General Medical Council

Delivering GMC credentials for doctors

A framework for delivery of the early adopters

April 2023

Contents

Introduction

Since publishing our updated framework for GMC credentials in 2021, we have engaged with partners to develop policy for the delivery of GMC credentials, while working towards approval of the early adopters. This delivery framework has been developed with input from our partners in the statutory education bodies (SEBs) and the early adopters.

GMC credentials aim to enable a more flexible training response to patient and service needs, and provide consistent standards to reduce risks to patient safety. We've focused on this in preparing for delivery, along with the principle of using existing mechanisms where possible to reduce burden.

We have therefore based responsibilities and processes on those used for postgraduate training. The SEBs will be responsible for governance and delivery, while the credential development bodies (CDBs) will maintain curricula, provide guidance, and support quality assurance processes. We will quality assure all delivery processes, and make the decision to award a GMC credential, based on partners' recommendations. It is important to note that doctors doing credentials may be highly experienced, however this system can best provide the structures needed for delivery. Annex A sets out the different roles in a process map.

This framework will enable delivery of training and associated processes to begin, though it has become clear that much of the detail will only emerge as plans and structures are put in place. This will be an iterative process informed by experience and we'll continue to work with partners as delivery is taken forward.

Further details of the design of policy and processes will be developed by the SEBs and will be included in updates to the *Gold Guide*. We will continue to support the early adopters still in progress including cosmetic surgery, and we'll update our credentialing framework to reflect developments as required.

Approval of curricula

Most early adopters have had their purpose statements endorsed by the curriculum oversight group (COG) now, and their curricular content reviewed by our curriculum advisory group (CAG)*. We are now in the process of seeking assurance from the COPMeD representative to the CAG, with support from the lead dean for the credential, that the curriculum meets outstanding *Excellence by Design* (EBD) requirements around deliverability. These involve assurance around:

- Feasibility – involving who is responsible for delivery, funding
- Communication with those delivering training – and guidance for educators
- Implementation and quality assurance (QA) plans – and monitoring of assessment data.

We've granted full approval to two early adopters and are now looking at final amendments which may be needed following recent policy development, before publication of the curricula.

For any future GMC credentials, earlier discussions between the CDB, lead dean and SEB representatives would cover deliverability, enabling the COPMeD representative to make their recommendation alongside advice from GMC education associates, as with specialty curricula.

Delivery of training

The SEBs will be responsible for the delivery of training for GMC credentials. This will ensure the necessary structures and associated resources can be put in place, and will enable us to carry out QA activities through existing arrangements and relationships.

Delivery of GMC credentials will have to meet the standards in *Promoting excellence* (PE) and we expect that, wherever possible, processes will mirror those used in the delivery of postgraduate medical training leading to the award of a certificate of completion of training (CCT).

As with specialty training, we expect the CDBs to work with the SEBs to provide expertise and participate in delivery processes as described in PE, and those described in *Excellence by design* (EBD). As curriculum owners, CDBs will be responsible for maintaining curricula and associated programmes of assessment. They will also be responsible for providing guidance†, working in partnership with the SEBs and others in selecting learners and on quality management issues, and contributing to and supporting our QA and statutory responsibilities.

* Before 2023, GMC education associates advising on approval were designated as our curriculum advisory group.
† As described at CR3.4 and CR3.5 in *Excellence by design*.

The SEBs are now working together to align their approach across the four countries, with England and Scotland working on implementation plans and resources. While Northern Ireland and Wales are not planning to begin delivery of training immediately, they are engaging in planning discussion to ensure four-country consistency as policies and processes develop.

Much of the detail around delivery areas such as committee structures, trainer arrangements, recruitment, and non-trainee learners, will only emerge as the SEBs put plans in place for each EA. While mechanisms may need to differ for different credentials, consistent standards will need to be maintained. This will also apply if any future credentials diverge from the standard training model and require specific arrangements and policies.

All SEB partners agree that it is necessary to begin delivery with the view that it will be an iterative approach informed by experience. They will monitor the effectiveness of processes and make any adjustments or improvements as plans are implemented.

As implementation progresses and details become clearer, this will inform future versions of the *Gold Guide*, which will be supported by standard operating procedures produced by SEBs.

Our standards are supported by a number of guidance documents, which will also support this framework and will be updated in due course, as processes for GMC credentials are developed. The AoMRC's guidance *Best practice for Specialty Advisory Committees* has been suggested as a useful supporting document.

Signoff panels

As part of their responsibility for the overall governance and delivery of GMC credentials, the SEBs will be responsible for decisions about the governance and operational management of signoff panels, mirroring the approach of annual review of competence progression (ARCP) panels where possible. Annex A describes key sections of the *Gold Guide* on the ARCP process.

