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NHS Foundation Trust

Crossing the Rubicon: How to achieve a CESR in Emergency Medicine

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Table of Contents

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1. Introduction

"This is the cost of living your life and doing things on your own terms" said my wife to me once when I was moaning, for the umpteenth time, about the endless requirements of the Certificate of Eligibility for Specialist Registration (CESR) process. Whilst there were opportunities for me to enter formal training, I think that anyone who attempts a CESR in emergency medicine has had a life story or journey that has made conventional entry onto the specialist register unfeasible. That such people have these differing life narratives can only ultimately serve to strengthen the depth of clinical and human experience that we enjoy in our chosen profession and we neglect the career progression of those that do not or cannot enter conventional training at our own peril…

I have been encouraged to write this piece as there has been a lot of interest amongst the number of non-trainees and also emergency department leads in finding means or a framework to tackle the often daunting task of a CESR. Whilst there is no magic formula to make the process easy, there is no doubt that the accumulation and organisation of this evidence can be made simpler if one follows the old maxim that in order to eat an elephant, it requires that one start with the first mouthful and then proceed one mouthful at a time… Whilst I, myself, have never eaten a whole elephant, I am in a position to say that the CESR process contains certain parallels in its size and the length of time it takes to 'eat' it. As such those attempting it require patience, good humour and a few tools that I have attempted to outline in the following document.

The main aim of this document is to create a framework that will allow potential candidates to navigate their way through a CESR application such that the process becomes less opaque and those who have previously felt intimidated by the sheer weight of evidence a CESR seems to require can take hope, strategize, and commence the process of getting on to the specialist register. I have drawn heavily on the work of Dan Boden who has already set up a comprehensive non-

training grade programme in Derby, replete with checklists and recommendations, for the kind of evidence that will be required for a CESR. Many people including myself are indebted to Dan for the commitment he has shown to Staff and Associated Specialist Grade (SASG) and non-training doctors.

This piece of work is more of a 'How To' guide but it is not a guaranteed formula nor, is it officially sanctioned by either the Royal College of Emergency Medicine (RCEM)or the General Medical Council (GMC). What I have written is drawn from my own experiences, opinions and reflections from having completed the CESR process. People may, at some point, find evidence contrary to what is contained herein and I would encourage you to contact me as this is a work in progress and relies on the collaboration of others.

Nothing would be complete without a little comment on the dense bureaucratic framework that underpins the CESR process. It may feel like you have, at times, stepped into the horror of a Kafka novel but I do believe that the framework exists in order to ensure that the public (and the profession) are protected from charlatans – of which there have been a few noted examples over the years!

Reform of the process is underway and as of November 8th 2018, the process has finally switched from a paper to an electronic submission! In addition, document 'validation' which was the process of having to get nearly every piece of paper you submitted stamped and signed by a consultant is out and has been substituted by the 'verification' process which will nominates a single person at a site to review and vouch for the authenticity of your evidence. The CESR process is evolving and iterative and my thinking is that it would be better to engage and have a voice than to continue to remain on the outside and be roundly ignored…

1.1 The structure of the document

This document has been structured to firstly outline some general considerations when contemplating the CESR route. I have tried to clarify what sort of attributes a candidate will need to have both as a doctor and as a person that might increase the chances of a successful CESR application.

From there, I have given an overview of the content of a CESR and what to expect once one gives formal notification to the GMC of one's intention to submit evidence. It will set out some rough timelines around the process and deal with what happens if you are not successful the first time around.

The third section provides a suggested toolkit that you will need when you start the CESR process. Some of the tools may seem rather obvious, but it is amazing how much time I wasted on certain aspects of evidence collection, which would, in hindsight, have been much easier if I had just had the right tools!

Following on from this I have added some suggestions on aspects of the Specialty Specific Guidance (SSG). I have tried to signpost to useful links as well as clarify what kind of evidence to collect and how to present it. I have gone into greater detail in areas that I found personally challenging.

There is a brief section on people who have already completed a post-graduate training programme in emergency medicine abroad with a focus on Australian and New Zealand EM physicians. I will add to this section over time as the network of overseas CESR applicants grows.

Finally, this document contains a section for trainers about how to support and manage candidates during this process: how to facilitate the specialities exposure, where to direct trainees on the GMC and RCEM websites and how to mentor them through a process that few people understand!

2. Personal Considerations

There are no rules about who can or cannot attempt to get onto the specialist register by a CESR application. Nevertheless, there are some factors that are worth bearing in mind before you decide that the CESR route is right for you. I really do not wish to discourage anyone, but it is a big commitment and you should go in with your eyes wide open!

2.1 Is it important enough to you?

The first question you should ask is 'Why do I want to be on the specialist register?' Some staff grades or associate specialists will feel that their current remuneration and job plans are such that the added bother of CESR entry onto the specialist register is not worth it. Without a relatively clear idea of why you want to be on the specialist register be it the extra money, the prestige or the opportunity to enact big changes, then your focus and motivation will get quickly bogged down by the onerous task of a compiling the evidence. Having said that, the process of undertaking a CESR is actually quite a good way of focusing one's career, starting with an honest appraisal of where one is, and where one would ultimately like to be – personal quality improvement project if you like!

2.2 Why Not Conventional Training?

The reasons for choosing CESR over a CCT are multiple, but generally the doctors that decide to undertake a CESR will fall into a few different categories:

- Consultants who have already trained in other countries and now wish to work as consultants in the UK.
- Staff grade or Associate Specialist doctors that have been working in departments for a long time who wish to develop their careers.

- Doctors who have established their lives in one place and do not wish to move around for training. They may have families, other interests or even careers that make rotation based training unattractive.
- Doctors who have left core training and wish to pursue other interests but are now returning to certain departments that can offer a 'higher training' type programme with a route to CESR.

The CESR route has obvious benefits for some people, but it is important to consider the alternatives before deciding. The CCT training route will offer you a set programme, a designated educational supervisor, Annual Reviews of Competence Progression (ARCP) and a road map towards your eventual entry onto the specialist register; these are the sorts of things you are unlikely to have if you decide to go the CESR route.

2.3 Do you have competence in the specialities related to emergency medicine?

It will help if you have high quality evidence of your competence in the specialities relevant to emergency medicine. As we shall discuss later, this is not a pre-requisite, but experience in the past 5 years of anaesthetics, intensive care, paediatric emergency medicine and acute medicine will definitely decrease the amount of time that it will take to complete the process. The specialty specific guidance (SSG) for emergency medicine has been updated to reflect the amount of time you need in the associated speciality to meet the standard required for a CESR. Please read it!

2.4 Are you organised enough?

Be organised! This process in long and no one will be breathing down your neck telling you to get on with it. There is no formalised ARCP process that will ensure

that you, the candidate, are progressing adequately. If you are the kind of person that leaves everything to the last minute, then stop being that person because it won't work! There are no deadlines other than the ultimate submission dates set when you trigger the CESR process and submit your evidence. In the toolkit I recommend that you put together a project plan for the CESR together with important dates, secondments, courses and exams. A real sense of achievement and satisfaction will come from checking things off your list and will give you a sense of control over the evidence mountain!

2.5 Who is going to support you?

Have a good relationship with your department, previous departments and, most of all, with your current clinical lead… The quality of your relationships will be of untold benefit when you are feeling low and the whole CESR thing seems a bit overwhelming. You will rely on the consultants that know you to write your references, and, whilst the current CESR requirements regarding evidence verification remain, your consultant colleagues will need to spend a significant amount of time reading through and confirming that the evidence is legitimate!

2.6 Can you do this as a locum?

Please note the last point – don't be a full time locum! The opportunities to obtain good quality evidence, particularly in domain 2 (safety and quality), will be very challenging and the chance that you will have the support of the department or departments in which you work will be minimal.

2.7 Prospective or Retrospective?

The decision to undertake a CESR will be made exponentially easier if you decide several years in advance that you wish to go that particular route. In my particular case, I applied 4 years after moving to the UK with the express

purpose of getting a CESR in EM. I really had very little idea of what this actually meant until I sat down and looked in detail at the speciality specific guidance (SSG) in early 2017. On reflection, my life would have been made much easier if I had been constantly referencing the SSG and collecting and filing my evidence against the outlined domains. This would have saved me a lot of time searching through 5 years of emails, my personal drive on the hospital intranet and 2 trips to Ireland to get about a thousand of pieces of paper validated!

3. The CESR Process and how it works

In order to be eligible to apply for CESR, you must have either 6 months of continuous Specialist training in EM (Foundation training doesn't count), or a Specialist qualification in EM that could have been obtained in the UK or elsewhere. You will then need to provide sufficient evidence for the four domains of good clinical practice as outlined by the GMC[1]. These are variously:

- Domain 1: Knowledge skills and performance
- Domain 2: Safety and quality
- Domain 3: Communication, partnership and teamwork
- Domain 4: Maintaining trust

Note that with the new curriculum in 2020 and the move to Generic Professional Capabilities (GPC), this will mean that the structure of CESR applications will need to change – the current 4 domain approach will cease to apply and whilst the kind of evidence that you will be expected to provide will be broadly similar, the framework and filing will inevitably change. However, the current 4 domain structure will continue for at least the next 2 years. These 4 domains have further subsections under which you can submit evidence.

