Credentialing: supplementary information

Annex to draft framework
For engagement September 2018-January 2019
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Why we’re introducing credentials

Background

We began looking at credentialing several years ago as a way to recognise doctors’ capabilities in particular practice areas. We consulted on a proposed framework in 2015, and Council agreed in 2016 that we should continue working to test the model. Since then we have been challenged to work towards a broader definition of credentials, to enable development of the medical workforce to address emerging service and patient needs.

Our website has full details of the background to credentialing and previous papers.

Part of wider postgraduate training reforms

Credentialing can be seen as part of a wider movement to reform postgraduate medical training, and a potential solution to multiple problems. It has been a recommendation or expectation in a number of reviews and reports in recent years.
What problem are we trying to solve?

During 2017 we reviewed our earlier work in light of expectations that credentialing should enable more flexibility in training pathways and supporting doctors to meet patient and service needs. We looked at where there were concerns about assuring doctors' capabilities, and where using our regulatory function could improve patient safety and workforce flexibility. We wanted to define where credentialing will add real value to professional development and workforce management.

We undertook a problem tree analysis to help identify the different problems credentialing was expected to solve, and to clarify where credentials were needed and where there might be a more appropriate or proportionate solution.

We want to make sure credentialing meets the needs of patients and the services in the four countries of the UK, as well as the expectations of government and the profession for more flexibility in postgraduate training. We have been working closely with members of the UK Medical Education Reference Group (UKMERG) in recent months, to make sure that we develop our framework for credentialing with UK-wide consensus.

As the regulator, our goal is to address the areas circled in red below, which is linked to the UKMERG’s priority of addressing workforce concerns, circled in green.

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**Problem Tree Analysis**

- **Patient safety is at risk due to regulatory gaps in the recognition of doctors' capabilities**
  - Development after PG training lacks agility and regulatory oversight
  - Non-clinical expertise lacks formal recognition
  - Some areas of practice lack/recognise formal training/experience/PG training/unrecognised
  - Experience gained outside of training/education is not recognised
  - MR only recognises completed PG training/experience to CCT level

- **Medical workforce isn’t responsive to changing needs of population/planning**
- **Patients can’t tell if a doctor is capable in an area of practice**
- **Patients are at risk in areas of practice where regulation is weak**
- **Non-training grade doctors lack recognition and career support**
- **Doctors lack flexibility in career development**
Putting it into practice

How we propose to regulate credentials

From proposal to approval

Initial identification of suitable areas
As part of the current curricula review process, the Curriculum Oversight Group (COG) is working with colleges to identify areas that might be suitable for credentials. Some of these areas might be further developed into training components that can be delivered pre-CCT or as a stand-alone option after the CCT.

Proposals to the Curriculum Oversight Group
In phase 1, a college or other relevant body will submit the proposed training pathway to the GMC for approval. This will set out proposals for the specialty curriculum and any linked credentials.

For areas not delivered in a regulated training environment or not managed or commissioned within the NHS, such as cosmetic surgery, we will develop processes for organisations to submit proposals for stand-alone credentials. Work on these processes is ongoing, but we expect this to be part of the framework we launch and begin to implement in 2019.

COG recommends areas for approval
The COG will look at the purpose statement (addressing Theme 1 in Excellence by design) which describes the entire training pathway, to make sure the proposals meet our requirements in Excellence by design and are aligned to the principles of Shape of Training.

In evaluating the purpose statements, COG will test any proposed credentials against the agreed criteria.

Considering these factors overall, COG will make a recommendation to the GMC about which areas should become credentials. We will then evaluate these proposals through our full approval processes.

Approval
Proposed credentials will be approved alongside linked postgraduate curricula, through the processes that have been set up for approval against the new curriculum standards, Excellence by design.
The GMC will make a decision to approve the whole package, following recommendations from the COG, the Feasibility group, and the Curriculum Advisory Group (CAG).

For new areas, the UKMERG will consider if a proposed credential is necessary. If endorsed by UKMERG, the appropriate body will develop the purpose statement for submission to COG. Following endorsement at this stage, a curriculum will be developed and submitted to the GMC and will be reviewed by our CAG.

For proposed credentials in areas of practice that are carried out outside of the NHS and training system, such as cosmetic surgery, we will develop additional requirements to bring them into the above processes.

The diagram below shows the approval process that will apply to credentials.