Where the CDB is also a SEB, we will require assurance of effective governance to allow separation of responsibilities.

We anticipate that policy we have developed on panels will become part of the *Gold Guide* in the future, and that as the SEBs build on our initial policy development on panels, this will be incorporated into future versions. It will be for the SEBs to agree together on the appropriate principles for panels, and to develop operational procedures for local delivery in line with these.

We expect the CDB to have a similar role as colleges do with ARCP recommendations, in checking and sending us panel recommendations. The SEBs will need to agree broad mechanisms and terms of reference with the CDBs around making recommendations on awards to the GMC.

UK-wide panels

We expect a single, UK-wide panel will be used in most cases for GMC credentials, but there may be circumstances where the SEBs determine that regional or ARCP panels are appropriate. This may be where credential learners are trained in the same environments as trainees on a specialty programme which overlaps with the credential. Or multiple panels may be needed to evaluate larger numbers of candidates. In these cases, mechanisms will need to be in place to ensure consistency.

To ensure consistency, the same panels will be used for making recommendations about candidates on both the training and recognition routes to a GMC credential.

Panel membership and composition

The SEBs will need to agree principles for panel membership, which should mirror the ARCP approach where possible. As with other elements of delivery, panel membership may differ across credentials, and will be reviewed and developed over time to reflect learning.

While some principles may be similar, such as the inclusion of patient or lay advisors, others reflecting specific specialty training roles may not apply. We would expect the SEBs to adapt existing processes around lay, external and employee representation and roles as appropriate.

As previously advised in our framework, a panel should include representatives from the SEBs, deans and the CDB, and it should also include specialists or experts in the field if this is not already represented by the CDB, as well as other relevant specialties such as those reflecting candidates' backgrounds. It should also have cross-country representation. A key consideration will be ensuring balance and impartiality.

We believe the best way to ensure patient safety is at the forefront of panel recommendations is for the SEBs to base decisions about panel composition on advice from the CDB and lead dean about appropriate membership.

Panel chair

As part of the responsibility for panel management, it is for the SEBs to agree on principles and processes for appointing panel chairs.

We previously stated that the panel chair needs to be an independent voice who can adjudicate if there is any disagreement about a panel recommendation. If there is disagreement around a panel chair appointment itself, this decision can be escalated to the GMC.

Additional panels

Decisions about additional panels, such as for progression or appeals, are to be made by the SEBs, in line with the principles of the *Gold Guide*. We would expect this to resemble the approach used for the CCT with roles for lead deans and COPMeD.

Recognition route

Following initial discussions within the GMC, with SEBs and with CDBs, we have developed an approach for the delivery of a recognition route for credentials. This is aimed to align with our work on new pathways to GP and specialist registration. This will be managed by the SEBs, and as a new process, it will be necessary to learn, reflect, and develop it over time.

We believe it is important for GMC credentials, which aim to improve patient safety, that the recognition route should be aligned with the training route. Having the same signoff panel make a recommendation to award the credential for both routes is key to ensuring that consistent standards are applied for doctors gaining the credential via either route.

There are two key components which are being developed to create a recognition route.

- The CDB provides credential-specific guidance (CSG) describing the forms of evidence which will support a candidate to demonstrate they meet the outcomes of the credential.
- The SEBs identify individuals to advise and support applicants in collecting the evidence needed to demonstrate their knowledge, skills and experience, and to provide advice to the panel on whether the applicant meets the outcomes.

Evidence requirements

We have previously identified a need for CSG, describing the types of evidence which doctors can use for their application. This will be designed to reflect the curriculum, and to help doctors demonstrate they have the knowledge, skills and experience to meet the outcomes of the credential.

The early adopters are completing drafts of their CSG and we will work with the SEBs to agree on CSG proposals. These are being developed using an agreed set of principles for evidence requirements and a list of examples, developed to guide CDBs in developing their CSG. These are set out in Annex B. We expect that the CSG for each credential may look quite different, to fit the specific needs of the area of practice. These will also be reviewed and refined based on learning as the first applicants go through.

Roles and resources

We previously proposed several steps and roles needed for a recognition route. These were: advising and supporting applicants; collating and verifying evidence; and reviewing and assessing evidence to give an initial recommendation or advice to the panel.

The SEBs will need to consider these aspects as they proceed, but there has been support for suggestions which emerged in initial discussions with partners which may provide a way forward.