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3.1 Domain 1: Knowledge Skills and Performance

Qualifications

- Primary Medical Qualifications
- Specialist Medical Qualifications
- Curriculum undertaken (if overseas)
- Honours and Prizes

Assessments and Appraisals

- Assessments and Appraisals
- RITAs, ARCPs and Training Assessments
- 360 and Multi-source Feedback
- Awards and Discretionary Points Letters
- Personal Development Plans (PDP)

Logbooks, records of daily clinical practice and portfolios

- Logbooks
- Consolidation, cumulative data sheets, summary lists and annual caseload statistics
- Medical Reports
- Case Histories
- Referral Letters discussing patient handling
- Patient Lists
- Departmental (or trust) workload and annual caseload statistics
- Rotas, timetables and job plans
- Courses relevant to the curriculum
- Portfolios (electronic or revalidation)

Details of Posts and Duties

- Employment Letters and Contracts of Employment

- Job descriptions
- Job plans

Research, Publications and Presentations

- Research papers, grant, patent designs
- Publications within speciality field
- Presentations, poster presentations

Continuous Professional Development, Continuous Medical Education

- CPD record certificates, certificates of attendance, workshops and at local, national and international meetings or conferences
- CPD registration points from UK Medical Royal College (or equivalent body overseas)
- Membership of professional bodies and organisations

Teaching and Training

- Teaching timetables
- Lectures
- Feedback from those taught
- Letters from colleagues
- Attendance at a teaching or appraisal course
- Participation in assessment or appraisal and appointments processes

3.2 Domain 2: Safety and Quality

Participation in audit, service improvement

- Audits undertaken by Applicant
- Reflective Diaries
- Service Improvement and clinical governance activities

Safety

- Health and Safety

3.3 Domain 3: Communication, Partnership and Teamwork

Communication

- Colleagues
- Patients

Partnership and Teamwork

- Working in multi-disciplinary teams
- Management and leadership experience
- Chairing meetings and leading projects

3.4 Domain 4: Maintaining Trust

Acting with Honesty and Integrity

- Honesty and integrity
- Equality and human rights
- Data protection

Relationships with patients

- Testimonials and letters from colleagues
- Thank you letters or cards from colleagues and patients
- Complaints and responses to complaints

So in total there are 49 subsections across the 4 domains that you will need to provide evidence against. The kind of information that will be required for each of these subsections is outlined in the speciality specific guidance (SSG) that can be accessed on the following link https://www.gmc-uk.org/-/media/documents/sat---ssg---emergency-medicine---dc2293_pdf-

48457724.pdf [2]. For anyone wishing to undertake the CESR process, the SSG is undoubtedly the best point of departure. The document is long (32 pages), but there is little point in deciding to do a CESR unless you think you have – or will have - the evidence to file under all the categories and subcategories outlined in it. It is important to have the vast majority of the evidence to hand once this process is triggered. What follows is an explanation of the application process.

3.5 The Application Process

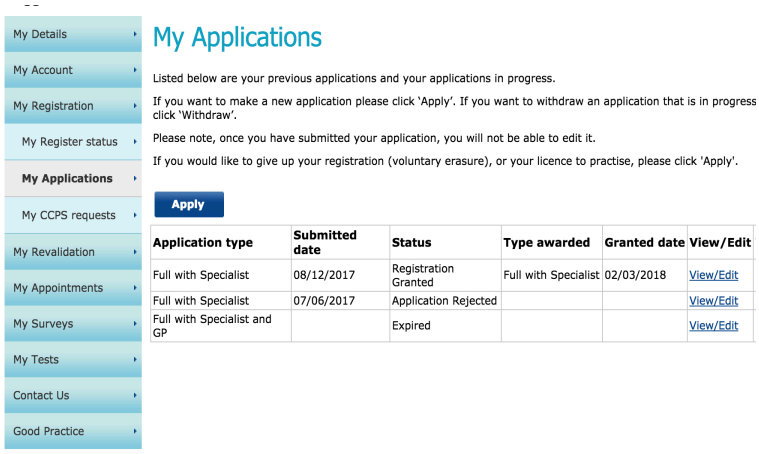
The decision to trigger your intention to apply for a CESR should really only happen when you feel you have enough evidence to apply for a CESR or will have enough evidence within a year. As mentioned earlier, the electronic submission of evidence now allows you a year to upload your evidence which is a very welcome development. Nevertheless, I still think it is important that you feel you have enough experience and evidence to complete the CESR process before you apply - the deadlines are tight and you do not want to be caught out by missing crucial pieces of evidence with a month to go.

If you are not sure if you are at the point at which you have enough evidence, then the GMC have explained how the process here: https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/specialist-application-guides/specialist-registration-cesr-or-cegpr/how-do-i-list-my-evidence. Within in this link is perhaps the most important user guide you will require for the submission process – it is clear and easy to use: https://www.gmc-uk.org/-/media/documents/sat---cesr-cegpr-online-application---user-guide---dc11550-76194730.pdf.

When the time comes for you to apply for your CESR, you will need to have a GMC online account. This link explains how to get a GMC online account, if you don't already have one.
https://www.gmc-uk.org/doctors/information_for_doctors/gmc_online.asp [3] .

process works as follows:

- Log in to GMC online
- Click on 'My Registration' and then on 'My Applications' as outlined in the picture below and then click on 'apply'



- The further steps are outlined about how to upload your evidence are outlined on the same link I included above but here it is again! https://www.gmc-uk.org/-/media/documents/sat---cesr-cegpr-online-application---user-guide---dc11550-76194730.pdf
- Once you are ready to fully submit, you will be taken to the payment page where you will need to pay the full amount which as of December 2018 is £1600.
- A member of the specialist applications team will review the initial application and they will provide with you, within 30 days, information about you application outlining what evidence they have accepted, which evidence has been rejected and what extra evidence you might want to submit to strengthen your application.
- You will then have a further 60 days you have to address the deficiencies of the application and submit outstanding evidence.

- You will then get notification from the GMC of their receipt of the evidence and be informed of their intention to submit it for review by the RCEM.
- The RCEM has a 36 working-day SLA to provide the GMC with an evaluation of the application and a recommendation to grant or refuse CESR. The GMC have a 3-month legal deadline, following submission of the application to RCEM, to issue a final decision as to whether or not CESR can be granted. If your CESR application is successful, then you will be added to the specialist register. If not, you can choose to either challenge the outcome by means of an appeal, or you can opt for a review of the application within 12 months of the decision.
- The review process is outlined in the next section.

3.6 Review of the Application

If you have been unsuccessful in your original CESR application as described above, you have the following 2 options:

- to appeal that verdict of the GMC or
- to apply for a review.

The review process is actually quite simple and does not involve you having to resubmit all your evidence. Typically what occurs, is that you are given a report back on your application by means of an excel checklist. In the checklist the assessors outline how they think that you have met the various requirements with an overall judgement on whether you have met the requirements in each domain. You cannot be admitted to the specialist register if you have failed to meet the overall requirement in each domain. The assessors will then issue a recommendation or list recommendations of what evidence you will need to submit in the review in order to satisfy the requirements for specialist registration.

In my case, for example, I was initially issued with a rejection of my application on the grounds that I had failed to provide evidence of the second cycle of an

audit. There was a single recommendation that I carry out the second cycle of an audit and then resubmit. This was straightforward enough and I after this evidence had been accepted and reviewed, I was granted entry onto the register.

Should this happen to you, the process then goes as follows:

- Log in to the GMC online portal.
- Trigger the application review process.
- The GMC then issue you with a checklist that typically will ask for an updated CV and then ask you about which evidence you intend to submit to meet the outstanding recommendations of your application.
- You fill this out, pay £695 and then, once again, you will need to submit the evidence to support the review as per the electronic submission process outlined above.
- The GMC review the application once again and provide you with more time to submit evidence if they feel it is lacking.
- Once then GMC and you are satisfied that you have enough evidence, then they will submit to the RCEM.
- The RCEM have 36 working days to review the application and issue their recommendation to the GMC.
- The RCEM issue their decision to the GMC who issue the final decision within the 3 month deadline.

If the outcome of your review is successful then you will be granted entry to the specialist register and if it is unsuccessful you have the right to appeal. The important thing to note, is that if your review is unsuccessful, you will have to start the CESR application from scratch. This means that it is really worth taking the time to be absolutely sure that you have enough information and the right kind of information on your review to increase the odds of them accepting the review.

3.7 Tips on the Application Process

3.7.1 Get the input of someone who has done it before!

I have mentioned before and need to stress that it is really important that you have a good idea that you have or will have enough evidence within the year of you finally submitting your application. It would be worth sitting down with someone who has gone through the process before to broadly review your evidence prior to submission. I have left my contact details at the end and will always be happy to answer your queries on this process, but you will be better off finding someone that you can talk to in person. I would suggest that you do some homework by asking your consultant colleagues if they know anyone who could help you in this regard.

3.7.2 Primary versus Secondary Evidence

The easiest way to think of this is that the evidence that you have generated yourself is the 'primary evidence' for example work based assessments, lectures you have given, posters presented, project reports you have written, e-learning modules that you have undertaken. 'Secondary evidence' on the other hand is more the verification of the 'primary evidence' for example an email confirmation of the date you were meant to deliver teaching, a conference programme that lists your poster abstract, minutes from the meetings you have attended, feedback on the teaching you delivered.

You really need both the primary and secondary evidence for the CESR process as the assessors are looking to 'triangulate' between:

- What you say you did (CV and online application)
- What primary evidence there is for your claim
- What secondary evidence can confirm that

Sometimes there is no source of 'primary evidence' for example if you have not kept contemporaneous log books of the patients you have seen, then you may need to rely on letters from consultants attesting to the case mix in the department as well as your role and seniority then cross-reference the IT printout of all the patients you have seen as a surrogate. There are numerous instances where you have to use the SSG guidance and then think, in the absence of good quality primary evidence, what good secondary sources you could use to adequately fulfil the CESR requirement. Note, however, that secondary evidence cannot replace WBAs.

3.7.3 Narrative is key!

Once you have your primary and secondary evidence, you will still need to explain how it meets the requirement. It will also become obvious to you very early on, that there is a lot of cross over in the information that you need to provide under the different headings. For example the information that is contained under 'job description' may include a review of the department in which you are working with respect to annual attendances, the population served, the staffing of the department and so forth but this evidence could quite equally be useful under a separate section such as 'departmental or trust caseload statistics'.

Your job is to clearly explain how the evidence submitted maps to the various domains and sub-domains throughout the online application process and later on when the GMC sends you their initial checklist (see below under 'The Application Process). The initial checklist comes as a long excel spread sheet and looks like this:

Dr William Niven - 7430152

Name: Dr William Niven	GMC Number	7430152	Application ID:	A1-1586929153
CESR in CCT specialty: Emergency medicine			Curriculum version: Emergency medicine 2015	
Link to curriculum that application will be assessed against: http://www.gmc-uk.org/education/emergency_medicine.asp				
Link to specialty specific guidance: http://www.gmc-uk.org/SGPC___SSG___Emergency_Medicine___DC2293.pdf_48457724.pdf				
Check for minimum requirements:	**CESR (CCT specialty)** - Applicant must have completed either a specialist postgraduate qualification or minimum of six months training in the CCT specialty they apply for. Training and/or qualifications can be from anywhere in the world.			
	CESR (non-CCT specialty) - Applicant must have completed either a specialist postgraduate qualification or minimum of six months specialist training in any non-CCT specialty. The training and/or qualification must be from outside the UK.			
State training post and/or qualification that fulfils minimum requirements or comment to applicant on what is needed to confirm eligibility:			SMQ = Fellowship of the Royal College of Emergency Medicine (FRCEM); SMT = various EM registrar posts, Ireland; SHO Ireland	
Evidence Item	**Submitted Evidence**	**Status**	**Notes**	**Re-submitted Evidence**
Application Form				
All posts since PMQ are listed Posts held match CV and employment letters		**Pending further information**	Accepted: - CV: although I have accepted your CV, please could you send an updated version - or just the relevant updated page(s) - to include your employment gap 06/04/2010-07/01/2011. I have also noticed that your email contact details differ on your CV to that we hold on our records - please could you update either your CV or the details we hold on record via your GMC online account. **Please note the information in your CV, application form and evidence must all match.**	

As you can see there are a number of columns that relate to the evidence item, the evidence you submitted, whether or not they have accepted, rejected or returned it, some explanatory notes and then a space for you to provide your response.

