RCEM
Royal College of Emergency Medicine

Patron: HRH Princess Royal
Octavia House,
54 Ayres Street,
London, SE1 1EU

Tel: +44 (0)20 7404 1999
Fax: +44 (0)20 7067 1267
www.rcem.ac.uk

ACP Credentialing (2017 curriculum)
Common reasons for an unsuccessful submission

1. Structured Training Reports

The Structured Training Report (STR) is a key element in the record of an ACP's progression and should be completed on an annual basis, looking back at the previous 12 months (regardless of whether the ACP is full time or less than full time).

- **Insufficient numbers**

  A minimum of 3 STRs are required for credentialing, with the final STR being completed within 3 months of submission. Where 3 cannot be provided, there should be a statement provided by the Educational Supervisor explaining why 3 could not be completed. For experienced ACPs, 2 STRs ***may*** be acceptable but should include clear evidence of continued skills development, and the final report must explain why 3 are not available for review. There should also be a record in the timeline of regular educational meetings to support this.

- **STRs completed retrospectively**

  STRs completed retrospectively are not helpful, unless the ES is able to confirm within the form that the content has been produced from contemporaneous notes and records from the time period concerned.

2. Faculty Educational Governance Statements (FEGS)

The Faculty Educational Governance Statement (FEGS) should summarise the collated views of the training faculty about the progress of a tACP and, specifically at the point of credentialing, their suitability for the award of the credential. If possible, the FEGS should include verbatim statements from the assembled faculty.

- **Insufficient numbers or completed retrospectively**

  A minimum of 3 FEGS are required for credentialing, with the final FEGS being completed within 3 months of submission. From Autumn 2024 it has been a requirement that 4 consultants must be present at each faculty meeting and contribute to the FEGS. The roles of each faculty member present must therefore be listed within the form. Where 3 cannot be provided, there should be a statement provided by the Educational Supervisor explaining why 3 could not be completed. For experienced ACPs, 2 FEGS ***may*** be acceptable, but the final report must explain why 3 are not available for review. FEGS entered retrospectively are not helpful as they are unlikely to represent the true opinion at the time.

- **Missing statement in final FEGS**

  The final FEGS prior to submission ***must specifically state*** that the ACP:

  - is ready to credential;
  - is performing at a level equivalent to an EM trainee at the end of CT/ST3 for the requirements of the ACP curriculum;
  - has adequate experience and has demonstrated competence across the breadth of the curriculum and in all areas of the department including resus, majors and minors.

3. Inadequate supervision

In addition to the annual FEGS and STR, the Panel needs to see evidence of regular educational meetings as these describe the ACP's journey and show the close supervision and mentoring that has been occurring. Inadequate supervision can be shown by a lack of evidence in the portfolio, or CIRs that do not adequately reflect the ES's experience of seeing the ACP in practice (see 12 below).

4. Evidence is out of timescale

All evidence must be within 5 years at time of submission with the majority of evidence in the portfolio being no older than 3 years. A portfolio is unlikely to be adequate if more than 30% of the evidence is from more than 3 years ago. ***All mandatory summative assessments must take place within 36 months of the date of submission***.

Evidence that is older than 3 years must be accompanied by reflection and evidence of practice development and maintenance of skills.

5. Assessment forms are completed too long after the event

The Panel believes that an assessor's capacity to recall in detail the ACP's performance will diminish considerably after a significant period of time has elapsed. Therefore, as from 01 April 2024, the Panel has required all DOPS and MiniCEX for patients seen after that date to be created by the ACP and sent to the assessor within one week of the event, and for the assessor to complete the form within 4-6 weeks of receipt. A limited number of DOPS/MiniCEX that exceed this timescale will be accepted for patients seen prior to 01 April, but ACPs should select tickets that were completed within a short time of the event occurring whenever possible.

6. Incorrect assessor, wrong form

Care should be taken to ensure that, where mandated, the correct assessment type is used, and the assessment is undertaken by an eligible assessor, e.g. PP1 requires a CBD or DOPS by Consultant, PP13 requires a DOPS by trained assessor.

7. Over-reliance on SIM and CBD

There should be an appropriate balance of MiniCEX and CBD in consultant assessments – approx. 50:50. A higher proportion of CBDs than this, with discussions conducted in an office concerning a hypothetical question or retrospective look, can suggest to the Panel a lack of clinical contact and adequate supervision. Care should also be taken that there is not an over-reliance on SIM with no discussion in relation to real cases.

8. Wrong choice of evidence

The assessment selected as evidence for a specific element of the curriculum must focus on that specific presentation. For example, a WBA on an arterial line must focus on insertion of a line, not on analysis of blood gases. The CbD for the airway must explore the airway management elements of airway. The Panel will not have time to search the portfolio for more appropriate evidence.

9. Audit/QI evidence incomplete, no evidence of re-audit

There must be evidence of leadership and implementation of actions from a minimum of one audit or quality improvement project with reflection, including evidence of actions completed and evaluation of the impact of those actions following recommendations or agreement by stakeholders. There must be a formal assessment of the audit or QI using the appropriate form and the role of the ACP in the audit and QI must be clear. There must be evidence of a re-audit.

10. Lack of personal reflection

A lack of personal reflection will result in an unsuccessful submission.

Reflection allows an ACP to make sense of a situation and understand how it has affected them. It allows them to identify areas for learning and development and supports sharing and learning from other professionals. Reflective practice is a way for the ACP to consider how they can put changes or improvements into action in their everyday practice.

To help guide thinking, the ACP should consider the following questions:

- What key things did you take away or learn from this experience/feedback?
- How did you address any issues or problems that arose?
- What would you do differently, if anything, next time around?
- How has it impacted on your practice?
- Are there any changes you can quickly apply to your practice?
- Are you able to support yourself and other colleagues better?
- What can you do to meet any gaps in your knowledge, skills and understanding?

