will be carried out by the UK Rural and Remote Credential Panel. The Credential Panel will meet at least twice a year to enable timely review of learners who have started training at different times and will be progressing at different rates.

The Credential Panel will provide overall governance of the following:

- Make decisions on progression through the credential programme, similar to the Annual Review of Competence Progression (ARCP) process provided in the Gold Guide 9th Edition (see appendix A).

7.3 Additional governance - external review of credential

Although the teams for development and delivery will be split within NES it is acknowledged that there could still be a perceived conflict of interest with this arrangement. To address this, it is proposed that we link with a Royal College that is

developing another early adopter credential to share best practice around governance of the programme and for them to act as an informal external auditor for the programme. This could be a reciprocal agreement across Credentialling Development Bodies to provide consistency and transparency.

7.4 Raising concerns

Any concerns regarding the learning environment, method of assessment, or curriculum can be raised to the UK Rural and Remote Credential Panel. This clear route for learners, supervisors, and employers to raise concerns will ensure that any issues are addressed in an appropriate manner depending on their severity. The UK Rural and Remote Credential Panel will be sited on issues and can build these into quality improvement initiatives and credential review process.

The UK Rural and Remote Credential Panel will report any findings, quality improvement plans and potential curricular changes to the Statutory Education Body, NES.

7.5 Equality and diversity

NHS Education for Scotland has considered the equality impact of the curriculum on the remote and rural population, and on the doctors who will undertake it.

Research on the inequalities faced by lesser heard voices in rural and remote communities has centred on LGBTIQ+ people, disabled people, ethnic minorities and carers. The proportion of disabled people it does not vary consistently with the level of rurality of domicile. Conversely, only 0.4% of rural and remote populations identify as ethnic minorities, compared with 6.7% in urban areas. Carers are evenly distributed between urban and rural environments, but limitations in health service provision affects recruitment and retention. Health inequalities for the LGBTIQ+ rural population are well recognised and are in part a consequence of fragility in health services. This credential, and its curriculum, will support the planning, delivery, and sustainability of clinical care in these communities and to the lesser heard voices[12].

While this curriculum is not applicable to doctors in conventional postgraduate training programmes, the principles within the GMC guidance “Welcomed and Valued” have informed the approach. An example includes the iterative removal and revision of redundant aspects of earlier components of the curriculum, such that the final curriculum only contains the crucial aspects required to maintain patient safety. The curriculum also makes ample provision for effective feedback and iterative dialogue between learner and supervisor.

NHS Education for Scotland and employers will comply, and ensure compliance, with the requirements of equality and diversity legislation set out in the Equality Act 2010.

The employing organisation for each credential learner is expected to ensure that those in their employment are covered by the local equality and diversity standards and that these are applied to the recruitment process as well as for the duration of training.

Compliance with anti-discriminatory practice will be assured either by the employing organisation or by NHS Education Scotland through:

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[12] Inclusive participation in rural Scotland: research report - gov.scot (www.gov.scot)

- Monitoring of recruitment processes.
- Working with the other UK statutory education bodies, it will ensure that educational and clinical supervisors have all undergone the necessary training to comply with these requirements as set out by the GMC.
- Ensuring that individuals participating in learner interview/appointments committees or processes has had equality and diversity training every 3 years.
- Recognising the distinctive context of Rural and Remote practice, it will also ensure that trainees have access to the necessary training, guidance, and support to ensure that they are effectively supported.
- Ensuring learners have an appropriate, confidential, and supportive route to report examples of inappropriate behaviour of a discriminatory nature. Learners will be made aware of the route in which inappropriate or discriminatory behaviour can be reported.
- Ensuring all assessments discriminate on objective and appropriate criteria and do not unfairly advantage or disadvantage a trainee with any of the Equality Act 2010 protected characteristics. All efforts shall be made to ensure the participation of people with a disability in training through reasonable adjustments.
- The UK Rural and Remote Credential Panel will include lay and learner representation.

8. Appendices

Appendix A. Progression review process

The process for reviewing learners' performance and making decisions on their progression through the credential programme will be very similar to the Annual Review of Competence Progression (ARCP) process that trainees in specialty training programmes undergo. Unlike ARCPs however, the reviews will be carried out by a UK Rural and Remote Credential Panel. It will be in addition to the local annual appraisal process.

The UK Rural and Remote Credential Panel will ensure that a consistent standard is applied to all learners across all training locations. It will be wholly independent of the individual learner's training location thereby ensuring impartiality and avoiding decisions on progression being made by the same people responsible for the training of any individual learner. All members of the Credential Panel will be sought and appointed by NES. Additional expertise may be sought for the Panel if required. Credential Panel members will be given any necessary training (including equality and diversity training) and will be fully briefed on the curriculum and the requirements within it.

The UK Rural and Remote Credential Panel will be organised and hosted by NES and administrative support will be provided by a member of NES staff.

The UK Rural and Remote Credential Panel will consist of the following:

- Representative from NES, statutory body for the credential
- Representatives from the four nations
- Lay representative

Frequency of UK Rural and Remote Credential Panel reviews

The Credential Panel will meet twice a year to enable timely review of learners who have started training at different times and will be progressing at different rates. It is anticipated that the Credential panel will meet virtually, although members may meet in person on occasions.