The trick in these cases is to provide sign posting for the person who will review your application at the GMC and the RCEM. It is worth remembering, that the application will be voluminous and contain a huge amount of information. The more you describe your evidence and how it fulfils the stated requirements, the easier it will be for the reviewers to navigate your application. What may seem obvious to you as the person providing the information will not necessarily be apparent to those people that have to review it. There is a specific area in the checklist that is provided for you to make comments about how you are meeting the evidence requirements for each section. It is imperative that you take advantage of it!

3.7.4 It will take time – be patient!

The process does take time, even once you have submitted your evidence. I submitted my evidence in June of 2017 but only received an answer in early December. My final review came back in the middle of March 2018! Take heart, it is a long process and worrying about the final verdict is pointless – it will not change it or make its arrival any quicker!

Phoning the GMC or RCEM will also not make the process any quicker. There are legislated time lines on the applications process and they will not be able to give you any commentary on whether your application is likely to pass or fail on legal grounds.

4. A CESR Toolkit

Before you get started, you need a toolkit to will make you life easier.

In your toolkit you will require the following:

Table 1: CESR Toolkit

A Hospital Stamp and a nominated verifier.	Previously every page of your evidence with the exception of CPD and your CV needed to be stamped with a departmental stamp. The good news is that this has now changed and you will need to nominate a verifying consultant for each trust you have worked in and are submitting evidence for. The hospital stamp will be required for some documents, but the way it now works, is outlined in the following link: https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/how-to-verify-evidence-for-specialist-and-gp-applications The link contains all the necessary forms and is very clear on which evidence requires authentication, verification or neither. It also gives guidance for the verifying consultant.
An online electronic repository for evidence: e.g Dropbox, google drive or a spread-sheet for your evidence	As the submission will be in electronic format, it would be a good idea to create an online repository of electronic evidence. You could then file your evidence under a number of sub-folders which will make the uploading much easier when it comes to submitting the evidence to the GMC. If you are not into something that 'tech' then create an excel spread-sheet under the headings outlined in the SSG and list your evidence together with an explanation as to how it meets the requirements of the SSG.
Project plan	Doing a project plan for your CESR! This is good experience for the quality improvement project that you will be undertaking! The sorts of things that you should include are projected date of submission, important milestones such as exams, necessary certification such as ALS/ultrasound, secondments and planned training reviews. A project plan will help to provide structure to your progression and could potentially be submitted as evidence of self management – a domain of good medical practice!
2 Box files (if submitting hard copy evidence)	If you are submitting your evidence in hard copy, the application needs to be filed as stacks of paper with the dividers that the GMC will post to you. You can use a punch initially and file your evidence conventionally, but I would suggest that you rather use plastic sleeves so that your

	evidence does not get damaged. Hard copy submissions of the sort that I submitted will become obsolete in the next couple of years.
Post it notes	Whilst you can initially file information in a lever arch file, you will need to eventually stack it in the method outlined above. It should come to about 1500-2000 pages. For this reason when you 'un-file' your evidence and then need to slot in another piece of evidence to this great big mass of paper you will want some colourful reminders to help you navigate!
e-Portfolio	The e-Portfolio is the best virtual tool currently available for helping you to organise your evidence and provide a clear, coherent record of your competencies in emergency medicine. If you are not already a member of the RCEM, you can register through the RCEM website as an associate member. At last check the cost of membership was £290 but this will give you access to the e-portfolio and RCEM learning. The following link will give you information on membership subscriptions: http://www.rcem.ac.uk/RCEM/Membership/Subscription_Information/RCEM/Contact_Management/Subscription_Information.aspx?hkey=f2c14198-19f1-43e6-bb66-7640672f4399 For queries on the e-portfolio call the RCEM on 020 7404 1999 and press option 2 'Training and ePortfolio' which will put you through to an advisor.
Educational /Clinical Supervisor	Having an educational supervisor is important, as that person will provide a vital resource in terms of directing and mentoring you through your progress in the CESR process. Structured training reports can be filled out at 6-12monthly periods and are a good source of evidence in the 'appraisals' section of Domain 1.
A heavy black marker for redaction	I went through about 5 different marker pens before I found one that actually was able to remove all traces of patient identifiable information. It may sound silly, but I have spoken to colleagues who can attest to having had documents handed back as a result of patient information still being visible. The GMC take this seriously, so get your redaction right! Here is a link to an Amazon product. https://www.amazon.co.uk/Redacting-Blackout-Private-Information-Markers/dp/B01I2706FG
PDF redaction tools	See point above – unfortunately you will need to download the software from the internet in order to do this redaction. If

	you have a lot of PDF documents in your application then this will be a good investment.
A basic knowledge of spread-sheets	Excel spread-sheets are often the raw material that patient lists are presented on. Knowing how to create a pivot table will make your life easier: https://www.youtube.com/watch?v=YxKaJP8I-mA [4]
A printer set to print on one side!	The requirement for you to print ALL your evidence has now largely diseappeared unless you have submitted your application before November 2018. If you are still submitting hard copy evidence I suggest you set it to print your evidence on one side as two-sided evidence may be returned to you. The reason, is that your application will have hundreds of pages that the GMC assessors will feed through a scanner and create a giant PDF that they will then review.

5. Approach to Evidence Collection

5.1 Domain 1: Knowledge Skills and Performance

This is by far the biggest of the 4 domains and the one in which you are most likely to get bogged down. Domain 1 contains 34 of the 49 subsections, so once you have sorted this bit out, you are three quarters of the way there!

The first big step is to show that you have covered the curriculum and have attained the level of competence expected of a consultant. The common question that is asked at this point is 'How do I provide evidence that I have covered the curriculum?' There answer is basically to use the same tools that are used by trainees variously:

- Work Based Assessments (WBAs)
- E-learning
- Teaching on curriculum mapped topics
- Reflective practice

If you are using the e-portfolio, then you will see that the curriculum is split into two main parts including the "Core Competencies" that cover the first three years of emergency medicine training and the "Higher Competencies" which cover the final three. The core and higher curricula are then further subdivided into three sections including: major presentations, acute presentations and procedures.

If you are doing your WBAs via the e-portfolio then you can 'link' these to various parts of the curriculum enabling you to see how you are progressing through the curriculum. Equally, e-learning certificates, teaching presentations and reflective practice can also be linked to the various competencies. You will need to evidence both the core as well as the higher curriculum. Unfortunately, once you have fully evidenced your competencies, you will then have to download, print it all off and then have it verified as per GMC guidance. It is still preferable to do your WBAs electronically than via paper, as the electronic versions are harder to lose, are easy to 'link' and give a much better idea of how you are progressing through the curriculum. The RCEM has created a competence versus evidence document that you can also use to monitor your progress. http://www.rcem.ac.uk/RCEM/Exams_Training/CESR_Article_14/RCEM/Exams_Training/CESR_Article_14_/CESR_Article_14.aspx?hkey=d2295381-d328-4fe1-a59e-7e6322c06212 [5]

Work based assessments are also required for the other relevant specialities including: Acute Medicine, Anaesthetics, Intensive Care Medicine and Paediatric Emergency Medicine. This is often a stumbling block for people wishing to do a CESR as the placements are often difficult to come by and the funding for the placements can be contentious. I have made a couple of suggestions for how this might be fixed in the 'trainers section' at the end of this document, but for now here is some general guidance for each of the specialities as suggested by Dr Dan Boden of Royal Derbyshire Hospitals.

Acute Medicine

- 6/12 previous experience with evidence (WBAs) of necessary skills and experience
  OR
- 3/12 secondment during which all WBA's covering the Acute Medicine mandatory presentations and procedures are completed. (see page 13 for further details)

ICU Medicine

- 3/12 previous experience as a trainee with evidence (WBAs) of necessary skills and experience AND a logbook of the basic competencies in ICM as set out by the Royal College of Anaesthetists (RCoA).
  OR
- 3/12 secondment during which all WBA's covering the mandatory presentations and procedures must be completed AND completion of a logbook of basic competencies in ICM as per RCoA. (see page 16/17). This secondment should be full time or six months part time.

Anaesthetics

- 3/12 previous experience as an anaesthetic trainee including the initial assessment of competence.
  OR
- 3/12 secondment during which all WBA's covering the mandatory presentations and procedures must be completed AND completion of a logbook of basic competencies in Anaesthetics as per RCoA. (see page 14/15). This secondment should be full time or six months part time.

Paediatric Emergency Medicine

- 6/12 in previous Paediatric/ PEM training post with WBA's.
  OR
- 3/12 secondment and WBAs for all paediatric major and acute presentations (see page 20/21). This secondment should be full time or six months part time.

The most recent SSG https://www.gmc-uk.org/-/media/documents/sat---ssg---emergency-medicine---dc2293_pdf-48457724.pdf has outlined on page 12 the suggested minimum number of work based assessments (WBAs) that will be

required for your CESR application. What follows is a summary of the type of WBAs that you need to acquaint yourself with.

5.1.1 Assessments and Appraisals

5.1.1.1 Work Based Assessments

Work based assessments are a fundamental pillar of evidence for a successful CESR submission. They are considered high quality evidence and testament to an applicant's ability to function at the expected level of a consultant. One of the best pieces of advice that I ever got was from my friend and colleague Helen Cugnoni, who told me that I should get as many of those work based assessments as I could! At the time, I was living in Ireland and didn't have the first clue what she meant by this, but I obediently went to the then College of Emergency Medicine Website and found out for myself what these work based assessment things were.

