General Medical Council

Agenda item:	**6**
Report title:	**Credentialing consultation: results and next steps**
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Considered by:	**Strategy and Policy Board**
Action:	**To consider**

Executive summary

In 2012 we began to develop a framework for how we would regulate a system of credentialing. The recommendations from that work were reported to the Strategy and Policy Board, and then to Council, at the end of 2014. Agreement was given to a public consultation on the proposed credentialing framework during 2015.

Our consultation ran from July to October 2015 and elicited 217 responses. Credentialing is a new concept for medical regulation in the UK and unfamiliar to many. The majority of respondents supported our proposals. Nevertheless, there was a significant minority who were unsure, opposed, or whose support depended upon how credentialing is implemented.

This paper sets out the results of the consultation and considers whether credentialing should be taken forward at the present time and, if so, how this should be done and at what pace.

Recommendations

Council is asked to:

a Consider the report of the credentialing consultation *Introducing regulated credentials*, at Annex A.

b Agree to working with a small number of potential early adopters to evaluate and test the cost effectiveness and efficacy of the model during 2016-17.

Background

1 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...'

2 The aims of credentialing include, but are not limited to:

- Providing a framework of standards and accreditation in areas outside recognised specialties where regulation may be absent or weak.
- Recognising the particular capabilities of groups such as Staff and Associate Specialist (SAS) grade doctors who may not have a Certificate of Completion of Training (CCT).
- Recognising the particular capabilities of doctors (both GPs and specialists) over and above their CCT.

3 The credentialing consultation ran from 1 July to 7 October 2015.

Key issues from the consultation feedback

4 The consultation report *Introducing regulated credentials* is at Annex A.

5 We received 217 written responses to the consultation, 68 from organisations and 149 from individuals. Almost all of the individual respondents were doctors and they divided roughly evenly between trainees, SAS doctors, and consultants.

6 The overall response to our proposals was positive: 69% of respondents agreeing with our reasons for introducing credentials and just 16% disagreeing. Nevertheless, among all categories of respondents there were some persistent concerns and questions which generated greater challenge. These are explored below.

Limiting the scope of credentialing

7 Despite the majority support for credentialing, that support was often qualified. Many saw the value of credentialing outside of recognised specialties, but were concerned that credentialing might seek to duplicate or unpick existing specialty training. We are clear that if credentialing is to be taken forward it must not overlap or compete with existing specialty or sub-specialty training programmes.

Shape of training

8 Linked to concerns about the relationship between credentialing and specialty training was the view that it was premature for the GMC to introduce credentialing until political decisions had been made about the *Shape of training* report. We have tried to develop a framework which is not dependent upon the outcome of *Shape of training,* but is sufficiently flexible to incorporate *Shape of training* should that be taken forward. Focusing initially on unrecognised (and unregulated) areas of medical practice would allow us to begin to improve patient protection in these areas, and test our model, while we await decisions on *Shape of training*.

Regulatory burden

9 Respondents were understandably concerned about the potential cost and burden imposed by a new layer of regulation. In part, this is mitigated by the fact that we do not propose that possession of a credential should be a statutory requirement and credentials would only be established in those fields where there was acknowledged need. Focusing our new model on a small number of key areas would allow us to test its efficacy and assess burdens before decisions are taken about more general rollout.

More information needed

10 Many of our respondents wanted more information before they could take a view on credentialing. When we asked respondents to identify the disadvantages of credentialing, many of the comments were about the detail of how it might, or might not, be implemented. Some of that concern reflected misunderstanding about what we were actually proposing. Credentialing is a new concept and if we are to progress there will need to be an ongoing communications campaign to educate and inform.

Equality and diversity considerations

11 One of the arguments in favour of credentialing has been that it allows recognition of capabilities possessed by groups (such as SAS doctors) within which we are more likely to see individuals with one or more protected characteristics. If credentialing focuses initially on areas outside of recognised specialties the benefits for SAS doctors, at least in the early days, will be limited. However, one of the three areas where we have piloted credentialing (breast disease management) was conceived, developed and tested on SAS doctors and some of the other areas of unrecognised practice about which we have been approached also include SAS doctors.

12 Around half of our respondents felt that credentialing would have an impact on particular groups. Most of these thought the impact would be negative, though the concerns did not always come from expected quarters. Trainees worried that the value of CCT would be undermined if doctors without a CCT were able to get

credentials. Some consultants were anxious that senior doctors could be disadvantaged if they were put under pressure to get credentials they didn't need. There was concern that women and part-time workers would be adversely affected, though some of this reflected anxiety about how employers might use credentialing rather than about the system itself.

13 As anticipated, those who saw benefits in credentialing often pointed to the potential for groups such as SAS doctors, GPs and those working in unrecognised specialties and, of course, patients.

Next steps

14 The end of the consultation marks the end of the policy development stage of the project. The next steps would be evaluation and testing of the model which, if successful, would lead to a final phase of wider implementation.

15 Despite majority support for our proposals, credentialing remains a controversial idea. In the current environment it might be tempting to put it on the back burner. But while widespread rollout would be premature, evaluation of the policy model in a small number of early adopter (unrecognised) specialty areas may bring benefits:

a Enable us to test the efficacy, cost and possible burdens of our model.

b Begin to strengthen patient protection in currently unrecognised areas of practice.

c Exploit the linkages with related GMC projects, including the review of educational curricula and assessment, introduction of general professional capabilities and the scope of practice recorded on the List of Registered Medical Practitioners (LRMP).

d Maintain momentum, recognising that some form of credentialing is beginning to take shape through other agencies, with or without our involvement.

e Enable us to make progress while we await the outcome of *Shape of training* .

16 The model we have designed puts much of the responsibility for identifying, developing, evaluating and recommending the award of credentials on credentialing bodies. Our role is essentially one of approval, quality assurance and registration. We would expect organisations keen to establish credentials to bear the cost of their elements of credentialing. The main expenditure of resource for the GMC of evaluating and testing the model in two areas of practice would be staff time and opportunity cost. Additional outlay would be in the region of £5,000.

General Medical Council

M6 – Credentialing consultation: results and next steps

M6 – Annex A

Introducing regulated credentials – report on the consultation

About the consultation

In December 2014, Council noted the Final Report of the GMC's working group on credentialing and our intention to consult during 2015 on the working group's proposals for introducing a new system of regulated credentials. This new system would allow us to provide accreditation of doctors' capabilities in defined areas of practice areas, in particular those that are not currently covered by specialty training.

The purpose of credentialing is to enhance medical regulation and patient protection by:

- Providing a framework of standards and accreditation in areas where regulation is limited or absent
- Providing patients with information about doctors' particular capabilities and current areas of competence
- Providing recognition of the capabilities of doctors to assure the public, service providers, commissioners and employers that they have met and are maintaining UK standards in their field.
- Providing better recognition of doctors' capabilities to support improvements in workforce flexibility and professional mobility as well as any new architecture for postgraduate medical education arising from the Shape of Training review.

Methodology

The consultation ran from 1 July 2015 until 7 October 2015. The purpose of was to seek feedback on:

- the principles for the credentialing framework

- the appropriate scope and level at which credentials should be set
- the process for identifying and prioritising potential areas of practice where credentials would enhance medical regulation and patient protection
- the process for how organisations would establish a GMC-approved credential
- the process for how doctors would get and maintain a credential and how we would show their credentials on the medical register.

This consultation was not intended to provide us with research data but to give people an opportunity to tell us what they think of our proposals. We have not weighted responses for this analysis. We have evaluated the responses for any trends or particular patterns, especially if these showed consensus or differences between respondent groups. We have used quite broad descriptors such as 'the majority', 'many', 'some', 'a number of' and 'few'. In general, 'majority' and 'many' refer to a pattern showing consensus or strong support. 'Some' and 'a number of' refer to a noticeable pattern but with more variation in the level of consensus or agreement. 'Few' refers to a small number of responses.

The consultation was public and was available on our website and through our online consultation service. We also engaged with individuals and organisations through meetings, seminars and presentations, as well as through our e-newsletters and social media. Our engagement activities were UK-wide.

We asked 16 open-ended questions and allowed for free-form responses. We undertook a qualitative, thematic analysis of the feedback. We broke down the analysis, where possible, by respondent groups. This helped us understand if there were any distinctions between the different categories of people and organisations.

About the respondents

We received 217 responses, 68 from organisations and 149 from individuals. Most of the individuals who responded were doctors or those involved in medical education, training or management. We also heard from a few patient and public groups and government bodies. Many of the medical colleges and faculties and other postgraduate institutions responded, as well as a number of organisations that employ doctors. We received responses from several organisations representing doctors, including organisations representing doctors involved in cosmetic practice (the field most often identified as suitable for credentialing).

Organisations

We received 68 responses from organisations:

- 29 were from UK-wide organisations, such as the BMA
- 10 represented organisations in England such as the Department of Health and Health Education England

- Five were from Scottish organisations, including the Health Workforce Directorate of the Scottish Government, and
- One each from Northern Ireland and Wales.

By far the largest number of responses in this category came from doctors' representative bodies, which is described further in the table below. 24 postgraduate institutions responded to the consultation and for this analysis, we categorised the colleges and faculties, deaneries/Local Education and Training Boards together because of their roles and responsibilities in developing and managing professional standards and postgraduate curricula. We had seven responses from organisations that employ doctors, including NHS Employers and NHS England, along with a few regional and local employers in England, Scotland and Wales. We received one response from a charity representing patients. But a few of the college responses were from their lay and patient committees.

Break down of organisation respondents

Responding Organisations	Responses
Body representing doctors	27
Postgraduate medical institution	24
NHS/Social Care organisation	7
Government	3
Medical school (undergraduate)	2
Other	2
Charity representing patients	1
Independent healthcare provider	1
Regulatory body	1
Total	**68**

When we looked at the 'body representing doctors' category in more detail, most responses came from organisations that represented a particular clinical or medical area. We received only two responses from doctors in training representative organisations but the British Medical Association (BMA) responded on behalf of all its committees, including the Junior Doctors Committee.

Details of 'bodies representing doctors' respondents

Bodies representing doctors	Responses
Specific practice areas, including specialty and subspecialty areas	19
Professional or trade union	3
Defence union or organisation	2
Doctors in training organisation	2
Unknown	1
Total	**27**

Individuals

We received 149 responses from individuals. 143 of these responses were from doctors, five of whom identified themselves as medical educators and one who was categorised as a medical manager. We also received a very small number of responses from medical students (2), members of the public (1) and other healthcare professionals (1).

Doctors

We have broken down the doctor category further and the details are in the table below. It is worth noting that many doctors indicated that they had a number of different roles and responsibilities, especially in management, research, education and training. In order to simplify our analysis, where doctors have identified themselves in more than one category, we have classed them in the one that they identified as their primary role. Consultants accounted for most doctor responses, but this was followed very closely by both Staff and Associate Specialist (SAS) doctors, doctors in training and GPs. This pattern suggests we have a good range of responses from doctors at different stages of their careers and in different types of practice.

Kind of doctor	Responses
Consultant	35
Staff and associate specialist (SAS) doctor	31
Doctor in training	26
Unknown	22
General practitioner	18
Medical director	6
Medical manager	4
Other hospital doctor	1
Total	143

We asked doctors to tell us where they worked. Of the 143 doctors who responded to the consultation, 99 of them worked in NHS practice settings, 17 in independent or voluntary settings and the rest didn't tell us about their workplace.

Demographics

81 doctors were men and 43 were women. Of the 126 people who told us their age, the largest respondent age group was 45-54 with 43 responses, followed closely by both the 55 – 64 and 35-44 age groups. We received 19 responses from doctors between 25-34 and three from doctors over the age of 65. 118 doctors told us about their ethnicity, which is described in more detail in the table below.

Ethnicity	Responses
White- English/ Welsh/ Scottish/Northern Irish/British/Irish/Other	85
Asian/Asian British – Indian	13
Asian/Asian British Pakistani	7
Other ethnic group	4
Asian/Asian British or background	4
Asian/Asian British – Chinese	3
Multiple ethnic background	2
Total	118

Feedback about our proposals

We asked 16 questions related to our proposals for a framework to accredit credentials and recognise doctors who gain the credentials on the medical register. Respondents were not required to respond to all questions.

