Credentialing Steering Group Report

April 2010
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**Introduction**

This report sets out the key issues and recommendations from work overseen by the Credentialing Steering Group (CSG) during 2009 and 2010 considering the concept of credentialing for medical education and training throughout the UK. The CSG focused on specialist practice and not on the particular status of doctors undertaking that practice. The background to the work is set out below, this first section reports on the findings/views of various groups – no judgement is made on what is reported. This is followed by a brief outline of the processes used for the exploration of credentialing since 2007.

The report reflects the wide ranging views of the potential benefits and dangers of credentialing; as expected there is still significant disagreement amongst the stakeholders. However the CSG was able to agree on this report, including the issues and recommendations it makes. The report addresses how credentialing could impact on patients and the public, the medical profession, Departments of Health and employers as some of the key interest groups. It sets out recommendations from the CSG that the Postgraduate Medical Education and Training Board (PMETB) considered and accepted with minor revisions.

Now agreed by the Board of PMETB, the final report will go to the Department of Health England (DH) in April 2010. The final report will also be circulated widely for information and debate; although this work was initiated by DH the report is applicable to the UK. The DH will ask the Minister to consider this report and its recommendations in the summer. DH will then communicate with all stakeholders on how this work may go forward.

**Background**

Recent years have seen growing interest in the concept of credentialing in UK medicine. There are four key factors that have prompted this:

- The general appetite for more information about the status and competence of doctors
- The changing nature of healthcare delivery
- The need to ensure that postgraduate medical training equips doctors to best care for patients now and in the future, and that this training can be shown to enable doctors to be fit for this purpose
- The need to promote doctors’ continuing professional development.

However, the enthusiasm for credentialing that is evident in some quarters has been matched by concern and lack of enthusiasm in others. The lack of consensus reflects widely differing views on what credentialing means, or should mean, the nature of the problem it is intended to solve or if there is a problem at all, and the costs or benefits it might deliver.
During 2007 the GMC Specialist Register Review Group considered this topic and reported to Council on what in their view could be potential benefits of specialist credentialing:

- Registering specialist credentials would enable recording of competences acquired throughout a doctor’s specialist career and not just at the award of a CCT/CESR
- Specialist credentialing might be used to reflect the increasing modularisation of specialist training and the more flexible training opportunities that will be necessary because of the changing demographics of the medical profession
- Credentialing would provide a way of giving formal recognition to the additional training undertaken and qualifications acquired by doctors
- The recording of that additional training would make the expertise of specialists more easily recognised and the register more transparent
- Specialist credentials would enable the recognition of specialist competences in fields of practice for which it is not possible to obtain a CCT and where regulation has been identified as weak
- Credentialing offers a more agile means of responding to developments in medicine than is possible through the recognition of CCT specialties
- It should be possible to extend the principle of credentialing to apply to general practitioners with special interests.

The debate was given further impetus by Lord Darzi’s 2008 report A High Quality Workforce: NHS Next Stage Review which stated that credentialing ‘gives assurance to patients and employers that professionals have the right skills to deliver high quality care, whilst giving recognition to professionals themselves’. The report went on to charge the regulators and professional organisations with taking forward the idea of credentialing: ‘In partnership with the medical profession, in particular the Royal Colleges and the professional regulators, we will develop plans to introduce modular credentialing for the medical workforce over the coming decade. This means the formal accreditation of capabilities at defined points within the medical career pathway that takes into account knowledge, capabilities, behaviour, attitudes and experience.’

Against this background, in 2008 the DH held a series of three meetings involving some of the Royal Colleges, PMETB, GMC, and other key stakeholders to initially explore the potential way forward. In December 2008 the DH invited PMETB to lead exploratory work on credentialing, in part because it is important to have a UK-wide emphasis and involvement for this work. The PMETB Board agreed to lead on this piece of work on the understanding it would frame the questions and not commit to delivering credentialing. The aim was to clarify and report by April 2010 on the circumstances (if any) in which credentialing could add value at the regulatory level.

