DRAFT FOR DISCUSSION

FEEDBACK WILL INFORM THE FINAL FRAMEWORK FOR LAUNCH IN 2019

General Medical Council

M4 – Credentialing update

M4 – Annex A

Credentialing: a draft framework

For engagement September 2018-January 2019

Contents

A case for change

We are proposing a new regulatory framework for credentialing. All four UK governments have agreed this must be put in place for particular areas of practice where:

- there may be significant patient safety issues, or
- training opportunities are insufficient or do not provide adequate flexibility to support effective service delivery.

What problems are we trying to solve?

There are two drivers supporting the introduction of a credentialing framework:

- Unregulated areas of practice where there may be significant patient safety risks. Usually, doctors develop expertise outside of an approved training programme and a consistent standard is absent, such as with cosmetic interventions.
- Flexible training in substantial practice areas are needed to address service gaps. These training components need ongoing regulatory oversight in order to maintain consistent, UK-agreed clinical standards and ensure continued high standard for patients. The ongoing postgraduate training reforms have identified these training areas that can be offered to either doctors who have not obtained a CCT (doctors in training or service grades) or as training available after the certificate of completion of training (CCT).

Proportionate response to risk

We will only approve and assure credentials if there is a demonstrable need for recognised standards. This will only apply where there is a significant risk to patients or a gap or need in service provision that can't be met by changing numbers in postgraduate training alone.

Benefits for introducing the framework

Credentials will offer a number of benefits including:

- Supporting more flexible career development and lifelong learning, allowing opportunities for doctors to change career direction or enhance their expert skills.
- Supporting the development of trained doctors more quickly for areas where they are needed by patients and the service – by allowing existing trained doctors to acquire new skills.
- Enabling patients to confirm a doctor is working as an expert in these particular areas of practice – ideally on the List of Registered Medical Practitioners (LRMP).

Phased approach

We will introduce credentials in a phased approach, to make sure we get it right. We will continue to work with all stakeholders across the UK, to align expectations and to gain four-country consensus through the UKMERG on the final framework.

We have set out our proposals in this 'straw man' for the purpose of engagement with stakeholders from late 2018 to January 2019. Following this we will launch the framework in spring 2019, with the first credentials expected soon afterwards.

Defining credentials

We are introducing a process which will support doctors to gain recognition for training or expertise in a particular area of practice. These areas are optional components within specialty training or substantial areas that exist outside training entirely. They are likely to represent significant areas of practice on the scale of a subspecialty or a larger special interest area.

Credentials as approved training components

The majority of learning and development, outside of formal training, won't need approved standards and outcomes. Some areas warrant the same treatment as postgraduate training. These components of training – credentials – will apply where there is a need to address particular areas of practice where there may be significant patient safety issues, or where training opportunities are insufficient or do not provide adequate flexibility to support effective service delivery.

Like postgraduate curricula, they will describe the expected outcomes and capabilities that doctors must demonstrate as they become experts in the field. The GMC will approve and quality assure these key areas if there is a demonstrable need, based on patient safety, for consistent standards, training, experiences and assessments. We intend to recognise attainment of the credential on the List of Registered Medical Practitioners (LRMP).

Emerging examples

We have looked at a number of existing or emerging examples where this approach might add value. We are not indicating that these will or should become credentials. They are helping us test the feasibility of credentials.

Increasing flexibility within broad specialty areas

Liaison psychiatry is a subspecialty undertaken by some, but not all, psychiatry trainees during a year of the three year general or old age psychiatry specialty programmes. About 50 doctors train each year in this subspecialty. Health Education England (HEE) has indicated that more liaison psychiatrists are needed because of the priorities from the UK government to improve mental health. Some practising psychiatrists have indicated they are keen to refocus their careers into this area. To address this mismatch between service need and the available trained medical workforce, HEE commissioned the Royal College of Psychiatrists to pilot a credential in liaison psychiatry aimed at consultant general or old age psychiatrists. The credential is a one year training programme based on the new outcomes, expectations and assessments a consultant would need to acquire from the subspecialty curriculum. Consultants are not required to repeat training gained from their specialty programme (eg leadership, research, communication and professional behaviour competencies). So far 17 doctors have completed this programme with positive feedback from both employers and doctors.