Support for the concept of regulated credentials

In the Final report and consultation document, we set out our rationale for introducing a mechanism that will give formal recognition of doctors' capabilities in particular areas of practice.

Feedback on our reasons for introducing credentials

We asked '*Do you agree with our reasons for introducing regulated credentials?* (Question 1).

Out of 196 responses to this question (individuals and organisations), 134 respondents (69%) agreed with our reasons for introducing credentials, while 32 respondents (16%) disagreed. A further 30 respondents were unsure about the reasons given.

Out of the individuals who responded, GPs, consultants and SAS doctors showed the strongest support for the proposals. Doctors in training, on the other hand, were more sceptical, with half opposing the GMC's reasons.

Organisations expressed a slightly higher level of support with just 3 respondents expressing opposition. Most conspicuous among the bodies supporting the reasons for credentialing were those representing doctors and postgraduate medical institutions.

Only 1 response was received from a member of the public. That person disagreed with the reasons given for introducing credentialing.

The table below gives more details about respondent groups. The detailed break-down in the tables in this report highlights the feedback from the largest responding groups and does not include the total number of respondents.

Respondents (Question 1)		**Yes**	**No**	**Not sure**
Individuals		**89**	**29**	**19**
	Consultants	*35*	*9*	*7*
	SAS Doctors	*24*	*2*	*4*
	Doctors in Training	*10*	*13*	*3*
	GP	*13*	*1*	*2*
Organisation		**46**	**3**	**11**
	Postgraduate institutions	*13*	*2*	*6*
	Body representing doctors	*18*	*0*	*5*
	NHS/social care organisation	*7*	*0*	*0*

What respondents said to us

There was clear support for the reasons for introducing credentialing, one medical director describing it as '*long overdue'*, while a consultant wanted to '*introduce credentialing for the whole profession*'. NHS Employers was one of a number of respondents which welcomed the GMC's proposals, noting that they would contribute *'towards greater safety for patients and…more flexible training for doctors*'.

Different proponents saw value for patients, doctors, employers and commissioners of services. One GP noted that with the new models of care planned as part of the NHS Five Year Forward View '*I want to give assurance to commissioners that I have the competences needed* and credentialing would be a means of providing that assurance. A CCG took a similar view, arguing that under the new models of care '*this could provide assurance that the medical staff has appropriate competences*'. The Centre for the Advancement of Inter-professional Education saw particular relevance for GPs with extended roles '*in the changing healthcare environment where GPs are expected to take on more responsibilities'*.

Respondents from the independent sector also saw the relevance to them. BMI Healthcare, for example, said that a '*trustworthy credentialing system would allow us to assess the quality of doctors applying for practising privileges in our hospitals*'.

But, as the consultation document had acknowledged, not every area of medical practice would be suitable. A body representing doctors felt that '*credentialing will be useful for areas of practice where there is not a clearly defined standard of practice*' and the Joint Committee for Surgical Training (JCST) saw *'scope for credentialing in areas currently*

lacking regulation or outside current curricula'. A consultant saw credentialing as '*very sensible*', though this was qualified by another who felt '*it only makes sense for areas outside current competency assessment frameworks*'. The Royal College of Obstetrics and Gynaecology (RCOG) also offered cautious support for the '*proportionate use of credentialing' in areas that 'do not have defined training pathways'* as that would '*provide clarity for patients in determining the capabilities of their doctor*'. This was echoed by Royal College of Psychiatrists (RCPsy) which saw '*advantages*' in credentials but wanted to guard against it '*mushrooming*' in areas '*directly linked to existing curricula'*. Similarly, the British Society of Head and Neck Training supported credentialing '*on a limited scale'* to maintain standards in those areas of practice which are currently poorly regulated.

A medical director from the independent sector echoed this qualified support, noting that there is '*a fundamental need to provide some form of recognised accreditation in areas[s] of practice which are not covered by traditional specialities or where an area of practice covers a number of different specialties'*. This was also the view of a number of organisations, such as the British Thoracic Society, which said '*credentialing should be limited to areas which are genuinely outside current specialty remit'* and Health Education England, which felt '*we should consider limiting credentialing to where it is most needed…where it provides a solution to a problem'*.

A number of responses identified areas outside of specialty or subspecialty areas for which credentialing might provide a solution including: gender dysphoria medicine, forensic medicine, geriatric emergency medicine, evacuation crisis mental health, cosmetic surgery, breast disease management and psychosexual medicine.

The Association of Gender Identity Specialists felt that the problem to be addressed by credentialing was twofold. First, where the skills required to deal with the specialty area are '*quite distinct from and are in addition to those generally found in the specialty'* from which practitioners come (in this case gender dysphoria). Second, to deal with the situation in which '*any doctor could declare themselves to be a specialist in this field and proceed thereafter to practise in any way they like'*. Similar views were expressed by a doctor working in psychosexual medicine. These provided helpful illustrations of the potential value for credentialing where there is not a clearly defined standard of practice.

The British Junior Cardiologists Association also saw value in credentialing as a *'mechanism for Consultants to acquire skills in new areas of practice which have developed since their CCT'*. This was echoed in the response from the Royal College of Physicians and Surgeons (Glasgow) which endorsed the view '*that there is a need to ensure those practising in new or specialised areas have a recognisable qualification to do so'*.

But among groups of doctors, it was SAS doctors who saw most value for themselves in credentialing (24 to 2 in favour). It was both a means of recognising their knowledge, skills and experience and would '*act as a powerful stimulus to encourage greater acquisition of skills by SAS doctors'*. A medical educator who was not a SAS doctor saw the

need to '*signal career pathways for some not currently accommodated in the training systems*'. As a counterpoint to this, a SAS tutor felt that SAS doctors were unlikely to benefit as most did not work in fields where credentials were likely to be created. Another SAS doctor anticipated that they would be deterred from attaining skills and *'barred from performing duties that are already well within their scope and capabilities'* if they did not hold a credential.

Although some welcomed credentialing as part of the future architecture of postgraduate training described in the 2013 Shape of Training review, the predominant concern among those opposed to credentialing was that it would undermine CCT training and doctors in training if it was possible to obtain credentials without having to complete the full CCT curriculum. This was the clear view of the doctors in training who responded. As one doctor in training argued, credentialing '*will allow for individuals to get a 'sign-off on bits and pieces without expecting completion of a rounded training curriculum'* so that *'it will render the concept of the training programme useless*'. The Royal College of Surgeons (England) similarly objected to '*pre-CCT credentialing'* which would '*deconstruct the CCT'* (even though this was not proposed in the consultation) and lead to restrictions on practice.

But perhaps the greatest concern among both opponents of credentialing and those who were undecided, was its relationship to the Shape of Training proposals. The Faculty of Pain Medicine felt it was difficult to answer the consultation proposals *'before the final outcomes of Shape have been agreed'*. Health Education England was similarly cautious. Although supporting the rationale for credentialing, it wrote that the '*GMC must recognise the role that [credentials] may play with regard to Shape of Training*'.

The BMA did not feel that credentialing offered any value in terms of patient protection that '*cannot be addressed through the appraisal and revalidation process'*. Others challenged this view, with one CCG questioning the ability of appraisal '*to assess competent and safe practice in specialist areas of medicine*'.

Cost and regulatory burden were also a concern for some. One medical manager saw credentialing as simply '*More burden for likely little real benefit'* while a consultant complained that the '*costs will inevitably be passed on to doctors'*. Those costs were described as not only financial but also in terms of '*creating a barrier for progression'*.

A few respondents argued that the existence of appraisal and revalidation meant that credentialing was unnecessary.

Disadvantages to our proposals

We asked '*Can you think of any disadvantages to our proposals for credentialing? If so, how might we mitigate them*?' (Question 2).

199 respondents answered this question, with 139 from individuals and 59 from organisations. Many of those opposed to our rationale for credentialing rehearsed the

reasons for their opposition given under question 1. Others identified risks which could arise depending on how credentialing was implemented or issues and challenges that would need to be taken into consideration. Few respondents commented on how risks or disadvantages might be mitigated or addressed.

Respondents (Question 2)		**Yes**	**No**	**Not sure**
Individuals		**102**	**25**	**12**
	Consultants	*29*	*4*	*2*
	SAS Doctors	*14*	*11*	*6*
	Doctors in Training	*24*	*2*	*0*
	GP	*12*	*4*	*1*
Organisation		**51**	**3**	**5**
	Postgraduate institutions	*22*	*0*	*0*
	Body representing doctors	*18*	*1*	*4*
	NHS/social care organisation	*6*	*1*	*0*

What respondents said to us

By far the greatest concern was that credentialing would be introduced in areas already covered by the CCT. This would undermine training and lead to the proliferation of narrowly skilled '*technicians*' being able to market themselves as specialists when they lack the more rounded competences and capabilities of those possessing a CCT. They argued it would provide a cheap, '*backdoor entry*' to specialist practice and would give patients false assurance of a doctor's capability. This view was particularly prevalent among the doctors in training who responded. For example, the Junior Cardiologists' Association was worried about duplication if credentials were introduced for domains of medical practice already covered by postgraduate training and revalidation. As one consultant put it, credentials '*should not create another way to practise in the same field*' as this would give a false impression of equivalence.

One respondent referred to credentialing leading to the Balkanisation of sub-specialties. RCPS Glasgow reflected a similar concern when it wrote that '*Compartmentalising what doctors do is also a risk*' and that good decisions required an understanding of whole patients and their associated co-morbidity. The processes for credentialing needed to reflect this. RCS England supported credentialing in areas of medicine which fall outside recognised medical specialties where there is a lack of existing regulation and patients are vulnerable. But the college saw grave risks in its more general application because it would undermine existing postgraduate training and lead to '*narrow credentialed roles*' at a time when doctors needed to take a more holistic approach to care.

One way to prevent fragmentation of training and the rise of the technician was for credentials to be available only to doctors already on the specialist register or GP register (Both the Association of Surgeons in Training (ASiT) and British Orthopaedic Trainees'

Association (BOTA)). A consultant warned that it would be important to make a clear distinction between credentialing and specialist registration.

As with the responses to question 1, some of the perceived disadvantages of credentialing were linked to uncertainties about the current Shape of Training agenda. The Faculty of Pain Medicine was one of several respondents that felt the GMC's approach to credentialing cannot exist in isolation from the decisions that will be taken by the Shape of Training Steering Group and that credentialing should be put on hold until the final recommendations from Shape were known. The British Geriatric Society was concerned that *'core areas of practice could be transferred to credentialing from within the pre-existing curriculum'*.

One college looked ahead to the effects of credentialing on the future development of specialties. It feared that by establishing credentials '*some specialties may not develop fully*'. The mitigation was to make sure that credentialing was not '*seen as the end point that precludes a formal specialty curriculum development in the future'*. Although the college did not explicitly say so, its comments suggest that credentials that have been established may also, over time, need to be retired as specialties develop or elements of the credential become absorbed into postgraduate training. This was picked up in comments from Health Education England which warned against '*assuming existing training curricula will be static*' and the dangers of '*proposed credentials cross[ing] existing specialty boundaries'* – a comment which appeared to lend weight to the importance of involving the colleges closely in decisions about the establishment of credentials in their areas of expertise.

At the other end of the spectrum were those whose fears were less about the implications for speciality training and more for the consequences on the existing workforce. In particular, there was concern that credentialing would *'undermine the position of existing practitioners'*, particularly those consultants working in relatively narrow fields of practice who might find it difficult to obtain a credential. The Faculty of Sexual and Reproductive Medicine warned that credentialing might '*hasten the retirement of doctors'* unless there was a process for awarding them credentials through grandfathering arrangements.

Some saw the greatest risk in how credentials may be perceived by other doctors or those employing doctors. SAS doctors were supportive of the proposals (see question 1) but one SAS doctor warned that '*you need to make sure that the specialty consultants do not discriminate against SAS doctors*' and another feared consultants would use it '*as a weapon'* to stop SAS doctors' career progress. From a different perspective a doctor in training objected that credentialing would '*undermine the importance of those trained to CCT level'* in favour of '*enhancing SAS doctors jobs'*, while another dismissed it as giving '*more scope for inadequate, potentially dangerous practitioners'*. Some foresaw that rather than enhancing workforce flexibility, credentialing could be exploited by '*unscrupulous doctors'* when on-call to avoid difficult cases in areas where they are not credentialed (RCA).

