Common reasons for an unsuccessful submission

Described below are some of the most common issues that have been identified in portfolios that have been unsuccessful in recent credentialing windows. The Panel recommends that ACPs and Supervisors refer to this guidance when reviewing the portfolio prior to submission to ensure these issues are addressed.

It should be noted, however, that each portfolio is assessed on an individual basis and the Panel will look at the evidence presented in its entirety. Therefore, an ACP will not necessarily be unsuccessful if some of these issues are identified, but an ACP would be unlikely to credential if the portfolio contains multiple issues. Similarly, the Panel cannot guarantee that an ACP who ensures that all issues are addressed within their portfolio will credential, but it will increase the chances of a successful submission.

WPBAs

1. **Incorrect assessment type and/or assessor has been chosen**
   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, etc. It is also important that the trained assessor is identified by role, not just by name, so that the Panel can be assured that they are appropriate to undertake the assessment.

2. **One case has been used for multiple curriculum elements**
   In general terms, one piece of evidence can be used for up to two competences, occasionally three, except for the ACAT-EM which can cover up to five competences. One common competence can be covered at the same time as a clinical competence on one assessment form. For clinical presentations, *particularly the trauma presentations*, it is expected each presentation has a different patient/form.

3. **Assessment forms have been 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.

4. **Incorrect use of ESLEs**
   In some instances, the ESLEs presented as evidence for CC4 and CC8 did not adequately focus on time management or team working and, sometimes, more closely resembled an ACAT. An ESLE is an extended event of observation in the workplace across cases and, ideally, for the ACP overseeing or coordinating an area of the department rather than focusing on only their own case load. It covers interactions, decision making, management and leadership, as well as the tACP's individual caseload. It is therefore primarily an assessment of the non-clinical elements of the curriculum. The event will characteristically be three hours in length, with around two hours of observation followed by one hour of feedback. The tACP will be observed during their usual work on shift, but the consultant observer will be supernumerary, i.e. not in the clinical numbers.

The ACAT is also a tool for evaluating performance over a period of time and, specifically, should focus on clinical assessment and management of a variety of patients, decision making, team working, time management, record keeping and handover. Therefore, it is very much a tool that helps look at behaviour across a function - managing multiple patients at one time, completing a ward round in CDU, looking at working to support the streaming function - rather than the non-technical skills that are reviewed in the ESLE.

There is of course some overlap, hence the recommendation for both ESLEs and ACATS during training, but the ACAT is usually something that is helpful in the early years of an ACP's development to focus on clinical management, and the ESLE for the more leadership type capability.

5. **WPBAs contain insufficient information to determine whether the required standard has been met**
   In some instances, the Panel was unable to determine whether the WPBA presented as evidence for a specific curriculum item was an appropriate case or met the requirements for credentialing, as details given were minimal. The form must include a summary of the patient case which gives the Panel a good picture of the clinical situation. This doesn't need to be more than about 10 lines and should not be a 'copy and paste' of the clinical notes - a succinct summary is evidence in itself of the right level of functioning. The comments from the supervisor should be detailed, particularly if there are any "should address learning points" or "must address learning points".

6. **WPBAs do not focus on the specific presentation for which the form has been used to demonstrate competency**
   In some cases, the assessment selected as evidence for a specific element of the curriculum did not 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.

Additional evidence

7. **MSF**
   MSFs should be completed annually, with at least 8 months between cycles. Some ACPs did not leave sufficient time between cycles, in some instances appearing to reopen a cycle many months after the first invitations were sent to colleagues when the initial cycle was found to have received too few responses to create a summary report. This led to an overlap between cycles making it difficult for the Panel to determine which period the responses referred to.

8. **Audit/QI evidence incomplete, no evidence of re-audit**
   Some ACPs did not provide evidence of re-audit, some did not make clear their role in the audit, and some were missing a formal consultant assessment.

   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.

9. **SIM was used where not permitted**
   SIM should only be used when permitted in the guidance. Where SIM is accepted, the ACP must have led the scenario and have a completed consultant assessment where relevant. It must be clear at the beginning of the description that it is a simulation and why that is being used. There should be a description of the simulation event i.e. for ACPs, as part of departmental teaching, etc.

10. **Patient case mix numbers do not accurately reflect ACPs' experience**
    In order to gain sufficient experience to develop the standard of competence required for credentialing, it would be expected that a tACP/ACP will have had direct contact with a significant number of patients covering the entire breadth of practice, and an adequate number where they have been the primary clinician caring for the patient.

    By the end of the minimum three-year (whole time equivalent) period of training, it would be expected that a tACP/ACP will have seen a minimum of 2000 patients for either an adult or children credential, and at least 500 children in addition to the 2000 adults over a four-year period for ACPs who are dual credentialing. Of these, at least 15% should be 'resus' patients.

    For credentialing, 'resus' patients are defined as those patients determined to be critically ill or significantly injured (identified by high NEWS2/PEWs scores, acuity 1 or 2 Manchester Triage, or requiring immediate intervention and resuscitation). The Panel understands that, due to departmental crowding, these patients may not be physically in the resuscitation room, but they must be evidentially critically ill or significantly injured by the case description/diagnosis and immediate interventions required.

    In order to achieve the required number of resus patients, at least 15% of a tACP's time during shifts should be spent seeing these types of patients.

    The Panel understands that Trust electronic recording systems may not always clearly identify different categories of patients and, consequently, relying on departmental physical location alone may not support this discrimination. Therefore, for the final credentialing window, the Panel is mandating that, in addition to (or instead of) presenting raw data, **the RCEM summary table template (available on the website or by using the links below) must be utilised**, collating the ACP's annual patient numbers by acuity (resus/significantly ill or critically injured, majors, ambulatory/minors) and those who are admitted/discharged/referred.