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1 A High Quality Workforce: NHS Next Stage Review, Department of Health, 2008, p16
In May 2009 PMETB and GMC hosted a workshop that built on a co-hosted seminar in 2007. In 2007 many different perspectives on credentialing were put forward and debated with little consensus. In 2009, although cautious, the general tone was of interest in the further exploration of the meaning and potential impact of credentialing.

A Credentialing Steering Group (CSG) was set up with terms of reference (appendix 1), chaired by Dr John Jenkins, the Chair of the PMETB Training Committee, on behalf of the Board. Dr Jenkins is also Chair of the GMC Postgraduate Board. The membership was deliberately wide and ensured a UK-wide focus; key interest groups were all represented. The purpose of the CSG was to facilitate the coherent development of proposals for the exploration of credentialing across all stages of doctors’ careers.

Following early discussion, it was agreed to focus on credentialing as a process, without restricting this through use of terms such as “modular” and “credential” at this early stage of development, although it was recognised that, if taken forward, further work would need to address these aspects at a later stage. It was agreed by the CSG that it would be most useful if it is possible to identify a (small) number of areas where there is potential benefit and where initial development and evaluation could take place. This included a clear acknowledgement that any such work should be taken forward with recognition of and integration into the wider context, including the implementation of revalidation and the ongoing development of specialty training curricula and assessment systems.

In order to add value, credentialing should help to provide stakeholders with confidence that doctors are able to deliver healthcare safely, including in relation to specialist services in contexts with limited direct supervision, access to supervision, or through independent practice. Credentialing could have the potential to facilitate this process as it would enable doctors to be identified according to their particular level of practice in a distinct and transparent way. This would apply in different ways in different specialties but must always be set in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice. Any credentialing process builds on pre-existing learning, and in medicine this would be building on basic medical training and the primary medical qualification. It was also agreed that at this stage of development this is not primarily a workforce issue and any implications in that regard should be considered subsequently.

The CSG agreed that this could best be taken forward through a focus on a number of specific aspects of the overall topic, rather than on timing before or after the award of CCT. Two initial work streams were defined: one to focus on training and the other on revalidation:

1. ‘Progression through training’ work stream (PTTW - led by PMETB and chaired by Professor Alastair McGowan)
This would:

- gather views on the risks and benefits of identifying capability at various points within the career pathway
- use the ongoing PMETB curriculum and assessment system reviews to help Colleges articulate more clearly transitions from year to year within the curriculum or at other sentinel points within the career pathway. For some this could include discrete modules within their curricula, which could have the potential for development into credentialing as a means of marking progression and defining requirements for the level of supervision.
- explore ways in which credentialing might help define and recognise those areas of specialist practice which do not fit well into current specialty/subspecialty structures.

2. ‘Supporting revalidation’ work stream (SRV - led by GMC and chaired by Professor Malcolm Lewis)

Recognising that revalidation will transform the Medical Register from an historical record of doctors who are qualified to practise to a contemporary statement of their continuing fitness to practise, this work stream would:

- explore the potential of credentialing to support more effective regulation for doctors in career posts, examine how such credentialing might relate to specialist training
- explore the potential relationship between credentialing and revalidation
- the relevance of credentialing to the current development of specialist standards and processes to support revalidation
- explore the recognition of increased expertise within highly specialised fields of practice, and how this could be used to support revalidation of these doctors
- focus on issues relevant to specialty doctors (including those in the Staff, Associate Specialist and equivalent grades) and those with special interests (including GPs).

The aim of both work streams would be to explore the issues, without any commitment at this stage to the actual introduction of credentialing. The work would be developmental in nature to consider the outcomes of initial exploratory work in a report by April 2010 for wide consideration prior to potential implementation in part or whole, making use of pilots where applicable.

The CSG agreed that there should be a clear recognition that any such work should be taken forward with recognition of and integration into the wider context, including the implementation of revalidation and the ongoing development of specialty training curricula and assessment systems.
During the group’s work period a number of other publications have made reference to credentialing. These include calls to improve access to part time working and flexible training, the Deech report states that: “The development of credentialing should be expedited, and there should be full recognition by the medical Royal Colleges that time alone does not indicate competence to practice independently” Baroness Deech (13.10.09) “Women doctors: making a difference – report of the Chair of the National Working Group on Women in Medicine”.