For many the worry was how employers would use or misuse credentialing. The RCA said that it could, if not properly managed, lead to the introduction of a sub-consultant grade. The Royal College of Radiologists foresaw the possibility of employers not encouraging, or even putting barriers in the way of, consultants with special interests who wished to obtain credentials. The Faculty of Occupational Medicine went further, fearing that '*managers will decide that only doctors with a credential can undertake work'* in a particular area of practice. Other respondents worried that employers would look to '*appoint doctors with credentials rather than CCT holders'* and that '*credentialing will in effect become compulsory*'. For the British Society of Head and Neck Training this meant the risk of employers trying to provide a workforce *'at reduced cost'*. If the idea of credentialing were to take hold, employers might expect doctors working in fields of medicine for which credentials existed, to obtain the relevant credential.

NES feared that doctors' career progression could be '*hampered or pigeon-holed into small areas of practice*'. An individual respondent saw credentialing as a '*Threat to the benefits of generalism as a discipline'* while an organisation warned of the need to '*avoid unnecessarily excluding generalists*'.

Linked to the concerns of others about credentials duplicating areas of postgraduate training, RCR also warned against the risk of consultants being disadvantaged if training they had undertaken within their CCT was not properly recognised as a result of a specific credential being established in the same or a similar area. The idea of inequality of access to credentials in different parts of the country was also picked up by the BMA.

All of these concerns pointed towards the need for great care in determining which areas of practice might be suitable for credentialing and whether there was a genuine need. For some, this meant close involvement of the medical colleges as they would be best placed to identify and avoid potential conflicts or overlaps with existing specialty and sub-specialty curricula, training and qualifications, as well as workforce implications (Faculty of Intensive Care Medicine). They were also seen as more likely to have the '*qualitative skills'* necessary to meet the required standards (JCST). This would help mitigate the risk of a '*free for all'* approach to creating credentials. Similar views were expressed by a number of colleges and other respondents. The Faculty of Pain Medicine said that creation of credentials must either be limited to the colleges or '*produce a very clear specification of what qualities a responsible authority must possess'*. The RCP Patient Liaison Committee also highlighted the need for '*ongoing and real patient and public involvement in the developments*'.

The counterpoint to the insistence on college involvement came from the Institute of Psychosexual Medicine. It was concerned that the requirements set by the GMC for bodies wishing to establish credentials could be too onerous for smaller organisations to satisfy. Thinking along similar lines, a SAS doctor questioned whether the establishment and maintenance of credentials would be '*sustainable in the long term'* for bodies with small memberships.

The feeling that credentialing was another regulatory burden being imposed on doctors was common to many of those opposed to the idea: '*another hoop to jump through when doctors just want to get on with the task at hand*'. Some organisations shared this view. A respondent from the NES SAS Project was concerned '*about the amount of time spent away from patient care by those trying to achieve a credential and those involved in the assessment process'* while the RCA was worried about the resources required to establish and maintain a credentialing system.

Linked to this were disadvantages related to the cost. NHS Ealing CCG noted the '*cost of setting up and administering'* the process and the training to acquire credentials. Cost was also among the disadvantages noted by the Faculty of Occupational Medicine.

Several respondents identified the risk of '*vested interest groups'* exploiting the process by establishing credentials as a way of creating '*barriers to entry*' to practise in order to protect an area of private practice. Others noted the possibility of organisations competing to be recognised as the authoritative body in their field, with the result that one or other group of doctors would lose out. The UK Neurointerventional Group noted that '*Turf wars may be fought via credentialing*', while RCA warned of a '*feeding frenzy'* among specialist medical societies eager to have their diplomas recognised as GMC credentials. NHS Employers warned of *'privately run training organisations cashing in on a doctor's perceived need to accumulate large numbers of credentials'*.

The idea that some organisations and individuals would suffer in the battle to gain recognition was to some extent reinforced by respondents from disciplines who feared that their field and expertise would be '*side-lined*' by other organisations or fields of practice. The way to mitigate this was for the GMC to ensure they do not claim '*monopolistic jurisdiction over the credential in this area'*. To prevent conflict between aspiring authoritative bodies in the same field, an independent panel convened by the GMC should be the final arbiter (HEE). Such a panel could also '*ensure that the credentials are for a narrowly defined area of practice, that not all specialists in that field would need to have (so would not be part of the CCT curriculum)*' (HEE). There may be another, more strategic advantage in HEE's approach to deciding upon the creation of credentials since it could help align their development with national priorities.

Public understanding of credentials was seen as vital by many. RCA said that '*patients are unlikely to understand the difference between credentials and a CCT'*. Patients needed to understand their relationship to CCTs and the implications of an individual having, or not having, a credential. RCOG warned of the risk that the absence of a credential '*either by a doctor or within a specialty field may be perceived negatively*' by patients and the public without due cause. This risk was also voiced by NHS Employers. Conversely, there was concern about possession of credentials giving '*inappropriate reassurance to patients'*.

Aside from the concerns about what was contained in the consultation proposals, some respondents felt they needed much more information about what was planned, including

workforce implications, funding, training arrangements, assessment methodologies and quality assurance.

MDU suggested a measured way to move forward amidst all of these concerns. It supported credentialing limited to areas of practice where there was a perceived need and advocated piloting in a few areas of practice to determine whether credentialing delivered the benefits expected.

Support for the principles of regulated credentials

In the consultation, we proposed that credentials should only be developed if they address four criteria: patient need, service need, feasibility and support from the authoritative body in the relevant field. We also set out a number of expectations for how credentials may be defined, designed and developed by organisations.

Feedback on our proposals for criteria to establish credentials

We asked '*Do you agree that regulated credentials should only be established if all of the four criteria we have identified are met*?' (Question 3).

197 respondents answered this question. 129 (65%) respondents agreed that regulated credentials should only be established if all of the four criteria we have identified are met, 32 disagreed and 36 were not sure. A further break down on respondents is set out below.

Respondents (Question 3)		**Yes**	**No**	**Not sure**
Individuals		**87**	**24**	**27**
	Consultants	*25*	*5*	*5*
	SAS Doctors	*18*	*4*	*9*
	Doctors in Training	*10*	*13*	*3*
	GP	*12*	*0*	*5*
Organisation		**42**	**8**	**9**
	Postgraduate institutions	*11*	*7*	*3*
	Body representing doctors	*17*	*1*	*5*
	NHS/social care organisation	*6*	*0*	*1*

What respondents said to us

The majority of respondents to this question supported the idea that credentials should meet the four criteria. For example, the Royal College of Radiologists commented that *'credentials must be limited to where they are needed and…the four criteria given provide a good basis for deciding this'*. Similarly, a doctor also commented that the four criteria were an '*excellent way of ensuring patient safety and quality'* and the Association of Breast Disease Management highlighted that without set criteria, the value of a credential would be undermined.

A number of respondents insisted that there would need to be oversight of any set criteria including a process for debating different views on the need for, and detail of, a credential. Some respondents also suggested that identification of service need must be done at a national level and the Joint Royal Colleges of Physicians Training Board suggested '*Without national oversight, there is the real risk of developing a mixed-economy in terms of delivery and sustainability*'.

Some respondents were not convinced that all four criteria should be required for credentials and recommended prioritising them. For example, the Joint Committee on Surgical Training commented that '*Patient need is clearly the overriding criterion and should be aligned with service need*'. Whilst the Royal College of Anaesthetists suggested credentials *'need to support national and local workforce (service) plans, long term policy agendas, existing and future workforces'.*

One doctor questioned whether patients would understand the criteria. NHS Employers was unclear how credentials would fit with the existing education and training system. The Faculty of Sexual and Reproductive Healthcare commented that doctors in areas of practice without a Royal College or Faculty may be left out and warned that '*Credentialing might become an economical exercise for the popular and more lucrative areas of practice and market forces could dictate the quality of credentials*'.

Others viewed feasibility and support as the most important criteria, commenting that patient and service need were not adequate criteria as they are both subjective. In contrast, some respondents suggested that patient need and feasibility were most important and others commented that the criteria should include either patient need or service need but not both.

A number of respondents expressed concerns about the inclusion of 'service need' as one of the criteria for establishing a credential, arguing that patient protection should be the over-riding consideration regardless of the needs of the service For example, the Royal College of Physicians Patient and Lay Committee argued that *'if service need becomes one of the requirements then areas in which patients need protection, such as cosmetic surgery, will not be included in developments as they are not of interest to the NHS*'. It would certainly be important not to take too narrow a view of what constitutes a service need. In the case of cosmetic surgery the views of patients, surgeons, providers and insurers (among others) would all be part of the evidence required to demonstrate service need.

There was also concern from one doctor that the criteria may be too restrictive for some areas of medicine, which could impact on SAS doctors who want to gain recognition for their skills.

But respondents also highlighted that greater clarity is needed around a number of aspects of the four criteria proposed. The Association of British Neurologists, along with other respondents, commented that the specifics of the criteria need to be defined. A

number of respondents stated that a clear definition of an authoritative body* was needed, including who decides what constitutes an authoritative body and what happens where more than one body wishes to be an authoritative body for one credential area. A few respondents suggesting the criteria would be '*difficult to operationalise*'.

Three respondents made suggestions for additional key measures under the criteria. The BMA recommended that organisations should demonstrate that *'the proposed credential does not undermine or supplant any existing specialist or GP registration or training certification, in the areas covered by the proposed credential and more generally'.* A similar suggestion was made by a doctor in training. The Picker Institute Europe suggested *the relational aspects of care (communication and respect for patient preferences)'* should be fundamental to the patient need requirement.

Feedback on our proposals for the breadth of credentials

We asked *'Do you agree that credentials should be developed for areas of medical practice rather than for individual procedures?* (Question 4).

135 individuals and 59 organisations responded to this question (194 in total). 69% agreed that credentials should be wider than individual procedures with 17% arguing credentials should be more narrowly defined and 14% unsure. Doctors in training were the only category of doctors in which the majority opposed our proposed approach. In contrast, consultants, SAS doctors and GPs were more supportive of a broader scope for credentials. The table below breaks down the responses further in some of the respondent categories.

Respondents (Question 4)		**Yes**	**No**	**Not sure**
Individuals		**86**	**30**	**19**
	Consultants	*21*	*8*	*6*
	SAS Doctors	*27*	*2*	*2*
	Doctors in Training	*7*	*12*	*7*
	GP	*13*	*3*	*1*
Organisation		**48**	**3**	**8**
	Postgraduate institutions	*18*	*2*	*1*
	Body representing doctors	*18*	*1*	*4*
	NHS/social care organisation	*6*	*0*	*1*

What respondents said to us

* We have defined an authoritative body in our consultation on regulated credentials as 'The body accepted by the GMC as having the standing, expertise and capability to provide assurance that the credentialing body is well placed to develop/deliver a credential in a particular field of practice'.

There was general support for recognising areas of practice as credentials rather than individual procedures. Even some respondents who were not supportive of credentials, nevertheless agreed that if they were to be developed this should be the preferred approach.

Many respondents suggested doctors must be able to treat patients holistically, even when they work in particular areas of practice. They argued that in order to keep up to date with new developments and knowledge, doctors have to demonstrate more than just the ability to perform one specific procedure. The Royal College of Anaesthetists commented that: '…*their scope should be as wide as possible as doctors should be able to deal with a variety of cases and patients in whatever specialty*.' This was echoed by the Joint Committee on Surgical Training: '*procedures are just part of an area of practice and in some areas of medicine are part of an approved curriculum of which competence may be assessed and gained in a number of ways, therefore a procedure would not need to be 'a separate credential'.* One doctor emphasised that specific procedures become out of date very quickly and that credentials should be *''maintained throughout a career rather than a test for a single or multiple procedures'.*

While there was support for our proposal on the breadth of credentials, some respondents called for a clearer understanding of how credentials will impact on postgraduate training. There were concerns that developing credentials for broad areas of practice may undermine the CCT. The Royal College of Surgeons of England commented that the scope of a credential should be above that of procedure but '*not of sufficient breadth that is threatens to replace or undermine the award of the CCT'*.