- The SEBs identify individuals with experience in the area of the credential, who can work with the candidate to advise and support them in collecting the evidence they would need to demonstrate their knowledge, skills and experience, and provide advice to the panel on whether the candidate meets the outcomes. This could be a mentor, an educational supervisor or other individual, but we believe they should be a GMC recognised trainer. Consideration will need to be given to how applicants will access these individuals.
- A referee with first-hand experience of the individual could attest to current roles and scope of practice, and provide assurance of the applicant's skills. For some credentials where CiPs across a range of experience are needed, a lead referee could provide an oversight role, with input from people involved in a process of onward care.
- A subset of panel members could evaluate evidence to provide an initial recommendation which the panel then reviews and confirms.

We believe these concepts can be usefully combined, and would encourage the SEBs and CDBs to work together to codify these roles.

The different evidence requirements needed for candidates with different backgrounds and experience is also a consideration, and may vary significantly. The CDBs are building this into the CSGs, which will support the SEBs to develop appropriate processes.

Consideration will also need to be given to different options for collecting and verifying evidence. We will look at how quality management (QM) and QA processes cover this.

Quality assurance

To fulfil the aim of improving patient safety, GMC credentials will be subject to our QA processes at every stage, in a similar way to postgraduate training leading to the award of a CCT. This relies on us providing QA, with the SEBs providing QM.

The first stage is approval of the curriculum, which is almost completed for the early adopters. The CDBs will be responsible for ongoing quality management of the curriculum, and we will inform the early adopters about expectations for post-implementation monitoring and evaluation of the curricula.

With the SEBs taking responsibility for delivery of training, our existing processes for QA of education and training will cover the training route for GMC credentials. While credentials are new, we will work closely with SEBs and the lead deans using our risk-based approach to ensure we properly consider anything new or different with credentials. This will include consideration of how to collect data akin to that gathered in the national training survey (NTS).

We will also approve programmes and sites, where the credential training route is separate from existing postgraduate training programmes. We will keep this under review following regulatory reform and ensure it aligns with any changes for CCT.

We are also looking at QA for the recognition route, and panel processes and recommendations. We will expect checks and externality to be built into QM processes, based on the SEBs and CDBs working together. We will then apply similar QA checks as we do for recommendations for the award of CCT. We will share plans and engage with partners as we develop these processes.

We have been developing a data strategy which will feed into a review process as part of QA and quality improvement activities, and will work with partners to support this.

Awarding GMC credentials

Award of GMC credentials will be modelled on processes used for awarding CCTs where we will receive recommendations from the panel via the CDB and then ask doctors to apply as confirmation they wish to have the credential recorded on the list of medical registered practitioners (LRMP).

As part of our processes, we will carry out appropriate checks before making the decision to award the credential to the doctor and subsequently updating the LRMP. If there is any fitness to practice activity, we will postpone a decision on award of the credential until this is resolved.

We will also have a process for reviewing and correcting any errors that might arise around any decisions we make, but if doctors wish to appeal a decision based on a panel recommendation, this will be managed by the SEBs.

Roles and responsibilities

We have set out below our expectations around the roles and responsibilities of each partner body throughout the credentialing process.

Credential development body

Credential development bodies (CDBs) are likely to be medical colleges or faculties but may be any organisation with the expertise to develop a curriculum. The credential development body will be responsible for:

- Design and development of curriculum and programme of assessment for a GMC credential in line with the requirements of *Excellence by design* (EBD)
- Ongoing quality management and maintenance and update of the curriculum and programme of assessment in line with the requirements of EBD
- Advising on appropriate representation on signoff panels
- Working with SEBs to provide expertise or externality in training and on QM issues, and contributing to QA processes where needed
- Developing credential-specific guidance for recognition route
- Participating in any delivery or recognition route processes as needed.

GMC education associates

GMC education associates are responsible for evaluating proposals for new curricula or curriculum changes and making a recommendation to the GMC about whether the curriculum meets the requirements of EBD, as part of our approval process. GMC education associates review submissions or change requests against themes 2-5 of EBD. Before 2023, these associates were designated as the GMC's curriculum advisory group (CAG).

Curriculum oversight group

The curriculum oversight group (COG) is chaired and run by the GMC with representation from the four health departments and the four SEBs. It is responsible for evaluating proposed changes to curricula, including their purpose statements, and making recommendations to the GMC about whether the proposal will meet the needs of patients and services across the UK. The COG assesses curricula against theme 1 of EBD.

General Medical Council

The GMC is responsible for providing regulatory oversight of GMC credentials. This consists of:

- Developing and updating the framework for GMC credentials
- Contributing towards decisions with UKMERG about areas for future GMC credentials
- Approving curricula, programmes and sites for GMC credentials
- QA of training and recognition routes
- Award and recording of GMC credentials on the LRMP.