The Cardiff discussion document suggested that consideration should be given to “a new intermediate step between Foundation and specialist registration. The curricula would be designed to ensure training to a level commensurate with a doctor providing a meaningful service contribution”. It referred to the need for doctors who would be “demonstrably qualified to practise with a limited level of direct supervision” and the importance of “providing a workforce more responsive to changing service needs and enhancing choice and opportunity for doctors in their careers”. An important emphasis in this document was that “medical career structures must be mapped across each administration to balance UK-wide strategy and single-country needs” Dr Tony Jewell (23.6.09) Cardiff Discussion Document.

The Council for Healthcare Regulatory Excellence (CHRE) report on advanced practice, despite its very limited review of the issues which would be relevant to the medical profession, reached conclusions which could potentially impact on the development of credentialing. It implied that this should be a function of organisational governance rather than professional regulation. However, the CSG agreed that its remit was to consider the issue from the perspective of the regulator, while not excluding the possibility that consideration could also be given at other levels such as by professional bodies (e.g. Colleges or Faculties who might wish to consider certification in specific areas of practice), or organisations - CHRE report 17/2008 (July 2009) Advanced Practice: Report to the four UK Health Departments.

In discussion the CSG agreed that it will be useful to increase flexibility in training, but avoiding reduction in standards. It is noted that standards of practice already exist at local level and that these are necessary to address the issue of “fitness for purpose” for a particular role. However, transferability of skills is also needed between employers, including for specialty doctors and so a process of credentialing to nationally agreed standards would have potential benefits not only for the doctors concerned (including those in the specialty, staff and associate specialist and equivalent grades), but also for the Departments of Health, employers and most importantly for patients and the public. There is support from many but not all doctors in these grades for this form of recognition of their expertise, and this has particular relevance to their revalidation against the nationally agreed specialty standards relevant to the
work they undertake. Pilots could test the most effective approach to develop and implement effective local processes that are set against national standards.

The CSG also recognised that the strategic review of the regulation of medical education and training being led by Lord Patel at the request of the GMC and PMETB will almost certainly have an interest in the regulatory implications of credentialing. Any work on credentialing will need to be considered together with the outcomes of the Patel Review following the period of consultation.

**Literature Review**

The literature review (see Appendix 2) commissioned by the DH and undertaken by MACE drew upon the literature available nationally and internationally. The literature was limited in breadth and research. The review found relatively little evidence and reached a number of conclusions.

There is little literature which relates directly to the concepts of credentialing as considered in this work. There is some literature which supports credentialing in demonstrating and supporting the maintenance of standards of doctors who had developed competence in discrete areas of specialty practice. In addition, there may be regulatory value in this in terms of public and employer reassurance. There may also be a related value in terms of giving better recognition to specialty doctors and their training needs.

There is evidence supporting the role of credentialing in the granting of clinical privileges in a procedure specific way e.g. the Canadian process of credentialing endoscopic procedures. This is seen as particularly useful where procedures cross traditional specialty boundaries.

The literature review report suggests that there is an urgent need for recognition of competence attained in discrete areas of practice, not covered by either CCTs or by PMETB recognised subspecialty training, e.g. forensic and legal medicine, breast disease management, remote and rural medicine, cosmetic surgery etc.

There was limited literature but the report suggested that “credentialed” practitioners deliver improved quality of care, clinical outcomes and better patient safety as compared with non-credentialed practitioners. It is also argued that credentialing may be of use in helping general practitioners develop a special interest in order for them to become GPs with Special Interests (GPwSIs), noting that a number of countries with remote and rural populations already use a similar system.

The report maintained, although with limited evidence to support this view, that credentialing may help to facilitate movement of trainees in and out of training programmes at the appropriate level, and give greater flexibility to professionals (and employers) to move between specialty training programmes, whilst having their capabilities and learning properly recognised.
The review concluded that credentialing is also useful in supporting effective workforce planning and the aims of the NHS Next Stage Review, namely improved knowledge of the skill sets available and through a more flexible workforce that can develop approved and recognised skills more rapidly to meet changing service needs.