Other respondents generally agreed that credentials should be introduced to cover whole areas of practice, but called for flexibility as one set of requirements may not be fit for all specialties/ areas of practice. Health Education England suggested the breadth of credentials *'need[s] flexibility to allow us to truly deliver patient care innovatively'*. Similarly, a doctor in training emphasised that credentials could be developed for both specific procedures and areas of practice. A few organisations provided examples where credentials may fit into this more flexible approach better. For example, the Independent Doctors Federation suggested credentials would be valuable in areas such as laparoscopic cholecystectomy and endoscopic surgery as a broad area of practice. In contrast, the Faculty of Occupational Medicine, while supporting our approach to credentials, thought that procedure-based credentials are *'likely to deliver a high quality patient outcome'* due to the frequency of the doctor performing the procedure.

Some respondents were particularly concerned that broadly defined credentials would impact negatively on the CCT and as a consequence, preferred the GMC to accredit specific procedures. The Royal College of Physicians of London Trainees Committee argued '*Increased specificity is the best way to distinguish a 'credential' from the achievement of a certificate of completion of specialty training or its equivalent'.* Although coming from a different perspective, an SAS doctor also supported recognising procedures

rather than scopes of practice because it would benefit SAS doctors because they '…*are doing procedures that consultants do not or cannot do and this should be listed.'*

A few respondents also commented that credentialing is best suited to non-clinical areas such as leadership and management. In the joint response from ASiT and BOTA, they commented'…*credentialing may be useful in non-clinical aspects not already covered by a specialty training programme, such as medical education or leadership and management. We feel that attainment of a credential in these areas is less likely to negatively impact directly on patient safety and therefore could be obtained by those not on the Specialist Register.'*

As with previous questions, a few respondents indicated that they were unclear about the definition of credentials, including how breadth will be determined. For example, a doctor in training was '…*a little unclear… what the difference between 'individual procedures vs areas of medical practice' will be'.* The Forum for discussion of the development of musculoskeletal medicine also felt there was *'no clear distinction between defining areas of practice or ranges of procedures'*. They suggested it was irrelevant whether a credential exists for a specific procedure or an area of practice since the outcome of a credential is that a doctor has '*the ability to function independently in the prescribed activities'*.

A small number of respondents, mostly individual doctors, reiterated that they did not support the idea of credentials and recited reasons described in question one.

Feedback on our proposals for the level of credentials

We said in the consultation document that a credentialed doctor must be able to practise safely and competently without supervision in the credentialed area within the context of clinical governance. The level will be comparable to the level expected of a doctor who has a CCT or equivalent, but only in the particular area related to the credential.

As well as any particular technical or specialist capabilities necessary for the field of practice, credentialed doctors must also have the generic professional capabilities associated with practice at that level (for example, in the areas of professional values and behaviours, leadership and team working).

Depending on the area to be credentialed, an individual credential could be set at a higher level of expertise. However, we said that, initially at least, we wouldn't establish different credentials at different levels within the same field.

We asked '*Do you agree with our proposal for the level of a credential*? (Question 5).

58 organisations and 133 individuals responded to this question with 64% agreeing with our proposal for the level of a credential, and 36% disagreeing or unsure about our approach.

Consultants, SAS doctors and GPs tended to support the principle that credentials should only be granted to doctors once they have demonstrated they are able to work independently in their particular area of practice. In contrast, most doctors in training rejected our proposed approach.

Whilst the majority of organisations supported our proposal on the level of credentials, a strong minority rejected the approach. This was particularly evident amongst some of the medical colleges and faculties. But NHS Employers and other service-based organisations unanimously valued a clear marker of level of capability through a regulated credential.

The table below sets out more details about respondents.

Respondents (Question 5)		**Yes**	**No**	**Not sure**
Individuals		**85**	**32**	**16**
	Consultants	*24*	*7*	*4*
	SAS Doctors	*25*	*2*	*3*
	Doctors in Training	*9*	*16*	*1*
	GP	*9*	*6*	*2*
Organisation		**37**	**14**	**7**
	Postgraduate institutions	*11*	*9*	*1*
	Body representing doctors	*15*	*4*	*4*
	NHS/social care organisation	*7*	*0*	*0*

What respondents said to us

The majority of respondents, particularly consultants, SAS doctors and NHS organisations agreed with our proposals about the level of credentials. As one SAS doctor stated *'A credential must be of a high standard and equivalent to other practising senior independent clinicians*'. A medical director in the independent/voluntary sector echoed this view: *'I consider that it is essential that a doctor should be able to demonstrate that they have attained a sufficient level of knowledge and skill for safe independent medical practice before they would be eligible for a credential'*. But the British Medical Association, which opposed our proposals for credentialing commented '*We …are not convinced that there are any areas in which doctors should need credentials in order to practise autonomously'*. A few respondents also commented that doctors should not need additional accreditation after CCT in order to apply for posts.

A number of respondents went on to clarify how levels may work. For example, some (such as RCOG) highlighted that doctors wishing to acquire a credential must demonstrate they have the necessary generic professional capabilities. Others suggested that credentials should include the 'whole scope of practice' of a particular area of medicine.

However, many respondents, regardless of their support for credentials were concerned about its relationship with the CCT. Health Education England, whilst supporting the level of credentials, suggested *'…it should not be possible for a practitioner to develop a series of credentials and then claim that they are the equivalent to a CCT'.* For the avoidance of doubt, we have no plans to develop credentials in this way.

The majority of respondents, who rejected the proposal or were unsure about it, were concerned that credentials would erode the value of postgraduate training. This view was strongly held by doctors in training and a very small number of colleges. The Royal College of Physicians of London Trainees Committee commented'…*it is important that credentialing does not become a requirement for CCT…being competent to practice independently should be sufficient'* .A doctor in training declared '*This devalues training programmes, and the hard work and dedication required to achieve CCT/CESR'.* A few respondents questioned the need for credentials when existing processes are already in place to develop skills, with a consultant indicating *'Any standard has to be at the level of CCT and it defies common sense why this should be introduced while a robust process is already in place*'. These comments reflect misunderstanding about what is intended; credentialing would be neither a pre-requisite for a CCT, nor a duplication of the CCT.

Some respondents, however, suggested the level of credentials may be different depending on the specific needs of different areas of medicine. One medical director commenting *'The credentialing process should support patient safety in each area, and the needs of different areas may be different in this regard'*. NHS Employers recommended a more flexible approach, arguing that *credentials would be helpful in acknowledging competence in highly specialised areas of practice', but also 'that it would be helpful if credentials could be used to acknowledge different stages of postgraduate medical training completed, when a doctor hasn't progressed to CCT'.*

Some respondents who answered 'no' or 'not sure' to this question commented that the level of credentialing proposed was not sufficiently clear. For example, Cambridge University Health Partners were concerned about the professional and public perception of the term 'credentialed' and felt this may lead to some confusion: '…*there will have to be a separation in terminology to reflect the differences between being credentialed as a sub-specialist in tertiary centre medicine and being credentialed for discrete areas of practice outside of standard training schemes'.*

Feedback on our proposals for tiered credentials

We asked '*Do you think that in future tiered credentials (several credentials set at different levels within the same field of medicine) could add value to our approach to regulated credentials?'* (Question 6).

Respondents had mixed views about tiered credentials with 41% opposing the proposal and 32% in favour and 27% unsure. This pattern was seen across both organisations and individuals who responded to this question.

Respondents (Question 6)	Yes	No	Not sure
Individuals	**45**	**53**	**32**
Consultants	*11*	*14*	*9*
SAS Doctors	*10*	*10*	*10*
Doctors in Training	*9*	*15*	*2*
GP	*8*	*5*	*3*
Organisation	**15**	**24**	**20**
Postgraduate institutions	*5*	*13*	*3*
Body representing doctors	*5*	*9*	*9*
NHS/social care organisation	*3*	*0*	*4*

What respondents said to us

Nearly all respondents who answered 'no' or 'not sure' to this question commented that tiered credentials would simply increase bureaucracy, confuse patients and be far too difficult to establish. The Royal College of Emergency Medicine commenting that *'the credential should confirm that the level of independent practice in the defined scope of practice has been reached. Having multiple levels will negate this benefit and make the process over complex*'. Similarly the Royal College of Anaesthetists suggested *'…this would complicate the system even more from an administrative point of view, and confuse patients, managers and commissioners about who is best qualified to practice in a given area*'. And the Royal College of Physicians Patient and Lay Committee commented *that a tiered system of credentials would further complicate this situation and be to the detriment of patients and patient care*'.

A number of respondents also worried that a lower level of credential may suggest a lower level of competence and the potential for some doctors to be seen as second class. One medical educator declared *'There are no levels of competency; a practitioner is either competent or not competent'.* Similarly, some respondents were also concerned that different levels of credentials could lead to the creation of sub consultant grades. Others views tiered credentials as devaluing the credentialing process with one doctor commenting: *'…it seems to be a back door way of bypassing the college credentials, they will have no value*'.

Respondents also highlighted that a process of tiered credentials would have resource implications which would increase regulatory burden, be impossible to maintain and, ultimately, be reflected in registrant fees. Cambridge University Health Partners commented: *'Credentialing cannot simply become a further tier of training paid for by the hospital or trainee, it needs to be a robust mechanism to engender excellence'*.

But there was also support for the idea that tiers of credentials could provide more flexibility to develop the medical workforce, particularly for SAS doctors. An NHS organisation explained *'Given that these credentials might be open to doctors who have*

not completed general practice or specialist training, tiered credentials would make it clear what level of competency and specialism the doctor had acquired' . A doctor thought '*The process of credentialing needs to encourage, not restrict innovation. Tiered credentialing would allow both a basic level of specialty expertise to be quality-assured, as well as more technical procedures that may be provided less commonly* '.Impact of feedback

Feedback on our proposals on the eligibility for credentials

Although we proposed that credentials should be set at least at the level expected of a doctor who has completed formal postgraduate training, we also said that eligibility should not in all cases depend upon a doctor having obtained a CCT or equivalent. In some fields a CCT may not even exist. The body that develops the credential will need to consider what is appropriate in each case.

We asked '*Is it right that eligibility for a credential should not depend on doctors having a CCT or equivalent?* (Question 7).

175 respondents answered this question. 59% agreed that credentials should not depend on doctors having a CCT or equivalent. The majority of individuals agreed with our approach, with very strong support from SAS doctors. Only doctors in training strongly disagreed with this proposal while consultants were divided in their view. Organisations followed a similar pattern with most endorsing this idea. The table below shows these trends in more detail.

Respondents (Question 7)	Yes	No	Not sure
Individuals	**79**	**36**	**17**
Consultants	*14*	*13*	*8*
SAS Doctors	*28*	*3*	*0*
Doctors in Training	*7*	*16*	*3*
GP	*13*	*1*	*3*
Organisation	**32**	**14**	**11**
Postgraduate institutions	*10*	*8*	*3*
Body representing doctors	*11*	*6*	*5*
NHS/social care organisation	*6*	*0*	*1*

What respondents told us

A significant number of respondents argued that limiting the eligibility for credentials to individuals with a CCT would deprive many valuable and competent practitioners from gaining recognition through the credentialing process. This was particularly picked up in relation to the contribution of experienced SAS doctors. One SAS doctor indicated that credentialing '*offers SAS doctors a chance of recognition at equivalent level. If a CCT is necessary before a credential can be applied, those doctors who cannot apply for a CCT by the nature of their work cannot be recognised.'* Some respondents, especially SAS doctors and bodies representing doctors suggested that if credentialing was designed to

capture fields not covered by specialty straining, it shouldn't be linked to a CCT. The Royal College of Emergency Medicine, for example, '*strongly supports the principle of experienced doctors within Emergency Medicine, independent of CCT, should be able to gain a credential in an area of practice.'*

But a few respondents, especially those who opposed credentialing in general and flexible eligibility in particular, argued that it would dumb down specialty recognition and as a consequence wouldn't protect patients. A doctor in training reflected that '*What is the point then of working hard to become a trainee, being subject to the high expectations of the ARCP panel and cherishing the prospect that your hard work will get you CCT when anybody else can do it in a round about way.'* This was reiterated by another doctor in training who was concerned that '*CCT is a high benchmark for independent specialist practice. It protects patients and maintains a high level of care and patient protection. This is being undermined by this proposal and will therefore lead to poorer care*.'