> 'The credential year came at a perfect time. It allowed me a structured learning environment with a well thought through teaching programme in liaison. The portfolio suited my (adult) learning style and gave ample chance for reflection. The peer group consisting of other consultants doing the credential was a valuable support system and new friendships were forged. My transition to liaison has been made feeling confident and empowered, and this has allowed me to progress very quickly in my new chosen career.'
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> (Quote from doctor who undertook liaison psychiatry credential)

Cross-specialty development

Mechanical thrombectomy is a proven treatment for stroke patients with large vessel occlusion – offering improved outcomes over conventional care in many cases. Doctors able to perform this interventional procedure work in a small number of tertiary hospitals. Providers are keen to expand this service to neuroscience centres and other large hospitals throughout the UK as a successful outcome is time critical. Training in this area is part of the Royal College of Radiologists' interventional radiology curriculum, but there are insufficient trained operators currently available to deliver this service 24/7 nationwide.

The college believes that the specific skills and capabilities may be taught to other specialists, including neurosurgeons, neurologists, stroke physicians and cardiologists. With a consistent and rigorous training package, additional doctors across the UK can learn this technique, with significant short and long term benefits for stroke patients. This approach could apply to both emerging techniques and areas where there are shortages caused by gaps in workforce capabilities, both applicable in this situation.

No formal training pathway

Cosmetic practice is a particularly risky area from a regulatory perspective. There is no formal or quality assured training for doctors to become experts in cosmetic interventions. Many doctors piece together qualifications in procedures or interventions from different sources – often overseas. Coupled with this unconventional training, doctors work predominately outside the NHS or managed care systems. The Keogh review, among other inquiries, indicated that people are often very vulnerable when they seek cosmetic interventions – and this vulnerability can put them at risk of poor or unethical treatment. A number of serious adverse events demonstrated that serious harm can be caused to patients by inconsistent and unregulated standards. In answer to this challenging area of practice, the Royal College of Surgeons of England has introduced a certification scheme for cosmetic surgeons. Doctors who want to be certified by the English College would be required to provide evidence to demonstrate that they have met specific standards around training, clinical outcomes and behaviours which are based on safe practice. This includes the completion of a course on the ethical and professional obligations of doctors working in cosmetic surgery. We are considering how this approach may support better regulation in cosmetic surgery.

Different needs across the UK

Officers from the four governments, on behalf of ministers, have been clear that they need a more robust and transparent way of developing their medical workforce to meet local needs. In particular, Scotland and Wales representatives have suggested they need a consistent approach to train doctors in rural and remote health. Large parts of these countries have populations that live a significant distance from places where they can access emergency healthcare. There is a clear patient and service need for a credential that extends the skills and capabilities of general practitioners or other generalists to care for people in these remote areas.

Terminology and definitions

It is clear that the word 'credential' is used to mean a number of different things, both within the UK health services and elsewhere. It might be better to use an alternative term for the processes we've described here – such as approved training component. We are seeking stakeholder views on the most appropriate terminology as part of discussions on the draft framework.

Identifying credentials

Strategic oversight of training

Credentials will be identified and prioritised by the UK Medical Education Reference Group (UKMERG) – which includes representatives from the four UK governments and their statutory education bodies. Employers and workforce planners across the UK – as well as Health Education England, the Northern Ireland Medical and Dental Training Agency, NHS Education for Scotland, and NHS Education for Wales – will have the flexibility to commission or fund credentials based on patient and service needs.

We will identify and prioritise these areas of practice in two ways:

- Our Curriculum Oversight Group (COG) will identify training components that can be delivered to doctors that have not obtained a CCT (trainees or service grades) or after the Certificate of Completion of Training (CCT). These credentials will likely align to, and lead from, specialties. They will be identified when we review curricula as part of our approvals processes.

- The UKMERG will consider proposals for new areas of practice and determine if they should be developed into a credential. If authorised, these proposals would then come to the GMC for consideration through our approval processes.