**Perspectives related to key interest groups**

**Patients and the public**

Patient and lay groups have emphasised that recognising the clinical skills and expertise of doctors in practice is not about a form of stratification or labelling, or attached to a particular qualification. It is seen as the means by which patients can be protected by recognising doctors’ skills and expertise in a formal way against nationally agreed benchmarks or standards or criteria. It should be clear as to a doctor’s particular skill set or attributes and at present there is no way outside completion of CCT or equivalent route or subspecialty that enables such recognition. It will also be important to improve the understanding of patients and the public regarding medical training as it affects their care – including the roles and expertise associated with different job titles.

**Medical Profession**

**a) Trainees**

Concerns have been clearly expressed by trainees that, as training is currently being restructured and adapted to address the competency based as well as time based curriculum, time is needed for this to be embedded before further changes are made. There has also been clear opposition to any concept that could lead to fragmentation of the integrity of training to the level of the CCT, and the possibility that this could be used to support creation of a sub-consultant grade.

Few specialty trainees want breaks in training other than those which are possible in the current processes. However, Deaneries have identified some trainees (numerically small) who do not want to progress directly through the CCT process and whose career choices are not easily accommodated within the current processes. For this group credentialing could have the potential to provide a method of recognising levels of capability reached if these were clearly identified as part of the relevant CCT curriculum and assessment system.

In addition the introduction of credentialing will not actually help trainees who leave specialty training to return to training towards a CCT unless some significant additional structural and procedural changes are made.

The CSG agreed that the issues raised by trainees and supported by other groups are an important element of the overall discussion. It was acknowledged
that PMETB’s lead on the exploration of credentialing ensured that all views were incorporated into the work of defining credentialing, and framing the potential strengths, weaknesses, opportunities and threats.

**b) Academy of Medical Royal Colleges**

The Medical Workforce Project (Dec 2008) included a section on **Service posts and Credentialing** which stated that:

*Some doctors may choose to step sideways from their training before achieving specialist registration and perform service roles. Their abilities will vary considerably and employers, colleagues, patients and the public need to be able to recognise their level of safe practice. Thus a mechanism to record the expertise doctors have achieved needs to be developed. The same might usefully apply to doctors who have performed additional training since completing their specialty training.*

**c) Specialty, Staff and Associate Specialist (SAS) Doctors**

Many consider that credentialing would have the potential to demonstrate and support the maintenance of standards of SAS doctors who had developed competence in discrete areas of specialty practice. There may be regulatory value in this in terms of public and employer reassurance. There may also be a related value in terms of giving better recognition to specialty doctors and their training needs.

Others (both SAS and CCT/CESR/CEGPR holders) are concerned about how such credentialing might be used – in essence it may actually raise more barriers to SAS doctors rather than lowering them if adopted wholesale by employers as a benchmark to recruitment. Concern has also been expressed that such credentialing could threaten the role of the consultant in delivery of high quality health care through providing an apparently more economic and flexible workforce from an employer’s perspective.

Some consider that determining a body of knowledge and skill for SAS doctors could appropriately recognise their skills, benefit employers and increase patient confidence in the context of the extensive range of specialist services already provided widely by this important group of doctors. Others affirm that there is no agreement on what credentialing might mean in practice and SAS doctors should be wary of vague promises; inappropriate introduction of credentialing could lead to SAS doctors providing a narrower range of care with fewer opportunities for development. It is also unclear as to the process of funding such credentialing in terms of time and administration. It is argued by some that SAS doctors’ skills could be effectively recognised through revalidation, rather than through a separate credentialing system, as this will require them to demonstrate the same relevant specialty standards as others providing those services.
Employers

In their 2008 report, NHS Employers favoured “a modular approach to postgraduate medical training built around care pathways that provide recognised ‘credentialing’ to support doctors’ development over a range of flexible career routes”. The document continued: "Employers want to enable specialty doctors and their trust equivalents to gain recognition for the knowledge, skills and experience they acquire throughout their careers”. “There is strong support for the development of a standardised system of recognition, or ‘credentialing’, which would, in time, support doctors to better evidence their skills when applying for entry to the specialist register via the CESR route and achieve greater autonomy of practice where their competence has been accredited” NHS Employers, Issue 52 (November 2008) Medical training and careers – the employers vision.