Some respondents linked the level of the credential with the CCT with a small number suggesting that independent practice should not be allowed without a CCT and that credentials should be confined to specialists with rare skill and expertise. This position was reiterated by British Junior Cardiologists' Association, which argued: *'A lot of skills are acquired on the path to CCT to ensure safe independent practice. Unless all the rigorous processes that are put in place during all stages of postgraduate training are replicated in the credentialing process…it is difficult to see how it could be extended to non CCT equivalent doctors* '.

Although most respondents agreed that a CCT was not the only appropriate measure, they commented that an equivalence process was needed for doctors to demonstrate they have the appropriate skills and experience. But a number of respondents indicated that access to a credential should only be allowed if the doctor can demonstrate both the appropriate expertise and the generic professional capabilities expected in a senior practitioner. A medical director in the independent sector argued: '*But the doctor must be able to demonstrate a minimum amount of basic general professional training to ensure competence and safety in independent practice*.' This is wholly in line with what we are proposing.

Other respondents, particularly a few bodies representing doctors, colleges and NHS Employers called for more clarity on how eligibility would be applied. They recommended the concept should be piloted or tested to determine which credentialing will need a CCT for eligibility and which ones may have a more broad entry requirement, such as research and education.

Support for the legal status of credentials

Feedback on our proposals on legal requirements for credentials

In our consultation document we argued that it should not be a legal requirement to hold a credential in order to practise in a field of medicine for which a credential exists. We explained the reasons for this and described some of the alternative regulatory levers that could be used to support better patient protection.

We asked '*Do you agree with our proposal that doctors should not be legally required to hold credentials?* (Question 8).

An overwhelming majority of respondents supported the proposal that it should not be a legal requirement to hold a credential in order to practise in that field of medicine.

Respondents (Question 8)	Yes	No	Not sure
Individuals	**99**	**14**	**18**
Consultants	*26*	*4*	*5*
SAS Doctors	*28*	*1*	*2*
Doctors in Training	*17*	*4*	*5*
GP	*10*	*3*	*4*
Organisation	**44**	**7**	**5**
Postgraduate institutions	*15*	*5*	*1*
Body representing doctors	*17*	*2*	*3*
NHS/social care organisation	*7*	*0*	*1*

What respondents told us

Many of those against the idea of imposing a legal requirement cited the rigidity, complexity and inflexibility this would introduce into medical practice, as well as the burden and expense of enforcing a mandatory regime. The British Geriatric Society worried that such inflexibility could '*paralyse both recruitment into, and further expansion of, geriatric medicine'*. A medical educator warned it would '*stifle individual approaches and risked destabilising the service'*.

HEE said a legal requirement would '*increase rigidity, and will offer no more protection than non-statutory requirements'*. The RCP London Trainees Committee went further, saying that '*patient care may well suffer due to the limitations placed on practice for those who are competent to work independently (as demonstrated by CCT or equivalent)'*. The Royal College of Radiologists shared this view, arguing that it would be a '*major threat to flexibility and responsiveness of services*'. It also pointed to the illogicality of such a requirement given that '*there are no current legal restrictions on scope of practice for anyone on the Specialist Register'*. The British Society for Gastrointestinal and Abdominal Surgery said that given the potential rigidity, expense and bureaucratic burden of a

legislative approach, it should only be introduced in those areas where there is '*evidence that a number of patients are being harmed*'.

As well as the potential harm to patients, some doctors and bodies representing doctors feared that a legislative approach would '*risk disadvantaging current practitioners in certain areas*'. One organisation felt that it would '*prevent…doctors progressing through their careers*'. A consultant who did not support a mandatory approach, nevertheless worried that the existence of credentials '*will make clinicians who don't have one vulnerable in the case of any adverse event'*.

One GP felt that insistence on a legal requirement could delay or even prevent the introduction of credentialing.

Several respondents argued that imposing a legal duty was excessive because it ignored doctors' own professionalism and the role of employers in effective regulation. One pointed out that '*All doctors have a duty to practice within their competence'*.

The Faculty of Medical Psychotherapy said it was '*the responsibility of the employer to ensure the doctor is fit to do the job at a specific level of competence*' and may want to '*employ credentialed doctor[s] to improve service standards'*. A medical Royal College also saw the role of employers as pivotal by applying '*nationally agreed service standards that can specify whether a credentialed doctor is required'*. Some respondents anticipated that '*in some circumstances the credential may become a "requirement" through custom and practice*' as possession of a credential moves from being "desirable" to "essential" in Job Descriptions' (Health Education North East). It went on to say that this '*would be reasonable in any industry on health and safety grounds and wouldn't require a legal sanction*'. The Faculty of Medical Informatics Steering Group came to the same conclusion; there shouldn't be a legal requirement but NHS employers should specify possession of the relevant credentials as a condition for certain appointments. NHS Employers had a more mixed view. It said that almost half of employers supported a non-statutory approach but that half of those felt that this should be backed up by greater scrutiny of practitioners who didn't have a credential when working in a field for which a credential existed. But just over one third of NHS Employers' members supported the case for legislation.

Some who agreed that there shouldn't be a legal requirement to hold a credential nevertheless pointed to a '*real risk that they will become "de facto" requirements by insurance providers, employers and ultimately the public, putting non-credentialed (but equally well qualified) doctors at a disadvantage'* (RCA). The identical view came from Medical Schools Council.

Like many others, the British Institute of Musculoskeletal Medicine objected to a legal requirement for credentialing because of the rigidity and impracticality, but felt that '*once a critical mass*' of doctors with a credential is obtained, '*the majority will follow*'. JCST shared the view that '*market forces are likely to make any existing credentials a de facto*

requirement' but unlike others concluded that for this reason it would be better to have a legal duty '*to ensure that both patients and doctors have clarity about what is required*'.

As well as noting that some employers may require credentials, respondents also suggested that they had a responsibility to '*actively encourage doctors…to obtain this where a credential is available*' (Public Health Wales).

While most respondents supported a non-legislative approach, some highlighted the importance of providing very clear messages about the significance of holding or not holding a credential. The JRCPTB wrote that the GMC '*must…ensure that the message surrounding the role of the credential is very clear, both to patients, employers and doctors themselves. We must avoid the perception that a doctor, well-established in an area of practice in which a credential may be offered, is less-equipped to work in that areas than a doctor with a credential*'. The Association of Nutrition expressed a similar view that there must be a '*concerted effort to give weight and status to a credential, or it could be ignored and end up as an…ineffective label*'. There should be a '*public information campaign*' to make the public more aware of the system.

A minority felt that without legal underpinning credentialing would indeed be ineffective. A doctor wrote that unless there is '*some form of compulsion unqualified people could still operate*'. The RCPS Glasgow was similarly concerned that '*an optional credential does not protect the public satisfactorily*' but was reluctant to impose credentialing on doctors who have been practicing safely in a particular area for many years.

Others were more emphatic. The RCP Patient Liaison Committee wrote that '*Making it a voluntary decision for doctors to choose whether to be credentialed or not will not improve public safety*'. RCS England only supported credentialing in areas of unregulated practice where there is a patient safety concern and felt that in such areas credentialing should be mandatory. The Faculty of Intensive Care Medicine shared the view that there are '*some areas where it must be a legal requirement…for the sake of patient safety*'. The British Society for Ecological Medicine disagreed, arguing that this '*underestimat[ed] the ability of patients to come to informed decisions on their own care*'. The Forum for discussion of the development of musculoskeletal medicine felt that a statutory requirement was appropriate where '*a potentially harmful treatment is available outside the NHS and there is evidence of mis-use*'. The British Society for Interventional Radiology concluded that the lack of a legal requirement would simply lead to '*confusion*'.

Some tried to specify the circumstances in which a legal requirement might be appropriate. A trainee felt that it should apply for '*independent practice*' outside of the areas of medicine covered by the specialist register. Several respondents identified aesthetic medicine/cosmetic surgery as areas where there should be a mandatory approach. But the RCP Patient Liaison Committee felt that a mixed economy in which some credentials were mandatory and others not risked '*further complicating an already complex system*'.

Feedback on areas where credentials should be a legal requirement

In order to explore the legal issues further, we asked '*If you think possession of a credential should be a legal requirement, are there particular areas of medicine where you think this should apply*? (Question 9).

As the responses to Question 8 show, most respondents did not think that there should be a legal requirement for a doctor to hold a credential. Nevertheless, when asked to identify particular areas of medical practice for which credentialing should be mandatory a very clear picture emerged.

Cosmetic surgery was by far the most frequently cited example of a field of practice where there should be a mandatory requirement. Even among respondents who said that credentialing should not be a legal requirement, this example was repeatedly offered. Out of 48 responses which included substantive comments, cosmetic surgery or cosmetic/aesthetic medicine were mentioned 17 times. In most cases, this was by individual respondents rather than organisations.

Even when cosmetic interventions were not explicitly mentioned, it was often implicit in the more general observations. Thus the JCST said that credentialing should cover '*areas that are currently unregulated or outside approved curricula, including new and emerging areas of practice*'. A GP who favoured a non-legislative approach nevertheless said that it would be *'particularly valuable in areas where there are high risks to patients from doctors who do not hold a CCT, such as cosmetic surgery'*. The Royal College of Psychiatrists said that it would be appropriate in areas '*where there is no competency based curriculum*'. Another GP referred to '*areas not covered directly by publicly funded care, where commercial interest may affect the practitioners' decisions to provide a service'*. A SAS grade doctor referred to work '*outside the NHS'*, while another doctor thought there might be a case if '*there is no clear clinical governance*' in the environment where the treatment takes place. The British Society of Interventional Radiology listed '*New areas of practice which lie outside the remit of existing training bodies*', while a trainee referred to '*areas of medicine outside the conventional areas covered by the specialist register*'.

Other areas of practice mentioned in individual responses included medical leadership and management, forensic medicine, psychosexual medicine, management of eating disorders, plastic surgery, abortion services, musculoskeletal services and working for the GMC. But none these was cited by more than one or two respondents.

The Faculty of Pain Medicine felt that the decision on whether a credentialed field required legal protection should be a matter for the body that creates the credential, and that this should be the relevant medical royal college or faculty. The British Society for Gastrointestinal and Abdominal Radiology did not favour making the process a legal requirement but said that if this was considered necessary in some areas it should only be '*if there is good evidence that there is a significant variation in outcome from different practitioners and that patients are being harmed'*.

A GP who identified cosmetic surgery as an area of practice where a legal requirement for credentialing might be valuable nevertheless concluded that it would be '*confusing to have both legally and non-legally required credentials*' and therefore did not favour '*a hybrid system'*. The Association of British Neurologists shared this view, feeling it would be '*messy and divisive to have some…credentialed areas designated legal requirements, while most are not'*.

Some were ambivalent. The British Society of Head and Neck Training felt there may be grounds for a legal requirement in '*potential high risk areas of practice'* but worried about the risk of patients '*not receiving life saving treatment'* because a doctor lacks the necessary credentials for a particular procedure.

Our proposed processes

In the consultation, we set out two processes for credentialing – how organisations might set up a credential and how individuals might get recognised for obtaining credentials.

Feedback on our proposed model for establishing credentials

We asked '*Do you agree with our proposed process for organisations to establish GMC-approved credentials?* (Question 10).

There was a small majority who supported our proposed model for establishing credentials, with 56% of respondents endorsing the approach. However, a significant minority either rejected or was unsure. In general, the scepticism about the process model was because respondents wanted more detail about how the different aspects would work.

Respondents (Question 10)	Yes	No	Not sure
Individuals	**71**	**30**	**24**
Consultants	*17*	*10*	*8*
SAS Doctors	*23*	*2*	*6*
Doctors in Training	*11*	*14*	*1*
GP	*11*	*2*	*3*
Organisation	**31**	**12**	**14**
Postgraduate institutions	*10*	*6*	*5*
Body representing doctors	*11*	*4*	*7*
NHS/social care organisation	*4*	*1*	*1*

What respondents said to us

A small majority of individuals and organisations agreed that the proposed process was acceptable. One consultant responded that '*This would seem to be appropriate for the*

medical professionals involved in the treatment of people with gender dysphoria' while an SAS doctors found the process '*thorough and robust'*. An NHS body also thought it '*robust and allows for smaller organisations…to help deliver the credential with other more established bodies*.' But some who agreed with our proposed approach qualified their endorsement with pleas to make sure it was cost effective and not unnecessarily bureaucratic. As a GP warned, it must not be '*not an additional cost to the profession'*.