Needless to say, I found the number and different types of work based assessment confusing, as I think most people do that are not accustomed to this particular form of assessment. When I was going through the WBAs from Ireland, prior to submission, I realised that I had about 20 DOPS officially labelled as 'Primary Assessment of the Airway' though not one of the cases described had anything to do with airway and one in particular described the assessment of a more inferiorly located orifice!

At last count there were about 30 different types of WBAs, but I think it is important to focus on a few as one attempts to evidence exposure and competence in the 'full breadth of the curriculum' as stated in the SSG. It is important that the people who fill out the WBAs are consultants as it is not enough to get colleagues or other registrars to fill them out. The minimum requirements for WBA's are summarised on page 12 of the SSG: https://www.gmc-uk.org/-/media/documents/sat---ssg---emergency-medicine-

--dc2293_pdf-48457724.pdf. The following is a summary of the important WBA's for the EM curriculum.

Case Based Discussion (CBD)

The main purpose of these assessments is for the candidate to take a case that they have been directly involved in, reflect on it and then discuss it with a consultant. You will require 6 CBDs over the past 3 years and, along with the mini-CEX described below, you will need to cover the 6 major presentations for adults and children (4 adult and 2 children) together with 6 acute presentations for adults and children (4 adults and 2 children).

Mini-CEX

A Mini-CEX stands for Clinical Evaluation Exercise and is designed to test the skills, attitudes and behaviours of a doctor in the setting of the clinical environment. Candidates will need Mini-CEXs specifically for the six major presentations in emergency medicine variously:

- Anaphylaxis
- Cardiorespiratory Arrest
- Major trauma
- Shock
- Sepsis
- The Unconscious Patient

Unlike the CBDs above, the Mini-CEX needs to be observed by the person who is filling the form. They will not, otherwise, be in a position to observe and provide vital feedback on the behaviours that you exhibit in the stressful situation. You will need a minimum of 6 mini-CEXs for your CESR application.

ACAT-EM

The Acute Care Assessment Tool (ACAT) is designed to test your ability to manage a range of cases during a clinical shift. It's original purpose was to assess doctors on traditional, medical ward rounds but the ACAT has been modified to

reflect the busy ED environment in which patients are often seen simultaneously and the case mix is more diverse. The ACAT requires more time to complete than CBDs or Mini-CEXs but, as it covers more presentations, it is a more efficient way of evidencing competencies in the curriculum. You will require at least three of these.

DOPS

Direct Observation of Practical Procedures are an opportunity to provide a record of your skills regarding the more hands on element of emergency medicine and its allied specialities. There are a lot of practical procedures that you are expected to provide evidence of competence in from the slightly ridiculous (intravenous cannulation) to the extremely rare (external pacing).

One of the requirements is to have a logbook in order to demonstrate the practical procedures you have completed. This is different from a DOPS because they do not have to be observed by a consultant. Once again you can log your procedures in the e-portfolio. You do not have to provide a DOPS for every practical procedure but the more you have the better. You will require six DOPS over the past three years.

ESLE

Extended Supervised Learning Event is the scariest but probably most useful WBA there is currently. During an ESLE, you will be followed around the department by a consultant with a clipboard. The consultant will make notes about your clinical performance, teaching and managerial style on the shop floor of the ED. These behaviours are then fed back to you afterwards in a debrief session. You should aim to have at least 2 ELSE's per year for 3 years.

This is obviously not everyone's cup of tea, but you will be required to submit evidence of 2 ESLEs per year for 3 years. ESLEs are a good indicator of engagement with the curriculum and often an invaluable tool to you as a doctor. I

genuinely wish that someone had done an ESLE for me at an early stage in my career - it could have rubbed a few abrasive edges off sooner!

Management Projects

Work based assessments that cover the Management Portfolio will be required as part of your evidence for the higher curriculum. You need evidence of at least four including the Managing a Complaint, Managing a Critical Incident and at a futher assignment that involves working with other specialities.

5.1.1.2 Appraisals

You should be engaged with the trust appraisal and revalidation system as per guidance from the GMC. Your annual appraisals should be printed off and validated. It is obviously both challenging and annoying, that whilst you are trying to complete your e-portfolio, that you have to participate in the trust appraisal and revalidation process. If you are smart, you will create a series of folders in your e-portfolio that map to the domains of good clinical practice (GCP) under the 'personal library' section that will allow you to upload evidence that can simply be downloaded and transferred across for appraisal purposes.

5.1.1.3 ARCPs and Training Assessments

You may or may not have evidence of Annual Reviews of Competence Progression (ARCP). If you have done ACCS or other core training, these are good evidence as they are bench-marked assessments against a field of your peers. One of the real challenges when doing a CESR is not being aware of how you compare to other doctors in the speciality field. I hope that this will change as the CESR route becomes more defined, but in the interim, I suggest that you aim to meet at least 6 monthly with your educational supervisor to fill out a structured training report (STR). If it is possible, you should discuss with your ES about the possibility of having an annual ARCP with themselves and one or two other consultants. This is to allow you to benchmark your progress against trainees and you should use the ARCP checklists that are available on the RCEM website.

5.1.1.4 Multi-source Feedback (MSF)

MSF is a great tool to gain insight into the perceptions of your work colleagues as to how you operate in both a clinical and non-clinical environment. You should ideally be completing one of these a year either through the e-portfolio or through your trust appraisal system. You will need a minimum of 3 when it comes to applying for a CESR.

5.1.1.5 Personal Development Plans (PDP)

I used to look at personal development plans as a bit of a waste of time, but I have really taken to them as useful tools to see where it is that I am going and how it is that I wish to progress in my career. I think that I had 'Complete the CESR process' on as an annual objective since 2015 and it only actually came about on March 2nd 2018! However, given that the evidence required for a CESR is so great, you would do well to set yourself some defined objectives every few months to keep yourself on track.

The CESR process typically happens with bursts of energy in which you get a lot done combined with periods of boredom and frustration in which you question why in God's good name you are subjecting yourself to it!. Having a PDP that encompasses the principles of SMART (Specific, Measureable, Achievable, Reasonable, Time bound) objectives is an insurance policy against your natural apathy. Remember that the tortoise won the race and not the hare!

5.1.2 Logbooks, records of daily clinical practice and portfolios

I found this area of the CESR probably one of the most tedious and time consuming parts of the process. The purpose of this section is to show that you are have been working in an environment in which you see the entire breadth of the emergency medicine curriculum. You cannot expect to get a CESR in Emergency Medicine if you spend your days working nine to five in minor injuries!

It will make your life a lot easier if you get an early handle on the capabilities of the IT system in your trust. The reasons for this is that you will have a much better idea of what information they can and cannot get for you and if they do not hold it, you will need to get creative about how to evidence this requirement. The SSG clearly outlines that you should have a list of all the patients you have seen over the past 5 years under the following headings:

- Age
- Gender
- Date and Time Seen
- Presenting complaint
- Diagnosis
- Procedures performed
- Reflections on the case

In addition it would be a good idea to include another column with the curriculum number that the case maps to. It may not be possible to get a full five years of patient lists, and the most difficult part of the logbooks section to evidence is finding out what procedures were performed on each of the patients. I would suggest that you use the RCEM provided logbook in spread-sheet format on the following link https://www.rcem.ac.uk/RCEM/Exams_Training/CESR_Article_14/RCEM/Exam

s_Training/CESR_Article_14_/CESR_Article_14.aspx?hkey=d2295381-d328-4fe1-a59e-7e6322c06212. You do not have to do this for every patient you have seen over the past 5 years, but it would be useful if you could provide a logbook that showed a couple of hundred cases that mapped to the curriculum.

From personal experience, the system at my hospital was good enough to get information for the age, gender, date and time seen, presenting complaint and diagnosis. I was not able to get information on 'procedures performed', something I actually doubt the majority of trusts hold in a sufficiently digestible format for your purposes. My work around was to use the 'procedures log' in the e-portfolio and provide ample evidence of reflective notes – again using the e-portfolio structure. The take home message is that you have to work within the resource constraints of the trusts you have worked at. The GMC and RCEM are more likely to view your application sympathetically if you explain these constraints clearly and demonstrate what you have done to address them.

An example patient list could look like this:

Table 2: Logbook of Patient Seen by Dr SSG Caesar 01/01/2016 to 01/01/2019 at the Roman Royal Infirmary NHS trust

Site	Age	Gender	Date and Time Seen	Presenting Complaint/ curriculum number.	Diagnosis	Procedures Performed	Complications
RRI	72	F	2016/01/02 12:03	Chest pain/CAP7	ACS	ECG, troponin	VF arrest
RRI	2	M	2016/01/02 02:04	Cough/CAP6	Bronchitis	X-ray	Nil
RRI	10	M	2016/03/02 04:05	Testic. Pain/	Orchitis	Urinalysis	Nil

RRI	34	F	2016/04/02 05:07	Vag. Bleeding/CAP34	Threatened miscarriage	FBC, VBG, IV, US	Transfusion req.
RRI	19	M	2016/05/02 06:08	Arm injury/PP18	laceration	X-ray, sutures	Nil
RRI	61	F	2016/06/02 09:19	Syncope /CAP5	Pulmonary Embolus	ECG, VBG, CTPA	Nil
RRI	56	F	2016/06/02 07:35	Sepsis/CMP 4	ARDS	FBC, VBG, cultures, IV	Ventilator req.

5.1.2.2 Cumulative Data Sheets

If you do not know how to create a pivot table in excel, I suggest you learn now. I have provided a link to this in the 'toolkit' section. The reason it is important, is that by using a pivot table, you can summarise the number of patients you have seen with a particular curriculum presentation.

I had to manually check and refine the patient's presenting complaint and final diagnosis sections to match the RCEM curriculum items because the current SNOMED coding system allows too many options when doctors enter a discharge diagnosis. I had about 10 000 patients for a 4 year period that using a pivot table refined the diagnoses into 3000 categories. I then cross checked those 3000 patients and then recoded them in line with the curriculum presentations.
Thus for CAP presentation: limb swelling traumatic and atraumatic I included all patients with a diagnosis of 'ankle sprain, ankle pain, ankle injury, foot infection, cellulitis, elbow fracture etc. and I gave each of these diagnoses a unique curriculum identifier. I then created a pivot table in an excel spread-sheet and created a document that looked like this.