Threshold for approval

The decision to approve a credential by the GMC has to be a proportionate response. The threshold for credentials will restrict approval to those areas that meet patient safety or service need though a risk 'test'. We have identified criteria that will consider the level of risk involved in an area of practice, and therefore whether it needs our full regulatory approach of approval, quality assurance, and recognition on the register.

Criteria for credentials

We will make a prospective judgement about risk and scale to determine the answer to two questions.

- Is there a need for consistent professional/clinical standards and outcomes in this area of practice?

- Does the area need GMC oversight?

A proposed credential will be considered against these factors:

These criteria will be considered together, looking at the balance of all the factors, though key considerations are risk to patients and service need.

Complexity (more complex in procedures or clinical context = more need)	Breadth of practice (broader than clinical techniques or CPD = more need)	Level of specialty expertise (general/generic = less need/part of PGT)
Service needs/gaps (more experts/expertise = improve service/ patient outcomes)	High risk to patients (any other factors that indicate significant risk to patients)	Number of current/future doctors (larger numbers = more need)
Delivery of service (multiple site/hub and spoke = more need	Outside NHS (outside NHS/weaker clinical management = more need)	Number of current/future patients (larger numbers = more need)

Regulating credentials

We are proposing that credentials will go through approval and quality assurance processes in the same way as postgraduate training, but will be recognised on the register in a different way. Annex C contains more details on how these processes might look.

Approval

Credentials will be approved alongside any postgraduate curricula to which they are linked as part of the training pathway, through the processes that have been set up for approval against the curriculum standards, *Excellence by design*.

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 our processes.

Quality assurance

We are currently carrying out a review of our quality assurance processes. Our new processes will need to consider how we quality assure credentials including those outside the NHS.

Recognition on register

We will consider how credentials will be annotated on the LRMP. Our intention is that credentials will be noted on a doctor's entry on the LRMP in a similar way to how trainers are recognised. This will remain separate from being on the specialist or GP registers, but will allow employers and patients to see if a doctor has a credential in particular area.

Future work on developing the register will consider how to align the ways different levels of attainment are presented. If legislative change is granted we can review how we might recognise credentials differently on the register.

Maintaining credentials

Credentials, like postgraduate curricula, will be reviewed regularly through our curricular approval processes.

We anticipate that doctors with credentials will confirm they are continuing to meet the standards and expectations of the credential with the organisation responsible for the credential. These organisations will have to have a process by which employers can ensure doctors are maintaining their capabilities in the area of practice – the outcome of these evaluations will feed into appraisal and revalidation.

Other developments to support flexibility

While our focus now is on developing a way to regulate particular areas of practice, we are also exploring how we might support other training outside the CCT pathway.

This is early thinking which we may develop further.

Endorsed modules

Some parts of curricula can be, or already are, modularised – usually as a special interest option. These stand-alone modules could be offered to doctors who are not in that training pathway to support their development. Employers might use them to develop particular skills in their training workforce to support local service needs. We would expect the same standards, outcomes and quality assurance to apply. These would be areas within existing training programmes which may not be large enough to be considered areas of practice, such as specific clinical interventions. They wouldn't be recognised on the register.

An example might be the SPINS in paediatric training.

Additional skills areas

Some areas of practice may not meet the threshold to become a credential. They would be managed by education organisations. We want to explore bringing them into our quality assurance system, including meeting relevant requirements in *Excellence by design* and *Promoting excellence*.

These would include post-CCT fellowships.

Implementing credentials

A phased approach

We intend to introduce credentials in a phased approach starting in April 2019.

The framework will set out criteria and processes for identifying and approving credentials, including our plans to support the curricula review and for regulating cosmetic surgery.

Phase 1 implementation

We will work with both the UKMERG and our COG to prioritise areas suitable for the first credentials. We will aim for these first credentials are approved shortly after their proposals are considered by COG.

As the curricula review progresses, we expect that most curricula will be reviewed by 2020, and will be in the process of being signed off. We anticipate that during this process, it will become clearer which areas will be appropriate for credentials.

Phase 2 development and implementation

As the first credentials are introduced, we will learn from the process and make ongoing improvements. Once we have successfully completed phase 1, we will consider how to identify and approve new and emerging areas of practice into 'credentials'. We are developing a number of policy workstreams to support further development and implementation of credentials.