Regulating cosmetic interventions

We recognise the importance of bringing regulatory oversight to cosmetic practice. The UK government has identified this as a priority, and our Council agreed we should progress this in 2016, following our credentialing consultation. Events in recent years have made it clear that more is needed to protect patients in this area, and while we have focused on developing the framework first, we will prioritise a credential in cosmetic surgery.

We expect that this type of credential may initially need to be based around demonstrating experience, rather than training. We are currently considering the possibility of a ‘practice credential’ where proxies might be used for training and quality assurance requirements.

We will continue working with the RCS England to pilot for cosmetic surgery as a credential while we carry out engagement from September 2018 to January 2019. We will look at options for what we might be able to do in the wider area of other cosmetic interventions – and ensuring they are relevant for practice in the four UK countries. We will also look further into what we can do more generally around regulation in the independent sector.
Plans for implementation

A phased approach
We aim to introduce credentials in a phased approach, starting in April 2019.

We have identified the main areas of work and approximate stages.

Phase 1 implementation
We will expect the first submissions for credentials to be in priority areas, or areas where discussions with COG have progressed and colleges and faculties are ready.

We will continue to test and refine our processes as the first credentials are submitted for approval, to help to ease the transition over the next few years.

Phase 2 development and implementation
Following the first phase, we will continue to work with organisations that are ready to submit credentials.

During 2019 we will also begin work on a number of related workstreams:

- explore how SAS doctors might have existing skills and competences which could be recognised through credentials
- develop processes and systems for annotating the List of Registered Medical Professionals (LRMP) with credentials
- develop QA processes for credentials, working with the QA review
- piloting and developing processes for QA of endorsed training modules
- work with training organisations to explore any educational governance issues
- continue to explore options for further development of cosmetic practice credentials, which will include looking at regulation of the independent sector.

From 2020 we expect credentials to be embedded in our QA and curriculum approval processes and subject to periodic review.
Impact and issues

Benefits to patients and health services

Patients and health services need a workforce that can adapt to changing needs, and credentialing is designed to enable doctors to move more quickly to areas of practice where there is greatest need.

Credentials will allow employers and workforce planners to better meet patient need, and to plan for anticipated future population healthcare needs. Credentials will support the need for more generalism, and will support patient safety by improving opportunities for doctors to supplement their training.

Credentialing will directly benefit patients by enabling better workforce management. Individual patients will also benefit indirectly through improvements to services.

Publishing credentials on the list of registered medical practitioners will improve information available about doctors’ skills, assuring employers and the public about a doctor’s capabilities in an area of practice.

Providing a process for regulated credentials in cosmetic surgery will potentially reduce risks for cosmetic surgery patients by offering a recognised standard, and informing the public whether individual doctors have met the standard.

Impact on the profession

We have developed the framework with an awareness of the conflicting interests and depth of feeling among some stakeholder groups. While some doctors see credentialing as providing opportunities for training or recognition of their capabilities, others see possible negative effects. We will continue to work to deal with these concerns through engagement with the profession.

One issue that could potentially affect doctors at any stage of their career is the possibility that doctors without a credential could be disadvantaged by being restricted in their ability to practise. While we do not have the legal powers to make credentials compulsory for doctors to be able to work in a particular area of practice, concern remains that employer or patient choices could lead to this situation.

One of the criteria for approving a credential is that there is a clear patient or service need in an area of practice, so it is unlikely the introduction of a credential will lead to doctors who are otherwise qualified being unable to work in one of these areas. Where credentials have already been introduced, such as liaison psychiatry, this hasn’t happened. Similarly, many doctors currently work in areas of practice without being on the specialist register in that specialty. And while introducing credentials in areas of practice where patients are at risk may affect patient choices, this is in the interest of improving patient safety.
Doctors in training

While there are some concerns among doctors in training that credentialing has the potential to impact negatively on training programmes, it also offers clear benefits. Credentialing will support flexibility in career development, allowing opportunities for doctors to change career direction or enhance areas of practice. It will bring flexibility to benefit doctors throughout their career, and support bespoke career pathways.

We know that some doctors in training have concerns that credentialing will shorten training and/or lead to a CCT of lesser ‘value’. However, credentialing is designed to be complementary to training, not to replace or alter it. It is intended to provide a more flexible model so that when training clearly needs to adapt to keep up with patient needs or medical advances, it will be easier for doctors to keep up to date, and easier for the service to meet the needs of patients.