Table 3: Cumulative Data Sheet for Patients seen at the Homerton Hospital 2015-17

Presentation	RCEM Curriculum no.	Number seen
Cardio-respiratory Arrest	CMP2	205
Abdominal Pain and Swelling	CAP2	794
Aggressive and disturbed behaviour	CAP4	564

5.1.2.3 Medical Reports

You can use any police statements, coroner's statements or, if you are involved in medico-legal work any medical reports that you have created. The key here is to carefully redact any patient identifiable information as this will result in the assessors returning the evidence to you and possibly referring you to the GMC for breach of information governance principles! Refer to the earlier toolkit for electronic and paper redaction strategies.

5.1.2.4 Case Histories and Referral Letters discussing personal handling

You can use patient notes or grand rounds presentations as evidence in 'case histories' and any outpatient referral letters including discharge summaries can also be used as evidence of 'referral letters discussing personal handling'. The problem I see is that some trusts do not actually have referral privileges to outpatient clinics. This means that replies from outpatient clinics may be few and far between. Email chains are a good substitute for formal letters as these are relatively easier to come by. I used some email chains regarding a particular patient with sickle cell disease and a few other frequent attender conversations that I had had input to. And once again, don't forget to redact!

5.1.2.5 Departmental (or trust) workload and annual caseload statistics

When considering this section, a useful source of information is the annual report from the trust. In the majority of cases, a link to the annual report will be often be available on the trust website. Alternatively, there may be a description of the sort of your emergency department under the 'departments' section of the hospital intranet or a description of the department may be available on the original job application for the post in which you are currently working. You can download this and print the relevant pages to the emergency department making sure that you have stamped and validated each page!

This purpose of this particular section allows the applications manager to get an idea of the department you work in and whether or not your emergency department that sees the full spectrum of emergency medicine presentations. If your day job has been working in a minor injuries unit for the past 5 years then the exposure to the major presentations will be limited and this may prejudice the application. The sort of information you need are things like: The area served for example 'The London Borough of Hackney', the town of Bradford and an approximation of the total number of people in that area. You might want to include the number of beds in the emergency department in majors, resuscitation, minor injuries, urgent care as well as:

- Number of full time consultants
- The presence or absence of an observation unit and the number of beds
- Whether or not there is a specific paediatric area
- The number of annual attendances to the emergency department

It is a good idea to get this information from all the trusts that you have worked at for the past 5 to 6 years. In my case, this meant going back to Ireland and going to various human resources/medical manpower departments! If you are

working in the same trust for the past few years, getting this information will be much easier and you will not need to spend as much time as I did.

5.1.2.6 Rotas, timetables and job plans

Your work rota should not be difficult to get hold of, but you need to ensure that your name appears on the rota! The rationale for submitting this evidence is that it will help to communicate to your assessors the kind of work you undertake, whether you are in full time employment, what areas of the department you work in and what your non-clinical duties are.

My strategy was to copy my rotas across to a trust headed word document. If you have an 'example rota' that gives the generic shift patterns, shows when teaching times are and describes your clinical and non-clinical duties, you will be in possession of evidence gold!

Job plans may not be something you can easily get hold of unless you are a consultant or SASG doctor with a specific contract stipulating your duties and working patterns. A lot of job plans are now done electronically but most platforms have the capacity for you to download and print off the job plan. I don't think you need to worry if you do not have a documented job plan – a working timetable and rota may suffice – but I would say your priority should be to provide the assessors with a clear idea of what kind of work you are doing on a daily basis and how this proves that you have been effectively working as any other higher trainee would in your average DGH emergency department.

5.1.2.7 Courses relevant to the curriculum (including ultrasound)

The courses which you need to have and which must be in date are:

- ATLS (or ETC)
- APLS (or EPALS/EPLS)

- ALS (or ACLS)
- Level 3 child safeguarding
- Level 1 Ultrasound training

If you have instructor status and have done a general instructors course (GIC), then that is excellent evidence. Your GIC course will also provide evidence of having had some formal training in how to provide feedback and teaching which you should reference in the other section. You do not have to do MIMMS, but it is a good course that is labelled as 'desirable' on the SSG. This potential pitfall that you need to avoid, is being out of date during the application process – make sure you are well in date when you apply.

The ultrasound requirements for CESR applicants are the same as those for any other trainee. You need to have level 1 accreditation in order to get a CESR. The pathway for training has been outlined by on the RCEM website and here is a PDF link https://www.rcem.ac.uk/docs/Training/1.14.5 RCEM-EMUS-booklet (3).pdf.[6] In practical terms, you will be required to do the following:

- RCEM ultrasound learning modules of which there are currently six.
- A level 1 ultrasound course or local approved equivalent
- A logbook of supervised scans in each of the following: FAST, AAA and IVC, Focussed Echo in Life support and Ultrasound Guided Vascular Access. Whilst there is no absolute requirement for the number of supervised scans you need to log for each of the four types of scan, you should aim to have 10-20 as a rough guide. You can create an excel spread-sheet or start a paper based logbook in which you should outline the:
    - Type of scan
    - The indications
    - The scan findings
    - Your interpretation
    - Printed or uploaded images (optional)

The degree of supervision for scanning may vary between trust and trainers but you should be able to communicate the indications and findings of the scan together with the images to a person with at least 6 month experience post level 1 training.

- You will need to have 10 cases in which you go into a bit more detail then reflect on cases that you have been involved in and for which you have good, anonymised images. You can use the e-portfolio ultrasound case reflection log for this purpose which has a space where you can upload your images
- Triggered assessments – these are where you are observed and marked on a live or simulated case using a specific mark schedule
- Regional sign off – there are regional ultrasound leads that need to sign off that you have met the requirements above. You will not be considered competent until you have done this!

Many trainees have reported difficulty fulfilling the level 1 ultrasound requirements, but this is becoming less of an issue as increasing numbers of new EM consultants are fully level 1 accredited and understand the process of accreditation better. You do not necessarily have to cough up the £1000 odd pounds for a commercially run sign-off course, but it does require you to be meticulous and committed whilst you are completing your log-book.

5.1.2.8 Portfolios (electronic or revalidation)

You should be enrolled in your local trust appraisal and revalidation system. The electronic or paper reports from the annual meetings you have with your appraiser, will be a great piece of evidence to show that you are engaging with the GMC requirement of Good Clinical Practice (GCP). There is obviously a certain amount of duplication that may occur here, since you may already have an e-portfolio and an educational supervisor. This is a legitimate frustration for CESR candidates, as this is not a requirement for trainees and there is extra work

involved in preparing for an appraisal on a different platform. Unfortunately, this is not going to change for the foreseeable future and you will just have to bite the bullet and do it!

5.1.3 Details of Posts and Duties

This should be straightforward enough for you to get hold of depending on how many previous places you have worked and how good you are at keeping records. I had to go back to Ireland a number of times in order to get old employment letters, contracts and even job descriptions. The main issue was that they were not 'validated' as was required at the time (verification now) and this meant that I had to go around to each hospital, navigate the extensive prefab mazes and finally locate the HR person with the required stamp. As far as I know, this evidence still has to be validated by an HR department, but you should check this with the GMC as they may accept verified copies instead.

At one such hospital, the man with the stamp also happened to have the job adverts from previous years including a job description for the job I had worked in 2011. Such adverts often contain the job description component that the GMC and RCEM assessors are looking for, so this is a good place to start if you are working at a different trust or hospital from the ones you were working at a few years ago. Similar information may be acquired through your contract in the preamble section. Otherwise, there is normally a consultant who is in charge of recruitment and who writes the adverts, so ask the consultant body and you might strike lucky!

5.1.4 Research, Publications and Presentations

This area often strikes fear into CESR applicants, though maybe I am just speaking for myself! There never seems to be enough time to start, let alone complete an audit before even considering a full-scale research project. The good news is that, unlike a CESR in General Surgery, there is no absolute requirement to have published articles. Let that not deter you from engaging in research however, since the more evidence that you can get in this section, the better.

In my case, I undertook a Masters in Advanced Emergency Care through the University of Sheffield that included a dissertation which I submitted as a 'research paper'. If you are planning to do a prospective CESR, I cannot recommend this course enough. It is modular based and provides an excellent framework to developing yourself as a doctor in emergency medicine. I have attached a link to the prospectus.

Other things you can submit include any case reports, the FRCEM clinical topic review, poster or oral presentations. The trick, if you to find good supplementary evidence that corroborates that you actually did carry out the presentations that you did. Examples of this include:

- Emails that confirm the abstract has been accepted for presentation.
- A copy of the relevant page of the conference programme that confirms your poster or oral was presented.
- A certificate of presentation for CPD purposes.
- A copy of the poster or a printed set of slides if it was an oral presentation.

If you have published papers in the emergency medicine field, then you will just require a copy of the paper and this does not require validation or verification.

In summary, don't stress too much if you have not been published in the NEJM or Lancet, but provide good primary and secondary evidence of the research you have been involved in and you should be fine!

5.1.5 Continuous Professional Development

The CPD requirements for the CESR are clearly set out in the SSG. This is an area in which you need to be strategic. Your use of the RCEM CPD diary will make your life a lot easier. You can access the CPD diary as a member and it is hosted by RCEM learning. Here is the link https://www.rcemlearning.co.uk/ [7]. You should think about what kind of CPD you undertake, how you evidence it and where you file it. If you are participating in annual appraisal with your trust, there is a section where you can upload your CPD certificates and there is usually additional space where you are able to reflect on how the CPD has affected your practice. This evidence of reflection is considered good practice and you should get into the habit of reflecting – even if it is a line or two after you have been to a CPD event. The good news is that you do not have to verify the majority of your CPD!

One of the potential issues with CPD evidence for the CESR is that it tends to cross over between other sections and subsections. An example would be certificates for posters and oral presentations presented at conferences. You could file these under the 'CPD' section, but equally, you could file it under 'posters, presentations and publications'. Another example would be if you had taken a number of online modules in order to become an educational supervisor, then this could either be 'CPD' or filed under 'attendance at an appraisal or teaching course'. The answer to this dilemma is to provide as much narrative as you can in the original online application and later on the checklist. You have to remember that what makes sense to you may not make sense to your assessors – especially not by the time they have waded through 1500 pages of evidence.

If you are struggling to find records of your CPD here are some suggestions for where you might find it:

- Weekly registrar teaching – getting a teaching attendance log for the past few years and then having it verified with a cover letter from a consultant.