The Panel suggests a number of ways, and provides a variety of tools, to assist an ACP in evidencing that they are a reflective practitioner

- **Curriculum item rating (personal reflection):** the ACP should enter some reflection for each competence/presentation. This personal reflection should analyse their own capability – not just a description of the activity or list of evidence, but how the evidence demonstrates the development of their capability and progression to independent practice and the standard required for credentialing.
- **E-learning** is strongly encouraged as a way of developing knowledge, but e-learning certificates are not sufficient evidence alone for an individual competence; certificates should be accompanied by reflection on the impact on their clinical care, e.g. Self-directed Learning Reflection.
- **Life support courses**: certificates should be accompanied by reflection on the impact of the course on the care they deliver.
- **Teaching plans / presentations** accompanied by personal reflection and/or feedback.

- **Audit and quality improvement** work with reflection and data to show the impact.

- **Individual case reflections**, e.g. Reflective Practice Logs.
- **Educational activity**, e.g. Educational Activity Attended.
- **Other tools:** Reflection on complaints, Reflection of ESLE, Reflection on Serious Incident, etc.

11. **Lack of triangulation of evidence and unaddressed learning points**

ACPs should provide a variety of evidence to demonstrate competence across the depth and breadth of the ACP curriculum. As much of the evidence will be self-produced, it must be supported, or 'triangulated', by a range of other evidence to be given weight by the Panel.

For example, evidence of teaching may include:

- Teaching timetables
- Presentation slides
- Teaching Observation Tool
- Reflection.

Triangulation of evidence should also be used to demonstrate progression and development to the required standard at the point of submission. For example, an ACP undertakes an assessment, and the assessor identifies various learning points to be addressed. This would not reassure the Panel that the ACP is practising at the standard required for credentialing. The ACP could then choose to complete some e-learning or other educational activity to improve their knowledge and understanding of the procedure, and some reflection as to what didn't go well, what they have done to address this and how this has impacted upon, and improved, their practice. The ACP may also wish to include a subsequent summative assessment which demonstrates that the previous learning points have been addressed.

Please note, learning points do not necessarily mean that an ACP has failed to demonstrate competency at the required standard during the assessment. It may be that the assessor has just suggested some ways to develop beyond the level required for credentialing. If this is the case, the assessor must make it clear in the assessment that the ACP has met the standard required for credentialing.

12. ES entered Curriculum Item Ratings (CIRs) do not include the assurance and level of narrative required

Educational Supervisor comments (CIRs) must be completed for all competences, presentations and procedures and must contain sufficiently detailed narrative to assure the Panel that the ACP is practising at the required level across the entire curriculum.

The ES confirms that they have reviewed all the evidence and seen the ACP in practice and, by referencing the descriptors in the curriculum, can confirm they are at the appropriate level.

As the credential confirms current competency, the Panel will expect to see a final CIR completed within 12 months (preferably 6) of the submission date. Comments that are much older than this could raise concern, as will the same comment against multiple elements.

13. Common competences and procedures incorrectly rated

Remember the rules:

- **Common competences:** Common competences (CCs) are rated level 1-4. To credential, an ACP is expected to demonstrate competence to level 2 in all CCs (level descriptors for
  each CC can be found in the curriculum document). Whilst an experienced ACP may be able to demonstrate up to level 4 in many CCs, it is unlikely that most ACPs will be at level 3 or 4 in more than 4. If a CC is rated level 4, the Panel will expect to see evidence within the portfolio supporting the higher rating.
- **Presentations:** Presentations are rated as 'achieved', 'some experience', or 'not achieved'. To credential, an ACP is expected to 'achieve' all presentations (descriptors for the presentations can be found in the curriculum and Assessment Descriptors document).
- **Practical Procedures:** Practical procedures (PPs) are rated as 'achieved', 'some experience', or 'not achieved'. To credential, an ACP is expected to 'achieve' all PPs (descriptors for some practical procedures can be found in the curriculum and Assessment Descriptors document). However, recognising that in some departments an ACP may not be permitted to perform certain procedures for local governance reasons, there are 7 mandated procedures (PP1, PP3, PP5–PP8 and PP14) that may be assessed by CbD rather than DOPS. For credentialing, a maximum of 4 of these 7 procedures may be assessed by CbD; these should be rated as 'some experience'. All procedures assessed by DOPS must be 'achieved'.

14. Insufficient paeds evidence for dual credentialing

In addition to the mandated assessments for paediatrics, there must be specific paediatric-related evidence in a minimum of 25% of all other presentations and competences. Within the CBD or DOPs, for example, the comments on the form should include sufficient discussion regarding the differences in adults/children.

15. Patient case mix numbers do not reflect ACPs' experience

The curriculum indicates that the case mix logbook should include a specific percentage of resus patients. However, your Trust electronic recording system may not be able to demonstrate this due to the way your ED is organised, e.g. some resus patients are seen in majors, etc. It may then appear that the ACP has insufficient experience of critically ill or injured patients and so it is important that the ES provides an explanation of this within the logbook summary table or resolution comment.

Similarly, if you are not an MTC and the ACP does not see major trauma cases, this should also be explained. There should be adequate evidence demonstrating that the ACP is able to identify major trauma patients and take appropriate action.

16. Too little or too much evidence

It is important to adhere to the guidance regarding the amount of evidence that should be included within the portfolio. Too much evidence means that the Panel will not be able to locate the best evidence, too little will suggest a lack of experience. If, for example, an ACP links one WPBA and one e-learning certificate to a curriculum element and the

assessment is weak, the Panel cannot be assured that they have achieved that particular competence if there is no other evidence to support it.