Emphasis has been placed on a flexible workforce to meet patient needs through delivery of a safe and high quality service. Some have also reflected a view that credentialing could relate to small discrete areas of practice based on experience and the mastery of a set of tasks/skills. These credentials could be gained within the work place, and are designed to recognise often quite small and specific areas of work.

Employers are keen to recognise the skills and attributes of specialty doctors as well as those who hold CCTs or CESRs. All those involved with workforce and workforce planning also need to be actively involved in any future discussions and development work.

The two work streams taken forward on behalf of the CSG

1. ‘Progression through training’ work stream (see appendix 3 for membership and a summary of comments)

Professor McGowan undertook a series of semi structured interviews with 17 organisations involved in postgraduate medical education (further interviews were planned). Royal Colleges and Lay Groupings uniformly wished to emphasise the view that the standard for unsupervised practice is a CCT. One of the definitions refers to a credential empowering someone to undertake unsupervised practice; this does not attract agreement among any of those interviewed.

Ten of the seventeen interviewed revealed the perception that at least some of the purpose was a drive towards producing a cheaper but less qualified workforce. There was a broad consensus that people were prepared to maintain but suspend their concerns in this regard and enter into dialogue where patient safety and the needs of the future GMC Registers are the key focuses of the discussion. All interviewed accepted that providing a mechanism to better recognise competencies of individual doctors in an aim to improve patient safety is a motivator of this initiative.
Most common was a concern about credentialing of capabilities part way through training potentially providing a means whereby a trainee’s progress could be stopped at that stage if that best suits the workforce requirements. Although meeting service needs in the short term, this was widely perceived as detrimental to the long term development of the profession and thus of patient care.

Many Colleges expressed the view that they were embarked on a training programme to produce additional CCTs in pursuit of a service that was predominantly delivered by CCT holders. They were concerned that the introduction of a new intermediate tier of credentialing could compromise this aim. Many expressed the concern that the production of a range of doctors with a narrower set of competencies than those indicated by a CCT would in fact reduce the flexibility of the service rather than enhance it. This was also of particular concern to the lay representatives.

Concern was also expressed about the potential medico legal consequences and possible restrictions of practices that could follow on from a rigid system of credentialing.

NHS Employers were keen to emphasise that it was not their expectation that opportunities to train to CCT would be curtailed. A potential contribution to transparency, patient safety, and enhanced relevance of the GMC Register, was listed by multiple respondents. Some doubt was expressed that the majority of patients would be interested in looking at the Specialist and GP Registers. Employers would value improved understanding of the competence and capabilities of doctors at the point of employment.

**Curriculum Review**

Early learning points from the review are that specialties are still grappling with being able to articulate the skills, knowledge and attributes to be attained on an annual basis by the trainee doctor which in turn should inform the annual review of competence progression (ARCP) process - the progression points from each specialty training year to the next. A lack of clarity which has been due in part to the introduction of a competency based as well as time based curriculum. This lack of clarity has led to varying degrees of confusion amongst trainees and trainers as to requirements for progression at ARCP. However some Colleges have been successful, through the revisions of the curricula and blueprinted assessment systems, in clearly communicating the requirements through the ARCP Decision Grids, for each specialty.

Some specialties were unable to clearly map workplace based assessment systems against the curricula to ensure proportionality and adequate sampling. The knowledge based assessments were not an issue in terms of acting as ‘key staging posts’. Each specialty or group of specialties will have unique key points of progression. These key points vary in time, length, complexity and are mostly driven by the need to identify key skills and knowledge that should be possessed by the trainees in order to deliver a particular type of care and with graded levels of supervision.
There was no evidence of particular stopping off points for trainees with the exception of completion of core training; and not all specialities (although the majority do) use this structure. The development of particular areas of expertise unsurprisingly occurred towards the end of CCT curricula with a wide range of options available for trainees. There is little evidence that trainees were limited in their choice of which areas they could gain further experience in other than practicalities of obtaining training – specialist areas of practice by their nature are limited in number and accessibility.