Mostly, respondents wanted more information to help them better understand how the model would work. The RCGP agreed that the first step '*for the GMC to review an initial proposal is welcome as this will prevent the unnecessary waste of resource on the further development of credentials that would be rejected*.' But a Care Commissioning Group stressed that '*we would also want assurance from the GMC that the credential had been developed using a wide base of input, including the relevant specialists, educationalists, lay members, relevant non-medical professionals, etc.*'. This is very much in line with our thinking. Just as we do for postgraduate training now, we will set high level standards for credentialing curricula and assessment which describe what is expected of organisations developing credentials.

Many organisations, including nearly all colleges and most bodies representing doctors, also indicated that the GMC must partner with others to deliver credentials properly. This is exactly what we intend to do. The Institute of Nutrition emphasised this by suggesting '*GMC must partner with external organizations*' but went on to argue that the '*resulting credentials must be 'owned' by the GMC if it is to hold any confidence with the public.*' But some bodies representing doctors and NHS organisations thought about collaboration more widely. They proposed that organisations with an interest in a particular field should come together to develop the credential. Again, this is consistent with our proposals; there would only be one GMC approved credential covering a particular field of practice, but we anticipate that one or more organisations may wish to come together to develop that credential.

A common theme among respondents who agreed with our proposals, and those who were not sure, was the role of the colleges. Given they already have a framework for developing curricula and assessing CCT/CESR applications, there was a push in some of the responses for colleges to lead on this work alone, or take the lead on but work with subspecialty associations. One college stated that '*All credentials must be developed by the relevant medical royal college or faculty in order to ensure alignment with current curricula requirements and provide reassurance to patients and the public…Universities, medical schools and employers should not be able to propose and create credentials unless they have the explicit agreement of the relevant royal college(s)/Faculty(s) and are working in partnership with them.*'

There was also a call from all stakeholder groups, regardless of their support for the model, to clarify how we will develop the role of authoritative body. For example, a body representing doctors, which did not support the proposal, indicated that it felt *'[t]he issue of consistency and an authoritative body responsible for standards and progress needs to*

be defined.' This view was echoed by HEE which suggested '*More detail of the role and potential for organisations coming together in terms of the authoritative body is needed*'.

Some respondents emphasised concerns about the considerable amount of work required to make credentialing work and the potential impact of cost and resource on the wider system. The Association of British Neurologists commented that '*It seems a common sense approach, and difficult to argue with the process, but it is also apparent that this represents a considerable amount of work, and not clear how this would be funded*'. Whilst HEE queried '*Have the costs and governance implications/arrangements for all of this been factored in*?' Further funding and resource issues are picked up in more detail in question 13. While these are legitimate concerns, we will work with employers, funders/commissioners of services and training and others to develop a system that is proportionate and does not introduce unnecessary regulatory burden. For example, we are likely to set fairly high level standards and expectations that will be evaluated when approving the credential, which will allow the credentialing body to develop the content and assessments for a particular area in the way that best suits its doctors.

Most of the respondents who rejected our process for establishing credentials were against the premise of credentialing as a whole. They rehearsed similar arguments to those described in Question 1. They argued that the process was too complex with a medical school finding that *'[t]here is the potential for this to become a "feeding frenzy" for specialist societies, interest groups, pressure groups, outfits with industry affiliation (or not) etc. etc. All of these will require bureaucracy, complexity, challenge etc*'. The BMA was particularly concerned that '*The interests that organisations might be pursuing could be commercial, or perhaps those of system regulators as opposed to professional regulators, and the pursuit of them could contribute to the fragmentation of medical training*.' The concern that there could be a 'gold rush' among bodies keen to establish GMC approved credentials is a legitimate one. We will therefore develop strict criteria to be met by organisations, much as we are doing for universities in relation to undergraduate medical education. Similarly, as described in relation to question 3, we will set out criteria to be applied when deciding whether a particular area of practice is suitable for credentialing.

Feedback on our proposed model for doctors to get credentials

We asked '*Do you agree with our proposed process for doctors getting a GMC-approved credential recorded on the medical register?* (Question 11).

There was stronger support for this proposed approach compared to the process outlined in Question 10. 176 respondents answered this question. 65% agreed with our model compared to 35% who rejected or were unsure about our proposal. Doctors in training were the stakeholder group most opposed to the model. NHS organisations, including HEE and CCGs, unanimously supported our approach.

Respondents (Question 11)	Yes	No	Not sure
Individuals	**78**	**29**	**17**

	Consultants	*20*	*10*	*4*
	SAS Doctors	*21*	*2*	*8*
	Doctors in Training	*10*	*13*	*2*
	GP	*15*	*1*	*1*
Organisation		**39**	**7**	**10**
	Postgraduate institutions	*13*	*3*	*4*
	Body representing doctors	*14*	*3*	*5*
	NHS/social care organisation	*6*	*0*	*0*

What respondents said to us

Nearly two- thirds of respondents supported our proposed model, with many commenting that it would make our registers more transparent about doctors' scope of practice. This was particularly valued by postgraduate institutions and NHS organisations. HEE said *'[t]his is a transparent and clear approach for patients'* and a postgraduate institution agreed that our approach '*allows patients and [the] public to know about the level of competency [of] doctors and the services*.' Other supporters confirmed they found our process practical and robust. One NHS organisation wrote that '*This is practical, reasonable and provides assurance, particularly because of the oversight by the GMC*.' But it went on to warn that the process must be flexible otherwise it risks '*…stifl[ing] innovative ways of working whilst maintaining standards of safety and assuring competence*.'

However, some respondents, especially those who were unsure about or rejected the proposals as a whole, were not clear or were not comfortable with credentialing bodies making judgements about individual doctors' suitability to be awarded credentials. A doctor in training feared that *'[a]llocating this type of responsibility to organisations/bodies that lack the experience and vigorous internal discipline may be risky*.' While such concerns are understandable, they should perhaps be considered in the light of our intention to establish criteria covering both the standards to be met by bodies wishing to establish credentials and the content and assessment methodologies they will use.

A few respondents across all response categories suggested this process would only work if there were formal appeals processes built into it. Some were uncomfortable with the GMC being able to refuse recommendations from the credentialing body. A body representing doctors explained '*If GMC is not going to trust the credentialing bodies, why have a separate step involving them at all? It would be simpler to have a single review step at which both the relevant specialist organisation and the GMC review the application.*' Other respondents recommended a consistent approach to assessment across all credentials and a few called for a robust quality management and assurance system. It should be noted that the proposed process would include a right of appeal for unsuccessful applicants. It is legitimate for the GMC to have the power to refuse recommendations from a credentialing body because we are responsible for the information we include in the register. What we have proposed is, in fact, not materially different from the current process for awarding a CCT and including a doctor's name on the specialist register.

In our consultation document we had said that the register would show the fields in which a doctor holds a credential (for example, cosmetic surgery (breast) or cosmetic surgery (facial) and the part of the country in which the doctor provided services. A postgraduate institution expressed a concern that to register details of practice nature and location of service provision could introduce patient and/or doctor safety/privacy issues. And another organisation questioned whether the public would be in a position to put their faith in a doctor based on the limited amount of information about a credential on the register. Decisions about the nature and extent of the information to be included on the register should be made in the context of our current review of the online List of Registered Medical Practitioners. However, it is worth noting that the credentialing information we proposed to include in the register is considerably more than anything currently shown.

But the dominant theme among all respondents to this question (regardless of their support, opposition or uncertainty) was resources. One SAS doctor warning that it *'[n]eeds to be recognized though that this is going to be a time consuming and probably expensive process for individual doctors (as is CCT and CESR).* While another SAS doctor worried '*Organizations who are not Royal Colleges are neither rich in funds or resources.*' NES stipulated that '*The doctor's journey seems reasonable, as long as they can get funding to follow it, and funded time to undertake the training*.' The concerns about time were again picked up by the Royal College of Emergency Medicine which suggested '*The workload for the recommending organisation and the GMC needs to be carefully assessed to ensure that inappropriate delays are not seen*.' It also emphasised the role of employers in credentialing and noted that '*NHS employers need to recognise adequate time for this to happen within job plans'*.

Maintaining a credential

Feedback on our proposal for maintaining credentials

In our consultation we said that we did not want credentials on our register to provide merely an historical record of qualifications once obtained. We wanted them to be a more up to date statement of the fields in which doctors are continuing to demonstrate their credentialed standards. We suggested two ways in which we could do this.

Where a doctor has obtained a credential and brought information to their appraisal and revalidation to show they remain up to date and fit to practise within their credentialed field we would like to show this on the register.

The alternative model would be for a credentialed doctor to go back to the body that first recommended the award of their credential for confirmation that they remain up to date in the credentialed field. The credentialing body would then tell us its conclusions. Doctors using this process would still need to be revalidated as a separate process. We asked '*Which model do you think would be the best way of doctors maintaining their credentials?* (Question 12).

There were 171 responses to this question, with nearly all of them expressing a clear preference for one or other of the models. A further response indicated both models were

acceptable and a further eight responses provided comments only. The majority of responses (73%) indicated revalidation as the preferred model with 27% indicating a preference for the credentialing body ('CB' route) model. Whilst 78% of individuals clearly endorsed revalidation as the mechanism to maintain credentials, organisations were more divided about the best approach with about 61% preferring the revalidation model.

Respondents (Question 12)	**Revalidation**	**Credentialing body**	**Both**
Individuals	**92**	**26**	**0**
Consultants	*24*	*8*	*0*
SAS Doctors	*25*	*4*	*0*
Doctors in Training	*24*	*2*	*0*
GP	*12*	*4*	*0*
Organisation	**32**	**20**	**1**
Postgraduate institutions	*13*	*5*	*1*
Body representing doctors	*12*	*10*	*0*
NHS/social care organisation	*3*	*2*	*0*

What respondents said to us

Comments from respondents that prefer revalidation argued that it would avoid duplication and reduce bureaucracy, reduce the financial burden on doctors and allow revalidation to remain the focus for doctors to demonstrate their continuing fitness to practise. Doctors were particularly keen to use an already tried and tested system with a SAS doctor stressing '*I am familiar with revalidation and believe it to be robust system that could be applied to credentialing.'* A GP also points out *'Separate recommendation of credentialing body would be unduly burdensome, and revalidation should cover this'.*

Very similar views were rehearsed by many organisations, especially postgraduate institutions. They generally argued that revalidation already had a robust evaluation process with trained appraisers and effective monitoring systems. It would be unnecessary to introduce a further mechanism into an already burdened workplace. The Faculty of Pain Medicine advised that *'If there are a large number of credentials, individual recommendation from the credentialing body would be far too complex. The revalidation process is in place to assess clinicians against their current practice and this should sensibly include[e] areas of clinical practice learned through credentials'.* Similar suggestions were made by three out of five NHS organisations. NHS Employers wrote that '*any new system of regulation should be built on existing processes'*. They thought credentialing would work best if '*maintenance of credentialed practice can be assessed through this revalidation without creating a new and potentially costly or labour intensive process that would draw doctors further away from patient care*.'

Although the responses and associated comments were in the main supportive of the revalidation model in principle, there were some who thought the addition of certain

elements could improve the model further. In particular, there would be a need for guidance for Responsible Officers, appraisers and appraisees on requirements for maintaining a credential through appraisal and revalidation. This echoed the feedback from Responsible Officers at our consultation events.