Credentialing does not directly impact on duration of training. While the curricula review aims to ensure that the right content is in curricula, Excellence by design requires that all curricula will be based on outcomes, not time. It also requires that stakeholder groups, including doctors in training, are consulted about changes to curricula.

We have heard concerns that credentialing could potentially devalue training, or create a sub-consultant grade. But what credentialing will actually do is provide opportunities for doctors to gain additional training to deliver what’s needed on the job, with recognition of their level of expertise. Advances in medicine and technology mean training needs to be much more adaptable, and credentialing will provide a mechanism to assure training quality and consistency in areas that might not be part of postgraduate training – now or in the future – and where patients are at risk. There will also be defined criteria for entry, providing fair and transparent access to these areas of training.

SAS doctors

We recognise the major contribution this group of doctors makes to the health service, and the need to provide better support and opportunities for their development and recognition. Along with the education statutory bodies, we are committed to developing solutions to support these doctors through credentialing and other means. We will be holding a symposium in 2019 to explore how we can do this.

There may also be potential benefits around outcomes-based curricula in terms of ability to gain a certificate of eligibility for specialist registration (CESR) or certificate of eligibility for GP registration (CEGPR).

Consultants and general practitioners

Many of the benefits described above in relation to doctors in training, are about supporting doctors throughout their whole career, and will apply to consultants and GPs.
The introduction of credentialing will provide opportunities for consultants and GPs for career movement, access to training in new areas, and recognition of skills in areas of development different to their original training.

**Cosmetic practitioners**

Introducing a regulated credential in cosmetic surgery will offer cosmetic surgeons an opportunity for recognition of skills, and a way to demonstrate their safe practice. It will bring the opportunity for skills development to doctors who meet the entry criteria.

**Other healthcare professionals**

We recognise that some credentials approved for doctors may be applicable to other healthcare practitioners. We will work with other healthcare professionals and their regulators to consider how these may apply.

Other professional regulators and employers may consider how medical credentials can offer opportunities for developing training that can be accessed by other healthcare professionals, working in multiprofessional settings. Although we only regulate doctors, we will look at how we can be more facilitative to help employers to develop other multidisciplinary team members.

**Managing issues and risks**

**Resource implications for organisations**

*Education organisations*

We know that as part of the curricula review following the launch of *Excellence by design*, the *Generic professional capabilities framework* and supporting guidance, colleges and faculties and the statutory education bodies have a significant job to do in revising all postgraduate curricula to make sure they are on track and delivered to meet the new standards by 2020.

We are concerned that the addition of credentialing could cause a strain on resources. Although credentialing will bring the benefit of more options for how to package learning, and allow the specialties to train up consultants in new areas more quickly, we are proposing a phased approach to allow time for colleges and other bodies to identify and develop proposals for credentials. We will however be ready to approve the first credentials in 2019.

A phased approach will also allow time for training organisations to develop arrangements around delivery and maintenance of credentials.
GMC

Our quality assurance teams who manage the curriculum approvals process along with the Curriculum Oversight Group (COG), and our visits and monitoring teams, will also need time to manage the changes credentialing will bring, and the potentially huge resource implications. The UK Medical Education Reference Group will also be taking on a significantly increased workload with credentialing.

Colleagues in the areas of registration and resources will also need to look at potential impacts on equivalence applications and on revalidation.

Some potential risks

We are aware of a number of areas of risk or questions around credentialing which we will need to consider as we continue our policy development.

These include the risk that while credentialing will allow opportunities for organisations to make training available to meet a patient or service need, it may be seen as a business opportunity. Clearly credentialing could provide a potential revenue stream for organisations to charge fees for membership, exams, ePortfolio access etc. It is not our intention to create a credentialing industry or generate ways for organisations to make money, and we will need to think about how to make sure credentials are developed for the right purposes and in the right ways.

Related to this is the question of how to decide which organisation should ‘own’ a credential if there are competing interests. There are currently a number of subspecialties which are linked to multiple specialties, and some areas which have been proposed as credentials are clearly opportunities for training doctors from more than one specialty. In some cases it may not be clear which college or faculty or other body is best placed or has more claim to create and manage the credential. This is an issue for cosmetic surgery too.

We will continue to work on these issues and others that may impact on training organisations or doctors, and welcome input from stakeholders on how we might deal with them.