- Any conferences you have been too will often email you a certificate so have a look through that.
- All online e-learning is an excellent source of CPD. I used RCEM learning sessions which accrue a certificate for 1 CPD credit and were an invaluable resource for the FRCEM.
- E-learning for Health (e-LfH) can be accessed on this link https://www.e-lfh.org.uk/ [8]. They also issue certificates for modules completed. Furthermore, e-LfH has some really good modules called the Common Leadership Framework which can be used to show that you are have engaged with this vital aspect of consultant practice.
- Teaching that you deliver carries a certain amount of preparation time that can also be claimed as CPD. If it is the same lecture you deliver every year, then it would be disingenuous to claim for it on an annual basis – be reasonable!
- Workshops that you attend for example the CESR Applicants Training day is also CPD! You will note that on the RCEM CPD diary, this event is registered on a drop down menu – so really simple to claim for. If you didn't get the hint, I am trying to say you should go on it!

5.1.6 Teaching and Training

You need to keep a log of all the teaching that you attend and provide – it shows a level of engagement with your own as well as other clinicians' development – and is critical evidence that you can perform one of the key roles of a consultant. The teaching you provide needs to be to all levels of trainee: medical student, foundation, core and higher and the more feedback you get the better. If you do not intend to sit the FRCEM exam, then this is one of the areas in which you need to provide a lot of evidence.

5.1.6.1 Teaching timetables

I nearly bought a ticket to Ireland to fly over and drown a doctor I had worked with in Champagne! The reason was that years ago, Jason had diligently set himself to creating a teaching timetable with curriculum mapped topics – a piece of evidence I didn't think I had a fiddler's chance of getting… Having a year or two of rotated teaching topics gives the assessors a sense of the kind of teaching and training infrastructure of the departments you have worked in. I advise that if there is not a teaching timetable or for that matter, any formalised teaching programme, that you initiate and implement one under the auspices of a consultant. You could use this project as evidence of 'Chairing meetings and leading projects' or 'Management experience'.

5.1.6.2 Printing your slides

If you yourself have delivered teaching or lectures, you should take the PowerPoint or Keynote slides and print them out on single sided paper with the SSG recommendation of six slide per page. Do not forget that they need to be verified too.

5.1.6.3 Feedback from those taught

You need to be persistent in getting people to feedback on your teaching, lectures, and presentations in written format. That means either sending and reminding people to fill in the e-portfolio 'teaching feedback' tools or distributing paper feedback forms at the start or end of your teaching session. The more of feedback you get, the more weight your evidence accrues.

5.1.6.4 Letters from colleagues

Any feedback you can get from the consultants that have watched you teach in the form of 'teaching assessment tool' WBAs, email confirmation of teaching time or any informal email feedback is once again important evidence that you can use to confirm that you have delivered the teaching you say you have. As you may have gathered, I routinely scoured my old emails for confirmations, documents, thank-yous, feedback or anything that I thought could be used to corroborate the primary evidence that I was supplying.

5.1.6.5 Attendance at a teaching or appraisal course

There are a huge number of face to face and online courses out there on how to teach or how to become an educational supervisor. In order to become an education supervisor I completed the e-Learning modules provided by the London Deanery http://www.faculty.londondeanery.ac.uk [9]. The modules were free, easy to use, informative and provided space for reflection after which you obtained an electronic certificate. Your local education department will be able to tell you which of the modules they require you to complete. Local trusts may vary, but my one required you to meet with the director of medical education, discuss the modules, formulate a personal development plan and then commit to regular appraisals. The whole thing took about 10 hours to complete but I came out with ES accreditation which is great evidence that you can carry out this particular consultant role.

5.1.6.6 Feedback to Junior Colleagues

Demonstrating that you are engaged in the formative and summative testing of junior colleagues is useful evidence. The easiest source of information in this regard, is completed work based assessment tickets. You should print out and anonymise a number of tickets that you have completed and then get then verify them. This will demonstrate that you know how to give feedback to junior colleagues and is relatively easy evidence to come by.

5.2 Domain 2: Safety and Quality

5.2.1 Participation in Audit and Service Improvement

It is really important that anyone who is wishing to undertake a CESR in emergency medicine gets involved early on in clinical governance activities. There has been a shift in emphasis in the management assessment of the FRCEM exam to demonstrate competence in management by means of a portfolio rather than an exam. This is actually a good thing for potential CESR candidates because the evidence contained in the management portfolio can provide a valid record demonstrating your ability to perform the auxiliary roles of a consultant over and above clinical performance on the shop floor. Here is a link to the Management Portfolio Guidance https://www.rcem.ac.uk/docs/Training/1.4.6 Guidance - Management Portfolio.pdf [10].

The FRCEM management portfolio will need to include a minimum of five (four if you count the QIP separately) different tasks variously:

- A Quality improvement project (QIP) (mandatory)
- Management of a complaint (mandatory)
- Management of a Clinical incident (mandatory)
- Two other tasks from a selection of management topics outlined in the table below

For the purposes of the CESR, I think that a good strategy would be to follow the FRCEM portfolio guidance above, but to go further and attempt to file evidence for the majority of the clinical governance activities outlined below. There are specific work based assessments that can be used to evaluate your participation in these activities, but the work based assessments will not necessarily be enough. You do not have to provide evidence of competence in all the activities, but the more of them you have in your application, the stronger it will be. Remember that the burden of proof for a CESR is probably higher than for a

trainee completing a CCT. Below the table, I have offered an explanation of a few of the tasks in the table and some sign-posting to useful links.

Table 4: Clinical Governance Activities and their Assessment

Clinical Governance Activity	**Eportfolio assessment form (WBA)**
Complaint	Complaint
Serious Incident (Mandatory)	Critical Incident
Human Resources / People Management	Appraisal of Others Recruitment Rota Management
Financial	Business Case Cost Improvement Plan
Medico-legal	Report for Coroner / Solicitor
Confidentiality & Data Protection	Information Management
Risk Management	Clinical Governance Meetings Risk Register
Management Leadership Training	Introduction of Equipment/Service Attendance of Formal Course Introduction of Guideline
Educational Management	Organise a Training Day Induction Programme Teach Confidentiality
Audit and Quality Improvement	Audit Assessment Tool

5.2.2 Audits and Quality Improvement Project (QIP)

You will need to provide evidence of audit for your application. This is really non-negotiable. As I have mentioned, this was the criterion on which my original application failed. A minimum of three are required in which you demonstrate the 5 stages of audit.

- Definition of criteria and standards
- Data collection

- Assessment of performance against criteria and standards
- Identification of changes (alterations to practice)
- Re-evaluation

So for example, you may have participated in an audit and done a report for the trust as well as produced a poster that you presented at a national conference. However, if you fail to show that you re-evaluated your original audit and performed a second cycle, then as far as the evaluators are concerned, you have not completed the audit and will not be seen to have fulfilled the 'audit' requirement. So once again read my lexical lips: 'Your audit needs to demonstrate ALL 5 STAGES of the process'!

Doing a QIP is now mandatory in the FRCEM and replaces the Clinical Topic Review in the exam. There is extensive information & guidance from the RCEM about how to commence, manage, deliver and write it up. I would start by reading the handbook on this link. http://www.rcem.ac.uk/docs/QI Resources/RCEM Quality Improvement Guide (Nov 2016).pdf [11]. The handbook provides a lot of the theory and links to useful resources at the end. The expectation is that a QIP will take approximately 1 year to complete and, if you are submitting it as part of the FRCEM exam, you can also use this as evidence in your CESR application. There was previously a viva for the QIP, but this part has now been removed!

5.2.3 Complaints

If you are involved in a complaint, this can be good evidence towards your CESR, particularly regarding your reflection on the incident. It is a good idea to keep a record of the complaint, and anonymise any patient identifiable information in it. Electronic redaction is possible using add on tools in PDF – see above in the 'toolkit' section. Alternatively you can easily redact a word document. Once you

have written a response to the complaint, you can then add reflective notes on what you have learnt using the e-portfolio.

Given the recent Bawa-Garba case, many doctors have been reluctant to use their e-portfolios for reflection on the grounds that it may incriminate them. The problem with this logic is that failure to provide evidence of reflection will prejudice your application. Reflection is not an exercise in self-flagellation or personal recrimination – it is one of the main tools you have to become a better doctor and you need to remember that it is anonymised and the patient will not be identifiable from your notes!

You should aim to investigate and answer at least one complaint as this is a mandatory part of the FRCEM. Your educational supervisor can facilitate answering a complaint and your willingness to engage with this aspect of management is unlikely to meet with a negative response. As the FRCEM management exam moves towards a portfolio based format, having evidence of your competence will kill 2 birds with one stone when it comes to the CESR application.

5.2.4 Investigating a Critical Incident

Most doctors will be familiar with the concept of an incident report, but the process of what happens after a report has been logged is also important to understand. There may be a designated consultant in the department who handles incident reports and it would be useful for you to establish who this is. The stipulation from the RCEM is that you must be able to demonstrate that you have investigated a Critical Incident. There is no better way to get to gain an understanding of critical incident management than by showing an interest and then asking the lead consultant or nurse to show you how it is done. Thereafter, you should attempt, under supervision, to investigate a case on your own – there

is never a shortage of critical incidents and so it is unlikely that your mentor will refuse the help!

Depending on the severity of the incident, it may be necessary to carry out a root cause analysis (RCA). These are generally reserved serious incidents (SI's) and constitute a significant amount of work. You can get training for how to perform an RCA and there are often local courses at your trust that you may be able to find in your local risk management office. Here is a useful link to an RCA toolkit http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901 [12].

5.2.5 Clinical Governance Tips

Your management portfolio is something that you should discuss early with your educational supervisor as the accumulation of competence in all the fields of clinical governance may take time. You should organise your management portfolio in such a way that it fulfils both the FRCEM and CESR requirements. This means that you should:

- Carry out as many of the clinical governance activities that you can evidencing your work concisely with good notes.
- Redact patient identifiable information.
- Complete the requisite WBA's.
- Ensure that any records you keep are appropriately stored in line with your trust's information governance requirements.

There is a timing dimension to the portfolio because it would make sense to show current or recent evidence of management/clinical governance experience for the FRCEM management portfolio viva. As mentioned before, it is the past 5 years that are looked at therefore evidence that is cumulative and evenly spread will suggest that you are both competent and comfortable in the various forms of clinical governance.