Some respondents, mostly postgraduate institutions and bodies representing doctors, recommended that specialist input from within the credential field would be necessary. The JCST, for example, suggested this would work by ensuring '*that the necessary evidence is reviewed by an appropriate individual who is able to give an informed peer review of activity and outcomes*'. But HEE warned that maintaining a credential '*needs to be in keeping with other processes. We do not go back to the eg RCP to ensure that practice is up to the standard of CCT'*

About 40% of organisations endorsed the 'CB route', particularly bodies representing doctors. Interestingly, the reasons for choosing this as the preferred model echoed some of the comments from the respondents who favoured the revalidation model. They centred on the notion that specialist knowledge is required in order to maintain a credential. A medical manager explained that *'While it is legitimate for a doctor to confirm at appraisal that they meet the requirements of credentialing, it is not appropriate for the actual credentialing to be signed off at appraisal.'* This was backed up by a consultant who suggested it was '*hard enough to evaluate the whole scope of practice, but to also be expected to assess credentials would be a step too far. It needs to be done by the body overseeing the credential.'* While most employers in the NHS Employers response backed revalidation, about a quarter supported the role of the credentialing body to maintain credentials because *'[t]hey questioned whether existing appraisers could develop the knowledge and skills required in order to properly assess maintenance of credentialed skills.*' It is certainly true that we could not expect appraisal and revalidation to support credentialing today. As some of our respondents have already noted, there would, at the very least, need to be specialty specific guidance for appraisers and Responsible Officers. As our consultation document acknowledged, we would also need changes to legislation. The question is whether this is the model we should be working towards.

However, many respondents who preferred the 'CB route' went on to comment on how the revalidation model could be improved to meet their concerns or that the two models could be combined. For example the CB could assess whether the credential should be maintained and this confirmation could be brought to appraisal. The Royal College of Surgeons was concerned that '*appraisers and ROs may not be sufficiently competent in very specific areas of credentialed practice to be able to make a judgement as to whether that practice remains at the right standard to allow a credential to be maintained.'* They thought these issues might be addressed by '*incorporat[ing] a review by a second appraiser in an area of very specific credentialed practice, where this is felt necessary by the designated credentialing body.'* Similarly Health Education North East recommended that an expert in the credential could feedback into the appraisal process. Yet it also argued that *'Re-affirmation' of the credential should be 'light touch' and primarily about whether the doctor has used the skills or knowledge to maintain them and if not, what*

they have done to keep up to date.' It seems fundamental that if credentialing is to draw on the existing revalidation process it must not complicate or impose unnecessary burdens on that process.

As with other questions, a few responses called for the model to be piloted, which would allow us to test the different approaches.

Paying for credentials

The way that the development of individual credentials is funded is not a matter for the GMC to decide. Similarly, the funding of the management and delivery of training opportunities associated with credentialing is a matter for others.

However, we did seek views on the costs of the regulatory aspects of credentialing. In particular, we asked how the costs of GMC approval and quality assurance of the credential, and credentialing recommendations should be met.

Feedback on how credentials should be funded

We asked '*Do you have any comments about how the regulatory aspects of credentialing should be funded?* (Question 13)

111 respondents provided us with feedback to this question. Generally, the responses tended to either identify ways credentials should be funded or they described funding arrangements that they thought would be unsuitable.

Most comments to this question rejected the idea that doctors should pay the cost of developing or awarding credentials. Respondents, especially doctors in training, argued that doctors are already overburdened with fees. The British Society of Rheumatology, for example, considered that there is the potential risk of restricting access to credentials to those who can afford to pay the costs, especially where *'[t]his would then limit the potential benefit of credentialing for delivery of care to all patients'.* Indeed, quite a few respondents echoed the view that since credentialing will have to address both service and patient needs to meet our criteria, the costs of developing and awarding credentials should be covered by the government, NHS or other employers. This was particularly relevant for credentials that would benefit the NHS exclusively. An NHS organisation commented that '*We do not believe that individual doctors should have to fund this. We think that the employers and governments should fund it*'.

Some respondents, like NHS Organisations, supported the view that credentials should be funded through employers or funders/commissioners of services, given that credentials are meant to provide a mechanism to develop the medical workforce to meet service needs. Health Education England, for example, was also not supportive of credentialing

being funded by individuals because '*In England, access to credentials will be through a workforce planning process agreed nationally through HEE.*' But HEE's response goes on to recognise that credentials will operate in a complex system where '*there are more issues with trusts supporting credentialing as a ways of attracting trust doctors to work for them*.'

A very small number of respondents argued that doctors should pay through the annual retention fee, but that costs should be kept to a minimum, and there should not be a [significant] increase in annual fees. Other respondents argued that it should be funded by doctors in the same way as the equivalence route for recognition on the Specialist Register, but an SAS doctor hoped employers would be '*willing to support them financially and in other ways to get the necessary experience to meet the requirements of the credential'.*

A small number of respondents recognised that there might be a mixed economy for funding credentials depending on the driving force behinds its development. The RCOG could foresee both NHS funding by employers to encourage doctors to undertake credentials or funding from education commissioners where credentialing is introduced in line with Shape of Training proposals. NHS Employers suggested '*a mixed economy of funding models where costs may be covered by the employer, through centrally commissioned training with HEE (in England), by doctors themselves or a combination of any of these routes*.' One doctor in training indicated that professional bodies might fund credentials through membership charges. Public Health Wales thought there may be options to introduce a national strategy on how contracts are altered once a credential is achieved, commenting that: '*This would provide clarity and equity for doctors going through a credentialing process which may have significant individual cost to them but will also have benefits to the employer'*. But this was in contrast to a medical school, which thought that there would be substantial costs for introducing credentials that will '*have to come out of either patient care or other educational resources or the pockets of the medical staff themselves, none of these are acceptable.'*

As with previous questions, some respondents called for more clarity about how credentialing might be funded, including more research on costs before credentials are introduced or a pilot to test the impact of different funding arrangements. For example, the Royal College of Emergency Medicine wanted clarity on how the credentialing process would differ from the CCT process where doctors pay a fee directly to the GMC and whether fees charged to credentialing bodies would vary. Similarly, the Royal College of Obstetricians (RCOG) and Gynaecologists commented that there needs to be an assessment of whether doctors will in fact be willing to pay for credentials, as to implement the framework proposed will be '*costly to credentialing bodies*' and *'[s]uch a system will only be financially worthwhile if… potentially a large number of doctors [are] willing to undertake the credential'.* Some respondents, particularly bodies representing doctors, suggested that developing the funding arrangements for credentials fell to the GMC.

Impact of Shape of Training on regulated credentials

Feedback on the implications of the Shape of Training model on our proposed approach

While we were developing our proposals for credentialing the Shape of Training review published proposals for the future architecture of postgraduate training. In broad terms, it recommended that doctors should be trained in the generality of their specialties. Highly focused areas of practice, such as sub-specialties, should be delivered through credentials outside of postgraduate training.

The departments of health are responsible for deciding how the Shape of Training recommendations should be taken forward. Our consultation was not about the Shape agenda. Indeed, many of the areas identified as possibly suitable for credentialing under our model would fall outside its scope of interest. However, we could not disregard the implications of Shape and therefore tried to make sure our own model was sufficiently flexible to incorporate any future decisions that might be made regarding the implementation of Shape.

We asked '*Do you agree that the model for regulating credentials described in this consultation document would be flexible enough to incorporate any future changes to postgraduate training brought about through the Shape of Training review?* (Question 14)

175 respondents answered this question with 47% of individuals and 49% of organisations agreeing that our proposed approach is flexible enough to incorporate any potential future changes from the Shape of Training review. However, 22% didn't agree with our assertion, and this was particularly noted from doctors in training and, to a lesser, extent consultants. A significant number of respondents in both individual and organisations categories (about 31%) were unsure whether our approach would be able to incorporate Shape of Training changes. More information about how people responded to this question can be found in the table below.

Respondents (Question 14)	Yes	No	Not sure
Individuals	**55**	**30**	**33**
Consultants	*14*	*12*	*8*
SAS Doctors	*19*	*4*	*4*
Doctors in Training	*9*	*10*	*6*
GP	*7*	*2*	*7*
Organisation	**28**	**8**	**20**
Postgraduate institutions	*10*	*3*	*8*
Body representing doctors	*11*	*3*	*8*
NHS/social care organisation	*3*	*0*	*3*

What respondents told us

Slightly under half of respondents agreed that the credentialing model is flexible enough to adapt to any changes to postgraduate training as a result of the Shape of Training recommendations. Around one fifth of respondents disagreed. However, the picture is far more complex when considering the comments made about this question.

Most respondents suggested it would be better to press on and address the service and patient needs now. Some commentators (mostly postgraduate institutions and NHS organisations) thought our credentialing model would meet any future Shape of Training requirements. The Royal College of Psychiatrists suggested *'it is difficult to see an alternative to the model proposed*.' And a NHS organisation speculated '*The likelihood is that the current mod[el] for regulating credentials would be of use for future changes in post graduate training brought about through the shape of training review'.*

Other comments valued the need for the two models to develop together. The Royal College of Physicians suggested that *'[i]t would be a missed opportunity'* if our model was developed in isolation from Shape. A small number of respondents were adamant that credentialing ought to be progressed alongside Shape with the Faculty of Pain Management arguing it '*should be in tandem with the Shape process, not an attempt to future proof against it*.'

In contrast, several respondents, particularly bodies representing doctors and SAS doctors, indicated that we must introduce credentialing as soon as possible rather than wait for any potential changes to postgraduate training. As one specialist organisation explained, '*established and experienced doctors must have a way of easily demonstrating competence to obtain a credential'.* The Institute of Psychosexual Medicine reiterated that credentialing would be the same regardless of the introduction of Shape of Training: '*Under Shape of Training changes there will still be a need for special interest areas and unmet patient needs to enlist doctors to develop their skills.'*

But most respondents who were supportive or unsure whether our approach is flexible argued that it all depends on how credentialing and Shape are implemented. For some, especially doctors, successful implementation hinged on setting effective education standards. A consultant pointed out that credentialing in either model would be fine *'[p]rovided the new process is as robust as the existing subspecialist training/competency assessment process'.* While quite a few commentators asked for credentialing to be kept flexible and continue to address the need for recognition of areas of practice outside training. A SAS doctor stressed *'[i]t needs to retain a flexibility to encompass those not on training schemes so that they can also become credentialed in a way that avoids their current situation of exclusion form the specialist register.*'

Most of those who didn't like credentialing or the Shape of Training proposals anyway, also answered 'no' to the question of whether our model was sufficiently flexible to accommodate Shape. These respondents tended to focus on the impact of credentialing on current postgraduate training and the currency of the CCT. There were very few

comments directly related to a concern that our model would be unable to meet future changes. Although a doctor in training commented, without further explanation, that *'[t]here is clearly not enough flexibility as described here*.'

A small, but significant number of respondents had concerns about the intention in Shape of Training to change sub-specialties into credentials. Some comments refuted the Shape recommendations, especially about the impact on the length and quality of training. Other comments, mostly from doctors and bodies representing doctors, worried that our proposals for credentialing would introduce the Shape model through the back door. For example, the BMA said that '*The model of credentialing proposed in the present document…appears to form part of the Shape of Training agenda*.' One doctor commented '*I would not think that credentialing suiting SHoT is a point in its favour*.'

A few respondents were unable to support our proposals because there was still too much uncertainty surrounding the Shape of Training recommendations. A few doctors in training pointed out that '*Shape is not a foregone conclusion'* and it is *'not even implemented*.' A body representing doctors made it clear that it could not answer this question because 'W*e do not know what the final Shape of Training proposals will be*.' Some of the postgraduate institutions were also worried about the lack of information or progress around Shape of Training. The RCGP said '*There is insufficient clarity regarding the implementation of Shape of Training proposals to be able to determine if this credentialing proposal will fit*'. A similar view was expressed by the Royal College of Physicians of London Trainees Committee which argued that because '*changes that may result from the Shape of Training review are still uncertain it is inappropriate at this time to determine their regulatory structure*.'

While not great in number, some respondents felt that the meaning of a credential in our proposal and in Shape of Training was different and using them interchangeably has caused confusion. A GP was concerned that '*The public may be confused about whether the credential was a subspecialty or a standalone narrow specialty.'* This led the JCST to comment that '*conflating these two exercises is a source of confusion and ambiguity. This whole subject needs further thought before any model is created as a result of the Shape of Training review*.'

A few respondents called for a pilot to test credentialing in areas outside current specialty in order to establish whether it would be beneficial to expand the approach more widely. The Medical Defence Union indicated that this would *'provide a better basis for making decisions, including deciding whether there is a need to introduce credentialing more widely and if so, how*.'