    - Adult case mix logbook template
    - Paediatric case mix logbook template

    We would expect the number of resus or critically ill/significantly injured patients to fluctuate or increase year on year depending on the tACP's level of experience prior to entering the credentialing pathway. However, if the total number of resus patients over the 3-year period (4 if credentialing in both adults and children) does not meet the required minimum, then it is essential that both the ACP and ES provide an appropriate explanation within either the summary table or the resolution comment for this area of the checklist. It is recognised that the more experienced ACP may see less patients themselves as they are supervising others; an explanation for this would also be expected in the ACP's reflection and from the supervisor.

11. **Mandatory evidence is out of timescale**

In many cases, assessments were outwith the permitted timescale. ***All mandatory summative assessments must be within 36 months at time of submission***. All *non-mandatory* evidence in the portfolio must be within 5 years with the vast majority being within 3 years. Evidence that is older than 3 years must be accompanied by reflection and evidence of practice development and maintenance of skills.

12. **Insufficient paeds evidence for dual credentialing**

In some instances, the paeds component of the portfolio was weaker than the adult, and there was a lack of discussion around differences between adults and children throughout. 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.

For the mandatory assessments, it should be remembered:

- **PP16, PP17, PP18 (PPs adults/children):** one of these 3 procedures must have a paediatric case in addition to the adult
- **PP1, PP3, PP5-8, PP14 (PPs adult/children):** comments on the form must include discussion about differences in children
- **PP2, PP4, PP12, PP13, PP15, PP46 (PPs adults):** differences in children must be discussed
- **C3AP1a-e (additional presentations adult):** each assessment must include discussion on the differences in children, or separate assessments for children may be included
- **C3AP2a/b-C3AP4 (additional acute presentations):** each assessment must include discussion on the differences in children, or separate assessments for children may be included.

Reflection and triangulation of evidence

13. **Lack of personal reflection (Curriculum item rating)**

Within some portfolios, there was a lack of, or weak, personal reflection within the curriculum item ratings (CIRs). 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. A statement of “I am able to manage head injuries of a range of severity” is not sufficient.

Ideally, the Panel will expect to see a final CIR completed within 12 months (preferably 6) of the submission date. In some instances, CIRs were completed between 3 and 4 years prior to submission without any recent reflection to show further development.

14. **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 that must 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 learning points have been addressed.

Please note, we recognise that 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.

Supervision and assessment

15. Structured Training Reports (STR)

The 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). In some cases, STRs were completed retrospectively or were missing without a reason being given.

- **Missing STRs**
  A minimum of 3 STRs are required for credentialing, with the final STR to be completed within 3 months of submission. Where 3 cannot be provided, there should be a reason provided by the Educational Supervisor. 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.

16. Faculty Educational Governance Statements (FEGS)

The 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. In some cases, FEGS were either missing or completed retrospectively without explanation. In others, the final FEGS did not include the required faculty confirmation.

- **Missing FEGS or completed retrospectively**
  A minimum of 3 FEGS are required for credentialing, with the final FEGS being completed within 3 months of submission. The roles of each faculty member present must be listed within the form. Where 3 cannot be provided, there should be a statement provided by the Educational Supervisor. 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.

17. **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 should be confirming 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.

18. **Common competences and procedures are incorrectly rated**
    In some instances, common competences, presentations and procedures have not been rated according to the guidance:

- **Common competences:** Common competences (CCs) are rated by 'level'. To credential, an ACP must be minimum level 2 in all CCs.

- **Presentations:** Presentations can be rated as 'achieved', 'some experience', or 'not achieved'. To credential, an ACP will be expected to have 'achieved' all presentations (descriptors for the presentations can be found in the curriculum and Assessment Descriptors document).

- **Practical Procedures:** Practical procedures (PPs) can be 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).

Exception for PP1, PP3, PP5–PP8 and PP14

The Panel recognises that, in some departments, ACPs may not be permitted, or rarely find an opportunity, to perform certain procedures; these have been identified as PP1, PP3, PP5–PP8 and PP14. Therefore, for this last application window we are reiterating clear guidance on these 7 PPs:

1. **3** of these procedures (to be decided by the ACP) ***must be assessed by Consultant DOPS on a real patient***; these must be rated as 'achieved'.

2. The remaining **4** can be either:

    a) Consultant DOPS on a real patient and rated as achieved, ***OR***
    b) Consultant CBD and rated as 'some experience', ***OR***
    c) Consultant DOPS on SIM and rated as 'some experience' (*providing* there has been a one-to-one assessment by a Consultant), ***OR***
    d) Consultant CBD and rated as 'some experience' (where there has been a group SIM procedural course, and the ACP has practised as part of the course but without a one-to-one Consultant assessment).

Where a CBD or SIM DOPS has been provided, there should always be an appropriate explanation from the ES as to why it has not been possible to obtain a DOPS on a real patient, i.e. why this competency cannot be 'achieved'.

19. Insufficient narrative (assessor) within WPBAs

In some instances, the Panel was unable to determine whether the ACP had met the standard required for a specific curriculum item as there was insufficient narrative and feedback provided by the assessor. The assessor must clearly indicate how the ACP has demonstrated they meet the specific requirements for credentialing. Areas of good practice should be described and reference the descriptors within the curriculum (where provided).

Specific care should be taken when including action points to be addressed. It must be made clear whether the action points 'must be addressed' in order to reach the standard for credentialing, or are suggestions for further improvement post-credentialing, i.e. 'should address'. Where 'must address' action points are listed, the Panel will want to see evidence in the portfolio that the ACP has addressed the actions through reflection and additional learning, possibly followed up by a further assessment which demonstrates the action points have been successfully addressed.