Finally, I was thinking of the kind of evidence that is useful for proof of clinical governance. The following list is not exhaustive, but here are some suggestions:

- Attendance at morbidity and mortality meetings including presentations given
- Attendance at quality group meetings
- Hospital committee participation/attendance
- Managing and responding to complaints
- Meeting minutes for all forms of clinical governance meetings
- RCA reports
- Speaker certificates
- Local faculty group meetings/minutes
- Letters from the chairperson for committees you have been on confirming your participation
- Management courses you have been on
- E-learning for health modules

Producing an evidence trail for any of these activities should be the focus of your efforts. From the time that you first start to understand what it is that you need, do not attend any meeting or governance activity without the hospital stamp and ensure that the minutes/certificates or any other paraphernalia from those meeting are properly validated! Once that is done, then file it - you will thank yourself over and over again when it comes to the time of producing the evidence for the CESR.

5.2.6 Reflective Diaries

Reflective practice love it or hate it, is nevertheless here to stay and whether you are a foundation doctor, core or higher trainee, nurse or consultant you are going to have to do it. As a general rule the more aspects of your application you can show evidence or reflection on, the better. This does not mean that you have to

write a page for everything, the art of reflection is to succinctly summarise your thoughts regarding clinical and non-clinical situations that you have been involved in.

There are many ways to reflect and, as doctors, we are often carrying out 'reflective practice' without realising that we are doing it. For example, whenever you discuss a patient's management with another doctor or have a discussion during teaching you are taking a step back and thinking about patients or issues in a different environment. The key is to be able to commit the discussions or the thoughts that you have had about a particular situation into text because this serves as the written records that you require for appraisal and the CESR process in turn.

You can use the e-portfolio's reflective template in order to do this as well as the RCEM CPD diary and log mentioned above to record your reflections. Regarding clinical scenarios reflection generally follows the format of:

- Describe the situation
- What did you do?
- What did others do?
- What went well?
- What did not go so well?
- How might you do things differently in the future?

With teaching/lectures/conferences it might be:

- What was/were the topic(s)?
- What do you already know?
- What did you learn that was new?
- How are you going to incorporate this into your practice going forward?

Other people follow the format of describe, analyse, apply but once again, there are no rules other than to say that reflective practice is an important part of your

development as a practitioner and for better or for worse, we are mandated to keep records of it as per the Good Clinical Practice guidelines set by the GMC!

5.3 Domain 3: Communication, Partnership and Teamwork

The majority of Domain 3 requirements have been covered in the section on 'Clinical Governance'. My reason for not sticking strictly to the specific domain requirement of the SSG is that I think it make more sense to approach clinical governance as a subject in itself. This is the approach of the FRCEM management portfolio and will make more sense to your ES by virtue of its familiarity. Once again, there is a certain amount of cross over between the Domain 2 and 3 where, for example, conducting and audit or quality improvement project in Domain 2 could be used as evidence of 'Working in Multi-disciplinary Teams' in Domain 3. The way that I would approach this, would be to provide the evidence of the 5 parts of your audit in Domain 2 and then any minutes or email communications that you had during the consultation or implementation phase can be used in Domain 3. As ever, you will need to signpost the assessors as to how the various pieces of evidence link up.

Equally 'Management and Leadership Experience' can be evidenced by:

- Taking an eLearning course on the Common Leadership Framework in e-LfH.
- Filling out the work based assessments mentioned in Domain 2.
- Answering complaints, sitting on interview panels etc. as outlined in table 4 above.
- Letters from your clinical lead attesting to the managerial duties you perform.

The 'Communication' section in Domain 3 has a degree of cross over with the 'Relationship with Patients' section of Domain 4. Evidence in this section will probably take the form of emails discussing patient handling or responses from clinic letters sent by various specialities (if you can get your hands on them).

Thank you cards and letters of commendation from colleagues or patients may also suffice, but read the SSG guidance and then think about which pieces of evidence you have and how you might divide them up between Domains 3 and 4.

5.4 Domain 4: Maintaining Trust

My advice in this section is to make sure that your statutory and mandatory training is up to date. This will cover things like 'Equality and Diversity', 'Antibiotic Stewardship', 'Information Governance' and various other non-clinical competencies. Find out who is responsible for statutory and mandatory training and see if you can get printed certificates for the training. Otherwise, get a verified print out of your compliance sheet and a cover letter from the responsible officer. It's a bit painful, but not hard to get this evidence generally.

5.4.1 Relationships with patients

The majority of evidence in this section will take the form of thank you cards, mentions in departmental newsletters, emails and letters of commendation from patients and colleagues. In our hospital we have a 'Greatix' system that allows members of staff to feedback the positive aspects of their colleagues performance. The formalisation of this process, along with certificates, has had a fantastic impact on team morale and has improved access to good feedback for appraisal and ultimately CESR purposes. All positive feedback is worth keeping and, quite apart from its utilitarian, documentary purpose it should serve as a happy reminder that you are great, appreciated and valued as a patient and colleague.

6. Overseas Emergency Physicians

For doctors who have already completed training in Emergency Medicine and passed the exam in a different country the path to getting on to the specialist register is generally easier by virtue of having completed an approved programme. For qualified specialists within the EU, there is automatic entry onto the specialist register and this guidance does not apply to these doctors at this point. Unfortunately this may change since there is no knowing what the effects of Brexit will be.

The doctors in my acquaintance who have trained abroad have generally come from Australia and obtained a FACEM. Their pathway to completing a CESR has not been easy principally because collecting physical evidence has meant not only obtaining evidence from current employment in the UK but also going back to Australia to obtain evidence of prior training. They also cite the following issues:

- The fact that Australian training has not, until recently, necessitated the keeping of logbooks or completion of work based assessments makes it difficult to provide evidence of having covered the FRCEM curriculum.
- The requirement for clinical notes, case reports, audit reports or letters discussing patient handling necessitate going back to hospital emergency departments and then trying to sift through patients seen and departmental drives in order to obtain the best evidence for the CESR.
- Training reports, verification of clinical workload, procedures, education and training and testimonials can often mean asking for favours from consultants with whom they had last worked a number of years ago and naturally had other priorities!

As mentioned before, a lot of my evidence was from Ireland and in my case I had to go back twice in order to obtain evidence and validate it. Ireland is an hour's flight away, Australia is further, pricier and comes with a jet lag price tag that

makes it all the more important to sit down and strategize as to what evidence you need and how you plan to obtain it prior to going back. I suggest you contact all the relevant parties such as IT and Human Resource Departments, Consultants and their secretaries well in advance and explain what evidence you require and in what format. This will hopefully decrease the lead time in obtaining what you need when you get there. Documents need to be verified at the hospital you worked at so, for example, you cannot get another doctor in the UK who might have worked with you in Australia to verify Australian documents. Essentially, you still need to go back to the trust and ensure that the documents are verified as per GMC guidance by a supervisor at the relevant hospital. Here is the link again to the verification guidelines: https://www.gmc-uk.org/registration-and-licensing/join-the-register/registration-applications/how-to-verify-evidence-for-specialist-and-gp-applications

Finally, contacting the Australian College of Emergency Medicine (ACEM) is a good idea as they hold record of your training. This also requires about at least 6 months for completion so, once again, be patient and plan ahead. Talks are on-going between the RCEM and ACEM, so there is a chance that things may change in the near future with respect to automatic, reciprocal recognition between the two countries. Let's hold thumbs!

7. For the Trainers

Part of the issue with the CESR process, is that it is generally not completely understood by the trainers themselves. The standard response I got when I first heard about the mysterious Article 14 – old name for CESR was 'You should talk to so-and-so who has done it before and it was totally rubbish'. Thanks again to the work of a number of people in the college, the profile of CESR is rising and there are more people who have done it and they are a useful resource to those who may want to travel down the same road.

I think that treating the CESR candidates as trainees in their own right will go a long way. Many of the candidates may have educational supervisors already, in which case, the standard roles and paperwork apply:

- Help with the work based assessments.
- Regularly monitor the e-portfolio.
- Discuss PDPs.
- Signpost to useful resources.
- Complete structured training reports.
- Oversee any teaching/quality/clinical governance and provide confirmation in writing of their role in any of these activities.
- Pastoral support – totally under rated and very important during the moments when the whole things seems a bit much.

Ultimately the content of this How To guide will give the trainees direction and provide them with the main tools for collecting evidence, but trainers often have the institutional memory and contacts to facilitate the evidence collection process.

7.1 Protected time to do CESR work

As you all know, the demands of this process are particularly onerous and rely heavily on the candidates being able to find time to collect evidence. In my case, I

had passed the FRCEM exam and was hired as a locum consultant. This meant that I had weekly SPA time to compile the evidence dossier. Departments may not be able to afford granting a full day a week, but even an afternoon every fortnight would be a help. An idea would be to make the protected time contingent upon a few bespoke contractual rules for example: registration with an e-portfolio and evidence of progression against the curriculum at six monthly meetings.

7.2 Candidate Selection

The situation in every hospital is different with respect to the workforce: some EDs have a whole tier of staff grades/SASG doctors whereas others may have only one or two on the higher tier. In departments where there are a large number of SASG doctors, then the decision of who to support towards CESR becomes more complex. Not least because of the potential sacrifice in service provision coupled with the possibility of fall out amongst those doctors that feel that they are not being given the same opportunities.

7.3 Considerations

As the staff make-up of every department is different, the development of this cohort of doctors will vary. I have no wish to tell anyone how to do their job, I can however offer a few principles that should be considered:

- Be transparent: the money is limited and the service needs to run, so not everyone is going to get the same educational opportunities as established trainees.
- Be fair: if you are promising secondments to anaesthetics and ITU to some doctors, then others will start to grumble that they are not being offered the same opportunities. Secondments are probably going to be the hardest part to arrange and negotiate so you might want to consider the input of the candidates as to who gets what and when before you decide.

- Be realistic: candidates need to understand what a CESR entails and whether they are likely to complete the process. The biggest roadblocks are not being able to pass the FRCEM, exposure to and documentation of EM associated specialty competencies and a failure to understand the minutiae of the SSG
- Establish the ES role early: they are indispensable in this process from the generation and verification of evidence to the more pastoral role that may be required when the whole thing seems a bit too much!
- Advocate for the candidate: getting some rather mundane and obscure pieces of evidence verified is very low on the priority list of some consultants. I can personally attest to evidence that took almost a year to get validated during the evidence compiling stage. The power of an email, a phone call or even a gentle reminder in the corridor can make a huge difference.
- Signpost: this document gives candidates some useful links for resources, and the contact details of some people who have knowledge of how the process works. I hope that as more people complete their CESR journey, a network will start to develop that can mentor future candidates.