**Specialist practice with no formal recognition**

This part of the work stream focused on four areas of practice identified by the DH. The four areas: forensic and legal medicine; breast disease management; musculoskeletal medicine, and cosmetic surgery, had been identified through a variety of mechanisms but they also shared some characteristics. These include not meeting the criteria and requirements to become specialties or subspecialties and their multidisciplinary nature, with the result that for some there was no one natural and obvious specialty or home to link to. For example, breast disease management covers several different areas of practice.

Each area had one person who was a key link and they were contacted to discuss the potential for setting up a meeting to discuss potential piloting within the consideration of credentialing. Initial exploratory meetings occurred in November and December 2009. Following those meetings four more formal meetings were planned and implemented in January and February 2010.

Each group of interested parties were keen to discuss the way forward but did not necessarily see credentialing as a first choice way forward. However as formal recognition through specialty or subspecialty recognition was not available, all agreed to move forward but in different ways.

The key challenge was that there were no specific national standards for these areas of practice, the meetings discussed the continuum of credentialing – one end has credentialing as a course with a curriculum, assessment, outcomes, and quality assurance. The other end of the continuum is practice based recognising doctors already in this specialised area of practice through experience, interest and a varied range of study/assessment opportunities. Two of the four groups confirmed they would look at working on recognising those attributes and characteristics that exemplified the existing “specialist” practitioner. Having quantified that, they would then look at the methods of affirming and assessing those attributes. One linked potentially to a membership process to an academy. The fourth was exploring a curriculum, drawing upon existing examinations and courses. All parties were asked to consider their potential way forward.

Concerns were expressed about the lack of a visible and national recognition of this work, in essence concerned about the pilot nature being discussed as the potential way forward.
All however felt it was a way forward to recognise practice and establish some formal recognition which would inform employers and help protect patients by a form of “kite marking”.

The meetings confirmed that there would be significant differences potentially in the pilots. While they can recruit from a varied background, breast disease management and musculoskeletal medicine are nonetheless discrete - for instance, breast disease management from GPs, radiologists, surgeons and possibly oncologists, musculoskeletal medicine from GPs, A&E doctors, rheumatologists and orthopaedic surgeons, but forensic and legal medicine could potentially be applicable within any College or Faculty. For cosmetic surgery additional issues to be considered include working outwith the NHS, the lack of training opportunities through access to supervised practice and the kind of managed environment that goes with it. Cosmetic surgery is a very diverse and varied field that involves surgeons who are doctors and very carefully trained, and those who are not. A significant dimension of credentialing such practice is the need to address the safety and quality perspective that patients and the public expect the practitioner to have the same knowledge and skill set to undertake a procedure whether they are a doctor or not.

2. ‘Supporting Revalidation’ work stream (see appendix 4 for membership, the full report and a summary of comments)

The group sought to distinguish between two related ideas. The first is the acquisition of a credential as a qualification or award after following a curriculum. The second is the process of credentialing which recognises the demonstration of continuing fitness to practise in a particular field. The former treats credentials as products which require curricula design, approval and quality assurance, and the resources to support these activities. The latter is more closely aligned with revalidation in being related explicitly to evidence of ongoing performance in practice within a particular field.

The group initially identified a number of areas where credentialing might help to meet an identified need:

- Providing more and better information
- Providing assurance that doctors are practising to the appropriate standards in their chosen field
- Providing recognition of doctors’ capabilities.

The appetite for more and better information about doctors’ competences, the need for assurance that doctors are practising to appropriate professional standards, and the desire for professional recognition, all suggest that there is a gap in the regulatory framework. The question, therefore, is whether credentials
or credentialing of some form could be an effective and proportionate means of plugging that gap or whether there are other, more appropriate solutions within our grasp.

**Credentialing and revalidation**

The GMC’s plans for revalidation are already well developed and the GMC is consulting on its proposals until June 2010. Revalidation is a set of procedures operated by the GMC for the periodic ‘evaluation of a medical practitioner’s fitness to practise’\(^2\) as a condition of continuing to hold a licence to practise. It will take account of doctors’ knowledge, skills, behaviours and attitudes as demonstrated through performance in actual medical practice. It is not difficult to see how the concepts of credentialing and revalidation begin to overlap.