Duties of the of UK Rural and Remote Credential Panel

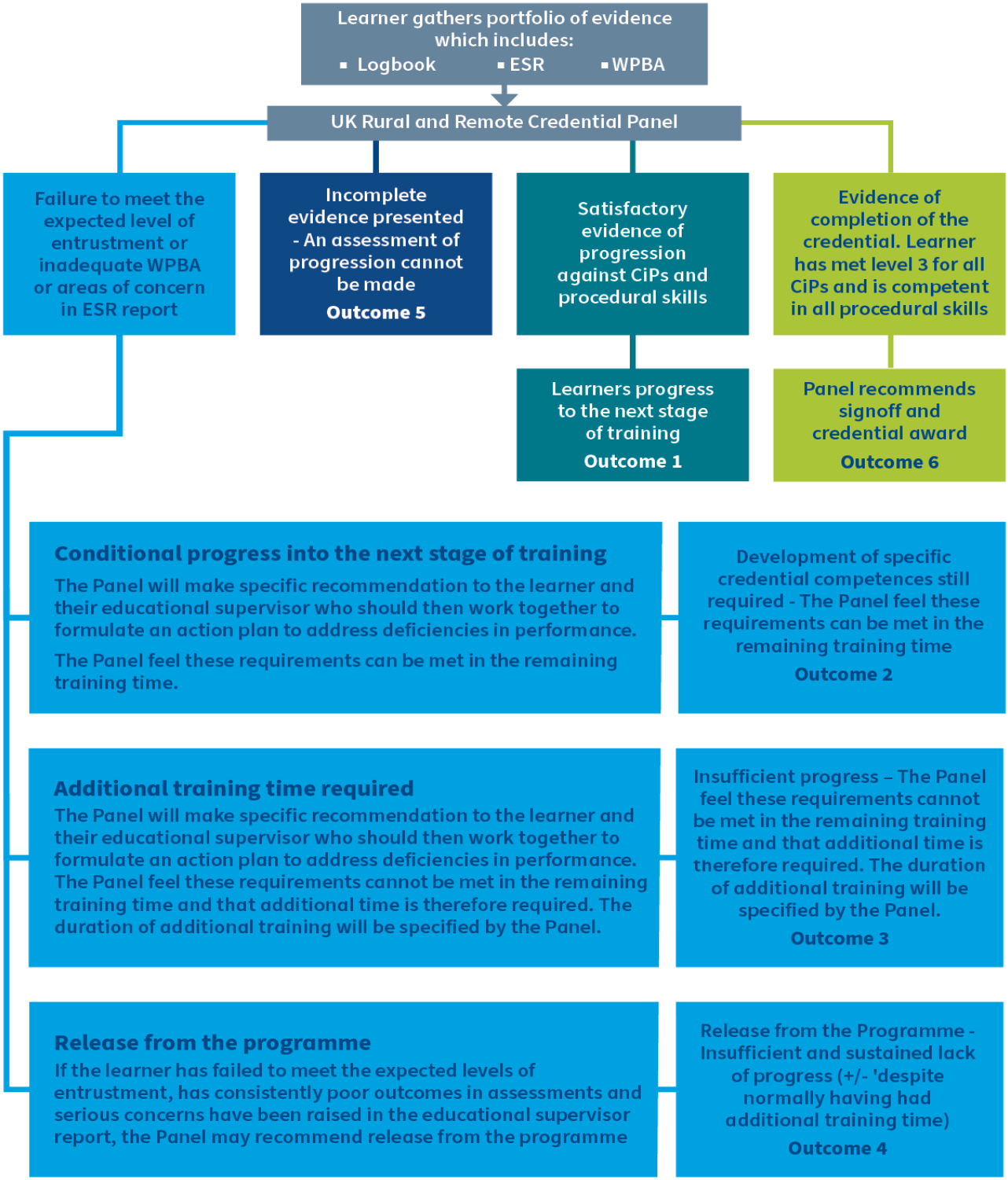
The Credential Panel will systematically review evidence about a learner's performance to facilitate decisions regarding progression through training, as well as identifying any requirements for targeted or additional training where necessary.

All necessary evidence for the UK Rural and Remote Credential Panel to review must be collected in the learner's portfolio and will include the following:

- Educational supervisor's structured report
- Workplace based assessments
- Logbooks

Appeals

If a learner wishes to appeal against a decision of the UK Rural and Remote Credential panel, an independent panel will be convened to review the evidence. The appeal panel will have a similar constitution to the review panel but with different individuals.



There are circumstances when a Credential Panel is not able to recommend an outcome. For example if the learner is absent due to statutory leave. In these cases, the Credential Panel will record the reason why no credential outcome could be recommended

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Appendix B. Glossary of terms

Abbreviation	Definition
ABG	Arterial Blood Gas
ACAT	Acute Care Assessment Tool
ALS	Advanced Life Support
CbD	Case-based Discussions
CCT	Certificate of Completion of Training
CDB	Credential Development Body
CDT	Credential Delivery Team
CiPs	Capabilities in Practice
CPAP	Continuous positive airway pressure
CPR	Cardiopulmonary resuscitation
DOPS	Direct observation of procedural skills
E-LfH	E-Learning for Healthcare
ENT	Ear, Nose, Throat
ES	Educational Supervisors
ESR	Educational Supervisors Report
GMC	General Medical Council
GMP	Good Medical Practice
GPC	Generic Professional Capabilities
MCR	Multiple Clinician Report
Mini-CEX	Mini- Clinical Examination
MSF	Multi-Source Feedback
NES	NHS Education for Scotland
OOH	Out of Hours
WPBA	Workplace Based Assessment

This resource may be made available, in full or summary form, in alternative formats and community languages. Please contact us on **0131 656 3200** or email **altformats@nes.scot.nhs.uk** to discuss how we can best meet your requirements.

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