7.4 Specialities and organisation models

There are many ways to approach this particular issue and a number of models that are being piloted around the country. The exposure to paediatrics and acute medicine is seldom a problem. Problems relate, in the main, to anaesthetics and ITU secondments. The main issue that seems to recur, is that anaesthetic departments perceive that they do not get any service out of those ED personnel if they train them for 3 months – a fact that is totally understandable. Whilst some anaesthetic departments may be able to facilitate secondments, their willingness to do this over the long term is risky. In the following table, I have outlined a few potential solutions to the Anaesthetics/ITU secondment.

Model	Time	Who pays?	Benefits	Problems
Candidates are seconded to the speciality for 3 months and do nights and weekends in the ED.	3/12 and 3/12	The ED	-Service minimally impacted. -Specialities do not pay - Secondments can be arranged ad hoc	-Specialities don't like it. -Training less good for candidates - Limited time to do WBAs - Questionable sustainability
A full year with six months each in ITU and Anaesthetics. The anaesthetic department takes on the role of ES for a year.	6/12 and 6/12	Anaesthetics Department	- Good exposure for the trainee - Time out from speciality with different pace - Cost transferred from ED	- lost service potential to ED - more disruptive to rotas - loss of contact with the ED department
6 months ITU with anaesthetic secondments.	6/12	ED or ITU	- ITU junior tier covered for 6/12 - ITU exposure increased and learning experience better - Less difficult to arrange	- risks with the new SSG not recognising the anaesthetics 'time' element - lost ED service
Rotation through different local hospitals with 9months service for 3 month secondment.	3/12 every year	Various EDs	- Candidate exposed to different departments - Service disruption minimal - Even spacing of secondments	- the department that has to organise the anaesthetics is in a harder position - candidate does not gain traction in one department and will struggle with accumulating other CESR evidence.

Once again, rotation's complexion will depend on the local setup, connections with specialities and the trust's strategic priorities with respect to SASG doctors. However, these models have been used in different trusts and serve as a point of departure.

7.5 Educational Supervisor

Having an educational supervisor will be of enormous support to CESR candidates. Having someone tell me when I arrived in the UK that I would be treated as any other higher specialist trainee, was incredibly uplifting and it felt as if someone was actually taking an interest in my development as a doctor. There are a number of areas in which the ES can help but the most important is probably providing a record of the candidate's progression towards the CESR. This basically means doing WBAs and then completing regular structured training report forms – this is high quality evidence that can be printed off and will really help when it comes to the application. I had to call around Ireland trying to get retrospective reports from various departments stamped and signed which was really a poor surrogate in comparison to the contemporaneous, e-portfolio report forms that my ES had completed after I moved to the UK.

Furthermore, sitting down with the candidate and planning, by means of a PDP or otherwise, how to divide up and meet the requirements of the SSG could be of enormous help. The SSG, despite its clarity is intimidating in size and the sheer weight of evidence required can overwhelm one. At this point, it might be helpful to sit down with the trainee and think about what evidence they already have and how to go about collecting or acquiring evidence in all the areas that they do not. This might require both short (6 months) and longer term (3 year) development plans that can be reviewed at the regular ES meetings.

Another suggestion that I would have is to create a review process for the CESR trainee. This would be something akin to an ARCP and could take the form of an informal panel in which the trainee is able to:

- Show evidence of their progression over the past year.
- Discuss how they are meeting the requirements of the SSG.
- Present a personal development plan
- Feedback on their experience
- Take direction on those aspects of the curriculum/SSG where they will need to provide further evidence

I would suggest that using the ARCP checklists already in circulation can be used for this purpose and there is no need to reinvent the wheel. Ideally, the consultant(s) performing this review would include persons other than the educational supervisor to facilitate a fresh pair of eyes and a measure of objectivity to the process!

8. Closing Remarks

There are few better pieces of advice that I can give that to keep your consultants on side! The references that they have to write are long (at least 7 pages) and tedious to have to fill out. Your chance of getting them done promptly and sympathetically will be exponentially increased by being a hard-working, reliable and indispensable team player.

This document as it stands is likely to need regular updating as the evidence requirements of the SSG and the GMC submission formats change. I understand that the GMC are currently looking in to an electronic method of evidence submission that would be a welcome improvement in my opinion. I nevertheless doubt that the amount, type and nature of evidence are likely to change. The GMC is currently in a consultation phase and I have personally advocated for a change towards a simpler and more user friendly means of submission.

Bear in mind that there is no means of contacting or interacting with one's assessors at the RCEM in the same way that you would not be able to directly question someone who marked your examination paper. Whilst this protects the independence of the assessors, it does mean that you have little recourse to explain or provide evidence that you may have forgotten to submit. This was my unfortunate lot and it cost me a further £700, so be absolutely sure that you have all the evidence and, if possible, someone to review it before you submit!

It goes without saying that my remarks on the bureaucratic process are in no way a reflection of the various people who I encountered during my CESR journey. I found the GMC and RCEM contacts extremely helpful and prompt in replying to my queries and I have nothing but thanks for their support. The point remains that CESR elephant remains an elephant: big, unwieldy and difficult to tame, so quite understandably it might make you want to quit on your first day on the job!

So… Take a deep breath, don't lose heart if the evidence is not immediately available and at your fingertips. There are an increasing number of trained game rangers that are there to help you get through this process and before long the elephant will have been tamed (or eaten)! Good luck!

9. Glossary of Terms

ACAT – acute care assessment tool
ARCP – Annual Review of Career Progression
CbD – Case Based Discussion
CESR – Certificate of Eligibility for Specialist Registration
CPD – Continuing Professional Development
DOPS – Direct Observation of Procedural Skills
ELSE – Extended Supervised Learning Episode
FRCEM – Fellowship of the Royal College of Emergency Medicine
IAC – Initial Assessment of Competence
ICM – Intensive Care Medicine
MIMMS – Major Incident Medical Management and Support
Mini CEX Mini Clinical Evaluation Exercise
MSF – Multi Source Feedback
PDP – Personal Development Plan
RCA - Root Cause Analysis
RCoA – Royal College of Anaethetists
RCEM – Royal College of Emergency Medicine
SSG – Specialty Specific Guidance
STR – Structured Training Report
WBA – Work Based Assessment
WPBA – Work Placement Based Assessment (same as WBA)

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11. Useful Contacts

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12. Appendix

CESR PORTFOLIO CHECKLIST

Domain 1: Knowledge Skills and Performance

EVIDENCE	DONE (Y/N)	DATE	NOTES
QUALIFICATIONS			
Primary Medical Qualifications	Choose an item.		
Specialist Medical Qualifications	Choose an item.		
Curriculum undertaken (if overseas)	Choose an item.		
Honours and Prizes	Choose an item.		
ASSESSMENTS AND APPRAISALS			
Assessments and Appraisals	Choose an item.		
RITAs, ARCPs and Training Assessments	Choose an item.		
360 and Multi-source Feedback	Choose an item.		
Awards and Discretionary Points Letters	Choose an item.		
Personal Development Plans (PDP)	Choose an item.		
LOGBOOKS, RECORDS OF DAILY CLINICAL PRACTICE AND PORTFOLIOS			
Logbooks	Choose an item.		
Consolidation, cumulative data sheets, summary lists and annual caseload statistics	Choose an item.		
Medical Reports	Choose an item.		
Case Histories	Choose an item.		
Referral Letters discussing patient handling	Choose an item.		
Patient Lists	Choose an item.		
Departmental (or trust) workload and annual caseload statistics	Choose an item.		
Rotas, timetables and job plans	Choose an item.		
Courses relevant to the curriculum	Choose an item.		
Portfolios (electronic or revalidation)	Choose an item.		
DETAILS OF POSTS AND DUTIES			
Employment Letters and Contracts of Employment	Choose an item.		
Job descriptions	Choose an item.		
Job plans	Choose an item.		

RESEARCH, PUBLICATIONS AND PRESENTATIONS			
Research papers, grant, patent designs	Choose an item.		
Publications within speciality field	Choose an item.		
Presentations, poster presentations	Choose an item.		
CONTINUOUS PROFESSIONAL DEVELOPMENT, CONTINUOUS MEDICAL EDUCATION			
CPD record certificates, certificates of attendance, workshops and at local, national and international meetings or conferences			
CPD registration points from UK Medical Royal College (or equivalent body overseas)			
Membership of professional bodies and organisations	Choose an item.		
TEACHING AND TRAINING			
Teaching timetables	Choose an item.		
Lectures	Choose an item.		
Feedback from those taught	Choose an item.		
Letters from colleagues Participation in assessment or appraisal and appointments processes	Choose an item.		
Attendance at a teaching or appraisal course	Choose an item.		

Domain 2: Safety and Quality

EVIDENCE	DONE (Y/N)	DATE	NOTES
PARTICIPATION IN AUDIT, SERVICE IMPROVEMENT			
Audits undertaken by Applicant	Choose an item.		
Reflective Diaries	Choose an item.		
Service Improvement and clinical governance activities	Choose an item.		
SAFETY			
Health and Safety	Choose an item.		

Domain 3: Communication, Partnership, Teamwork

EVIDENCE	DONE (Y/N)	DATE	NOTES
COMMUNICATION			
Colleagues	Choose an item.		
Patients	Choose an item.		
PARTNERSHIP AND TEAMWORK			

Working in multi-disciplinary teams	Choose an item.		
Management and leadership experience	Choose an item.		
Chairing meetings and leading projects	Choose an item.		

Domain 4: Maintaining Trust

EVIDENCE	DONE (Y/N)	DATE	NOTES
ACTING WITH HONESTY AND INTEGRITY			
Honesty and integrity	Choose an item.		
Equality and human rights	Choose an item.		
Data protection	Choose an item.		
RELATIONSHIPS WITH PATIENTS			
Testimonials and letters from colleagues	Choose an item.		
Thank you letters or cards from colleagues and patients	Choose an item.		
Complaints and responses to complaints	Choose an item.		

Page 3: [1] Deleted William Niven 12/24/18 5:57:00 PM