Equality and diversity issues in our proposals

We asked two questions about any barriers or opportunities for particular groups arising from our proposals. We wanted to identify and, where possible, mitigate, any unintended discrimination in our approach.

Feedback on barriers and opportunities for credentials

We asked *'Are there particular groups who would be helped or disadvantaged by our proposals for credentialing?'* (Question 15) and '*Are there aspects of our proposals that would provide opportunities for or present unfair barriers to such groups?* (Question 16). Because the responses overlapped extensively for these two questions, we have considered them together.

In question 15, just over half of respondents (about 52%) agreed that there were particular groups who would be either helped or disadvantaged by our proposals for credentialing. Only 20% foresaw no impact on any particular group and just over a quarter of respondents were unsure.

Respondents (Question 15)	Yes	No	Not sure
Individuals	**63**	**21**	**34**
Consultants	*19*	*5*	*9*
SAS Doctors	*19*	*2*	*6*
Doctors in Training	*15*	*4*	*6*
GP	*5*	*5*	*6*
Organisation	**26**	**14**	**13**
Postgraduate institutions	*9*	*6*	*5*
Body representing doctors	*11*	*5*	*5*
NHS/social care organisation	*4*	*0*	*2*

Responses to question 16 reiterated many of the points raised under Question 15. There was not much difference in the proportion of respondents who answered 'yes', 'no' and 'not sure' – answers were almost equally split. There was a marginally greater number of 'not sure' answers.

What respondents said to us

A small majority of respondents felt credentials would have some impact on particular groups. Most comments suggested that the impact would be to disadvantage specific groups of doctors. These concerns rehearsed many of the issues raised in previous questions and included: the costs incurred if charged to individuals; increased administrative workload for NHS doctors; limited uptake of credentialing among already busy practitioners if the process is onerous.

Most respondents who identified disadvantages raised concerns that credentials would devalue the recognition of the CCT. Some respondents also raised concerns about the capacity for already established consultant to get credentials. The Royal College of Anaesthetists suggested that '*Senior doctors could be disadvantaged, as they may not necessarily need to hold credentials, yet market pressure would put them at a disadvantage next to more newly qualified colleagues holding credentials*.' One consultant

thought patients would be disadvantaged because it '*would dumb down the specialist register'* although it is not clear why this should be the case

A few GPs worried that GPs with special interests (extended roles) could be disadvantaged if a credential was developed and managed by specialty areas rather than co-ordinated jointly with the Royal College of General Practitioners. A similar view was expressed by some of the representative organisations for particular conditions who feared that their areas of practice could be marginalised as credentials become more main stream. For example, the response from the British Geriatric Society, whilst supportive of our approach to credentials, was concerned that it may result in '*employers …potentially see[ing] a false equivalency between a credential in the care of older people, and a CCT in geriatric medicine…It would be harmful if, for example, an 'endocrinologist with credential in older people's care' was seen as more specialised than a 'consultant geriatrician.'*

Both part time doctors and women doctors were identified as groups at risk of being disadvantaged by credentials because they will not necessarily have the capacity or resources to undertake credentials, particularly in areas where employers may prioritise progression for doctors with credentials. A GP explained '*For instance, if there were a credential related to a sub-speciality of non-surgical gynaecology such as FGM or sexual and reproductive health, and the public wanted more female doctors (e.g. for religious or personal reasons), but more women work part time and take career breaks, this might make it difficult to maintain the credential*.' . Women doctors were mentioned frequently in the responses as a group likely to be affected by credentialing due to being more likely to work fewer hours, take career breaks and thus have reduced incomes. One organisation thought that credentialing *'risks driving gender imbalance back to the bad old days as it prolongs training and this is a major issue for those who wish to train less than full time'.*

The British Society of Head and Neck Training (BSHNT) highlighted that overseas doctors may be disadvantaged in applying for jobs in specialities where there are shortages because they do not have a credential.

A number of comments suggested credentialing would remove unfair barriers, especially for SAS doctors. The Faculty of Medical Psychotherapy wrote that credentialing '*opens up the barrier for formal recognition of competency.'* Indeed some respondents reiterated that credentialing would bring new opportunities for career development to many doctors. A SAS doctor thought '*the credential is definitely a major opportunity for many SAS doctors to require equitable status to consultants in a specific scope of practice. This is also an opportunity to provide clarity to the general public.'* A small number of responses also identified SAS doctors because of lack of funding and opportunities or because they tend to work in areas that will not be covered by credentials.

However, several comments identified clear advantages for some groups, and in particular for SAS doctors, GPs and doctors who work in areas not covered by established specialties such as cosmetic practice. NHS Employers highlighted that the group who will most significantly benefit from credentialing is likely to be SAS grade doctors, but that GPs may also benefit because *'…It is also likely that GPs might look to credentials as a way of*

validating their areas of more specialist practice currently viewed as areas of 'special interest'. An NHS organisation suggested our approach would advantage '*Doctors currently on the GP register, or those who are on neither the GP or specialist registers, yet are working to the standards equivalent to a CCT in their chosen area'* .

The British Association of Dermatologists highlighted that credentialing may also be a great advantage to patients as there will be increased transparency of the skills and competencies of doctors.

About a fifth of responses didn't identify any particular disadvantage or advantage from our proposals provided credentials adhere to standards, focus on patient safety, and are regulated adequately. The Royal College of Surgeons of England commented '*If credentials are developed in response to patient safety requirements and are based upon the standards required to provide a high quality, safe service, they should not overtly favour or disadvantage particular groups*."

Some comments echoed the view that the outcomes depended entirely on how credentialing is implemented and regulated– particularly if credentials are legally mandated. For example the Royal College of Ophthalmologists commented *'As Ophthalmology credentials are likely to include subspecialty surgery, these may not be accessible to SAS doctors.'* But the College went on to suggest that this could be mitigated by not making it a '*requirement for them to have that kind of credential. Therefore a lower level of management may be appropriate and would prevent them being disadvantaged.'* A similar view was expressed by a SAS doctor who commented that *'It must be possible to work without the credential as it may be too onerous for some and their contribution to the NHS should not be lost.'* Other organisations argued that credentials could in fact be beneficial to SAS doctors, provided that credentialing is *'flexible enough to allow entry and acknowledge variations in the achievement of training or if a credential was not mandatory in a particular scope of practice.'*

The BMA was concerned that credentials could make doctors in training feel pressured to acquire lots of credentials, in addition to everything else they have to do in order to become a consultant. An NHS organisation reiterated that '*Part time workers with other commitments outside of work have the potential to be disadvantaged as they may be unable to travel or to take time to study.'* And a SAS doctor was worried that '*SAS doctors do not enjoy the same access to training as their junior trainee counterparts.'*

The JRCPTB commented that '*Unless offered on a widespread basis, the geographical availability of credentials may also present a barrier to those unable to move…this may create issues for those with particular caring responsibilities or those that work less than full time.'*

Other comments

Of the 217 responses received for the consultation, only 18 provided comments in a format different from the consultation document. These generally took the form of letters or emails. Where possible, we attached these responses to the relevant questions, but have captured any other comments in this section.

Eight organisations and 10 individuals provided comments. . All 10 individuals were doctors, including one GP and one Medical Director. Of the organisations responding to this question, four were postgraduate medical institutions, two were government organisations and two were bodies representing doctors.

What respondents said to us

On the whole, additional comments from respondents were positive, with most highlighting their support for credentialing. A number of comments received related to specific areas of medicine and detailed analysis of how credentialing would work for those areas, e.g. aesthetic medicine, cosmetic surgery and musculoskeletal medicine. One doctor commented *'I am 100% in favour of this field of medicine becoming a GMC-recognised speciality…Cosmetic medicine is an ever-growing field and it is about time that this was taken seriously'.* This was reiterated by a doctor in the field of musculoskeletal medicine who suggested '*It has always been a frustration that there has been no process of recognition of further skills and qualifications in this area previously…I do think that credentialing could give an important recognition of this type of work where there is no current speciality certification by any of the royal colleges'.*

A few responses raised concerns that we need to engage more fully through discussions with the profession and representative bodies about how credentials would work in practice. The Health Workforce Directorate Scottish Government thought there was *'a real concern to us that the GMC consultation is so lacking in detail that it is not possible to gain any basic understanding as to how credentialing will work in practice.'*

Respondents also felt that greater detail was needed on a number of aspects including, clarification around whether credentials should be a legal requirement and more detail about the costs of credentialing. The Department of Health also suggested that a number of areas should be explored in more detail, including the legal framework in which credentialing will need to function; revalidation and the impact on Responsible officers; the impact on our registers and how the criteria will be used to make decisions.

Conclusion

While there was a clear majority of respondents in favour of credentialing, the commentary received suggests that this was in relation to areas of practice not covered by existing, recognised specialties and training curricula. Credentialing must not undermine or deconstruct the existing CCT. Linked to this was concern about the relationship between

credentialing and the future of postgraduate training envisaged by the Shape of Training review. The GMC's proposals should not prejudice the outcome of the Shape discussions.

Since the consultation invited respondents to list disadvantages associated with credentialing, it is not surprising that these were offered so comprehensively. Many of the comments were about how credentialing might be applied or misapplied and it was abundantly clear that if we are to proceed we must do so slowly and with caution if the system is to command confidence.

There is no support for establishing credentials which would compete with, overlap or dismantle CCT training programmes. That was never the intention. There was also a quite legitimate insistence that decisions about credentialing, which might affect postgraduate training should await the outcome of decisions on Shape of Training recommendations.

There was clear support for the view that possession of credentials should not be a legal requirement for medical practice. Other levers, including employer expectation, would be more important in driving the introduction of credentialing. The decision on whether possession of credentials should be a legal requirement for practice is ultimately one for government to decide. The evidence of this consultation suggests that there is no widespread support for mandatory credentialing.

Insofar as support does exist, cosmetic surgery and practice in other fields not covered by recognised specialties (usually in the private sector) were where a legislative approach was most likely to be valuable. However, the idea of a hybrid approach with both mandatory and non-mandatory credentials in operation is likely to be confusing.

Other regulatory tools are available and these are discussed in the consultation as an alternative to legislation. Indeed, a number of respondents noted that even without a legal requirement it was likely that employers, commissioners, insurers, patients and others would increasingly expect doctors to possess credentials. It should, therefore, be possible to achieve the same effect without legislation and without some of the risks this would bring. If it becomes evident that non-legislative measures are not working and patients are being harmed, there may be grounds to consider legislative intervention. In the meantime, there does not seem to be either the evidence or the support to justify this.

There was clear support for using the revalidation model to maintain a doctor's credential. However, many respondents argued that even within the revalidation approach, we need to find a mechanism to ensure the particular knowledge, skills and capabilities of the credential are consistently and robustly evaluated.

However, if credentialing is introduced before we have updated legislation that would allow us to align credentialing with revalidation, we might have to consider in the short term using the credentialing bodies to evaluate whether doctors have maintained the credential. If we go down this route, we will have to make sure it doesn't introduce undue burdens on doctors and the system at large

But more clarity and information about how regulated credentials might work in the wider training and workforce structures is needed and this came out very clearly in the consultation. In particular many respondents were concerned about the cost and burden of regulated credentials. Credentials should be, in the main, funded by organisations such as employers, funding/commissioning bodies and the governments. But it was recognised that funding arrangements will have to be flexible and, in some cases, doctors might need to self-fund the credential, particularly in the private sector. There was only a small amount of support for funding credentials through the annual retention fee.

Anxiety about how credentialing might be used or misused could partly be assuaged by ensuring proper rigour in the process for deciding what credentials get established and, just as importantly, what do not. The suggestion of an independent panel overseen by the GMC would be a means of bringing together key strategic, specialty and workforce expertise alongside patient and public interests to inform these decisions.

We must begin gradually, starting in just a few areas where there is a clear and agreed need for credentialing and use development in those areas to help us evaluate the efficacy of the system. We would want to work closely with key groups such as the colleges, employers and those commissioning or funding credentials to evaluate how the wider system might effectively use credentials.

We would need to use this period of testing by early adopters to develop an effective way of communicating about the purpose of regulated credentials, how they will work and the impact on particular groups.