As part of the development of revalidation the medical Royal Colleges and Faculties have prepared specialty specific standards that doctors working in their particular fields will be expected to meet in order to revalidate. They have also described the types of evidence that doctors might bring to revalidation from their practice to show that they are meeting the required standards. The evidence will vary from specialty to specialty, but will include information such as evidence of participation in audit, outcome data, prescribing data, information about complaints and feedback from patients and colleagues. The standards and evidence will apply to all doctors working in the specialty, regardless of whether they are consultants, GPs or career grade doctors. The register will provide a description of the field of practice in which a doctor has demonstrated ongoing competence through the process of revalidation.

Viewed in this way, revalidation becomes the means of recognising a doctor’s credentials in a particular field based on national standards developed by the colleges, and the GMC’s register becomes the visible expression of that credentialing process. The register thus also becomes a contemporary statement of a doctor’s credentials over time, capable of reflecting changes in practice between one revalidation cycle and the next. It might show, for example, how a doctor has moved out of clinical practice and into medical management.

Using revalidation as the means of credentialing doctors’ practice has some obvious advantages. Not the least of these is that work to introduce revalidation for all licensed doctors, across all specialties, is already well advanced. By contrast, establishing a separate regime of registrable credentials is likely to be slow, resource intensive and evolve piece-meal.

By providing a description of the scope of practice against which a doctor has revalidated, there is an opportunity to satisfy the appetite for further information about doctors’ practice. In doing so, employers, patients and the public will be able to be reassured that doctors are practising to appropriate professional standards.

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\(^2\) Medical Act 1983, section 29A (5).
standards in their chosen field. The fact that these standards will apply both to consultants and career grade doctors will help to ensure recognition of the demonstrated capabilities of doctors in staff grade and associate specialist posts.

**Some regulatory gaps**

However, if revalidation is the answer for the vast majority, this begs the question of what happens for the minority. The specialty standards developed by the colleges and faculties for revalidation do not address fields of practice which fall outside the recognised specialties, such as cosmetic surgery where the need for more effective regulation is well recognised. Nor do they provide the answer for fields such as medical management (though work on standards and evidence for revalidation in this area is underway) or areas of practice which span more than one discipline, for example breast disease management. The development of national standards in such fields will be important to support revalidation. Indeed, revalidation provides an impetus for identifying isolated branches of medicine where credentials may add value.

In the light of revalidation, for the vast majority of doctors it would be premature to introduce an additional system of credentials and credentialing at the present time. The group considered the need to be mindful of the opportunity cost of doing so. The need for additional credentialing should therefore be evaluated following the introduction of revalidation.

There are, however, some discrete areas of medical practice where the establishment of national standards in the form of credentials may add value by supporting doctors in their revalidation and thus providing assurance for employers, patients and the public that doctors in these fields are practising to the appropriate professional standards. These include fields for which there are no existing specialty standards or where medical practice embraces a number of different disciplines.

The group recognised the importance of the development of the Medical Register and its transformation to a dynamic instrument that provides accurate and up-to-date information on what doctors are currently doing. Moving from a register that details qualifications to a register that “demonstrates” performance was identified as a challenge and raised issues such as descriptors and their ownership, relationships, and underpinning standards. Enhanced information is required regarding doctors on the GMC register, including the need to provide assurance that doctors are practising to the appropriate standard in the chosen field. This is relevant to specialist services provided by doctors including those who are not on the Specialist Register and will entail further development of the specialty standards which have recently been established. There should be

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3 Expert Group on the Regulation of Cosmetic Surgery: Report to the Chief Medical Officer, Department of Health, 2005.
recognition of doctor’s capabilities, including doctors seeking ongoing acknowledgement of their professional achievements.

The group concluded that the majority of the gaps could be resolved by revalidation, through raising standards and providing evidence, rather than through a separate process of credentialing.
Key issues

Definitions

The following working definition of medical credentialing is now suggested:

“Credentialing is a process which provides formal accreditation of attainment of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice.”

This must be related to a sufficiently broad area of practice that it would not restrict workforce flexibility or quickly become obsolete (therefore avoiding procedure-specific credentialing). The relationship between credentialing and certification in a recognised subspecialty requires further consideration in order to avoid conflict and confusion. A subspecialty has a specific status within the legislation and the regulator has a specific role in relation to approving or decommissioning subspecialties, a role it does not have presently with credentialing. Such consideration is in hand, PMETB providing the springboard though recent work on the roles, functions and quality assurance of subspecialties.

Standards

Credentialing is an umbrella term referring to the various means employed to designate that individuals or organizations have met or exceeded established standards. Credentialing for the medical profession should help provide confidence that doctors are able to deliver specialist healthcare to new or specific nationally established standards of safety and quality for that area of practice. It should enable doctors to be identified according to their particular level of practice in a distinct and transparent way through the local application of national standards. This would apply in different ways in different specialties but must always be set in the context of effective clinical governance.

Risks

The group agreed that the introduction of credentialing would be associated with a risk that it could become inappropriately reductionist: ‘salami slicing, stamp collecting’. It could also be restrictive if credentials are related to the register and so having the credential becomes the only way to undertake practice in that area. Innovation that involves extending practice is essential, but there is a balance to be had so that development of practice individually and corporately is possible without unacceptable risks for patients. A system of credentialing that describes the multiplicity of areas and levels of practice may create a bureaucracy that out weigh the benefits it delivers. These risks must be recognised and managed in order to achieve the potential benefits without
reducing flexibility which will remain important for doctors, the Departments of Health throughout the UK, and employers.
Conclusions

Owing to changing demographics of the medical profession and changes within the needs of the service, credentialing has significant potential for benefit because there is a strong need to articulate the nature of a doctor’s practice and whether this meets national standards. Revalidation is designed to address these needs for all doctors, and credentialing should be seen in this context where it has the potential to support and complement this for doctors providing specialist services.

It is important to note that credentialing is seen as an additional opportunity for recognition and that it does not alter or replace existing routes to specialist registration. So credentialing has the potential to be beneficial for patients and the public, the doctors themselves, Departments of Health, employers, regulators and others. It could also potentially provide trainee doctors with more flexibility to stop training at different stages, although it is recognised that this is likely to be of interest to only a minority of trainees. It does not resolve the challenge of flexible access or re-entry to specialty training for all doctors.

Credentialing is relevant to all doctors providing specialist services, including those who are not on the Specialist Register. After much debate and feedback, the following definition is recommended:

“Credentialing is a process which provides formal accreditation of attainment of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practise in that area in the context of effective clinical governance and supervision as appropriate to the credentialed level of practice.”

Credentialing must be seen to be objective, reproducible, credible, validated and appropriate. It is an umbrella term and need not replace other concepts such preceptorship or certification where appropriate. In order to progress this there should be a further phase of work, a "bottom up" approach determining the need for and benefits of credentials including the development of pilots which address the areas of practice which have been identified as priorities. The work includes:

- Pilots in areas of specialist practice with no current formal recognition, including those where preliminary discussions have already taken place
- Pilots should involve specialty SAS doctors as well as CCT/CESR/CEGPR holders. As well as the subject specific processes, it will be helpful to include posts that might enable a credential to be an endpoint

In the development and introduction of any such pilots the following principles should be addressed:

- Agree standards and framework for assessment
- Determine methodology of delivery
• Develop, agree and manage a strategy and timescale for implementation
• Evaluate and report the outcomes.

• Clearer articulation of progress within CCT curricula or at other sentinel points within the career pathway. For some areas of practice this could include discrete modules within curricula
• Consideration as part of the ongoing development and implementation of revalidation of the need to provide assurance that all doctors providing specialist healthcare are practising to appropriate specialty specific standards.
• Consideration of longitudinal research as the literature review has highlighted the paucity of evidence. Such research should include exploration and identification of reliable outcomes of credentialing.

It is essential that any progression of credentialing is undertaken on a UK-wide basis in order to ensure that medical career structures balance UK-wide strategy and single-country needs. This does not preclude each country from developing processes that are relevant to the local context, pace and practice but that there is agreement on a UK framework within which those processes occur. The risks which have been identified must also be effectively addressed in ways which provide appropriate flexibility in the lifelong learning of doctors and support their contribution to safe and high quality patient care.