Lead dean

The lead dean for a GMC credential is based on the role of the lead dean in specialty training, and is advisory for the feasibility of delivering GMC credentials on behalf of the SEBs.

Statutory education bodies

The four statutory education bodies (SEBs) in the UK are responsible for the delivery of medical training in the four countries of the UK. This will now include delivery of GMC credentials, including management of panels and a recognition route.

UK Medical Education Reference Group

The UK Medical Education Reference Group (UKMERG) is currently the forum for the discussion and approval of matters relating to medical education and training. It will be responsible for agreeing on priority areas where GMC credentials can address patient safety and service needs.

Glossary

Approval

As part of our regulatory function, the GMC approves curricula for postgraduate medical training, as well as programmes and locations for delivery of training.

COPMeD

COPMeD is the Conference Of Postgraduate Medical Deans (UK).

It provides a focus for those responsible for the strategic overview and operational delivery of postgraduate medical training in the four nations of the UK, and by ensuring excellent training, is a key player in maintaining quality of care and patient safety.

A COPMeD representative supports our process for approval of curricula for specialties, subspecialties and credentials, by advising on deliverability and feasibility.

Credential development body

The credential development body* (CDB) will in many cases be a medical college or faculty, but may be any organisation with appropriate expertise, such as NHS Education for Scotland (NES).

Decision

The GMC is responsible for the decision to approve a curriculum for a GMC credential, and for the decision to award a GMC credential to a doctor. We base our decision to approve a curriculum on recommendations from the curriculum oversight group (COG) and GMC education associates, as well as a COPMeD representative. A UK-wide panel for each GMC credential will make a recommendation to inform the GMC decision to award the credential to a doctor.

* While developing plans for GMC credentials in the early adopter phase, we used the term 'credentialing bodies' and considered that these organisations may take a leading role in delivery, signoff and in particular, managing a process for doctors to demonstrate ongoing maintenance for GMC credentials. As plans for delivery were developed, and our revised 2021 framework removed the expectation that a specific maintenance process would be needed for GMC credentials, we have clarified the responsibilities of different organisations and 'credential development body' better describes this role. However, these bodies will still be involved in different parts of the delivery processes.

Early adopter

We have worked with five CDBs as early adopters for GMC credentials. These are:

- Faculty of Pain Medicine of the Royal College of Anaesthetists (pain medicine)
- NHS Education for Scotland (rural and remote health)
- Royal College of Psychiatrists (liaison psychiatry)
- Royal College of Radiologists (mechanical thrombectomy)
- Royal College of Surgeons (cosmetic surgery).

Excellence by design

Excellence by design (EBD) sets out standards and requirements for the development and design of postgraduate medical curricula in the UK.

Educational supervisor

We have used this term based on its use in the *Gold Guide*. However as processes are developed for delivery of GMC credentials, particularly for the recognition route, it may be that an enhanced role closer to a training programme director or a regional adviser will need to be used.

GMC credential

GMC credentials aim to enable a more flexible training response to patient and service needs, and provide consistent standards to reduce risks to patient safety. A GMC credential will differ from other medical credentials in the UK by being subject to GMC approval and QA processes.

Gold Guide

A Reference Guide for Postgraduate Foundation and Specialty Training in the UK (also known as the *Gold Guide*) sets out the arrangements agreed by the four UK health departments for specialty training programmes. It is maintained by the Conference of Postgraduate Medical Deans (COPMeD) on behalf of the four UK health departments.

List of Registered Medical Practitioners

The List of Registered Medical Practitioners (LRMP) is the only up-to-date, publicly accessible database of all doctors eligible to practise in all four countries of the UK. It is published on the GMC website and contains information about a doctor's education and training, status on the register, date of registration, entry on the GP and specialist registers, and any publicly available fitness to practise history.

Promoting excellence

Promoting excellence (PE) sets out standards and requirements for the management and delivery of undergraduate and postgraduate medical education and training in the UK.

Quality assurance

As part of our statutory duty, we set standards for providers of medical education and training, and we regularly check those are being met. Our quality assurance (QA) framework describes how we do this through our approval, proactive, and reactive QA processes.

Recognition

We are using the term recognition for when a doctor's knowledge, skills, and experience are deemed to meet the outcomes of a GMC credential.

Signoff panel

For each GMC credential, a UK-wide panel will be convened to agree on whether doctors have met the outcomes of a GMC credential.

Statutory education body

The four statutory education bodies (SEBs) in the UK are responsible for the delivery of medical training in the four countries of the UK. They are:

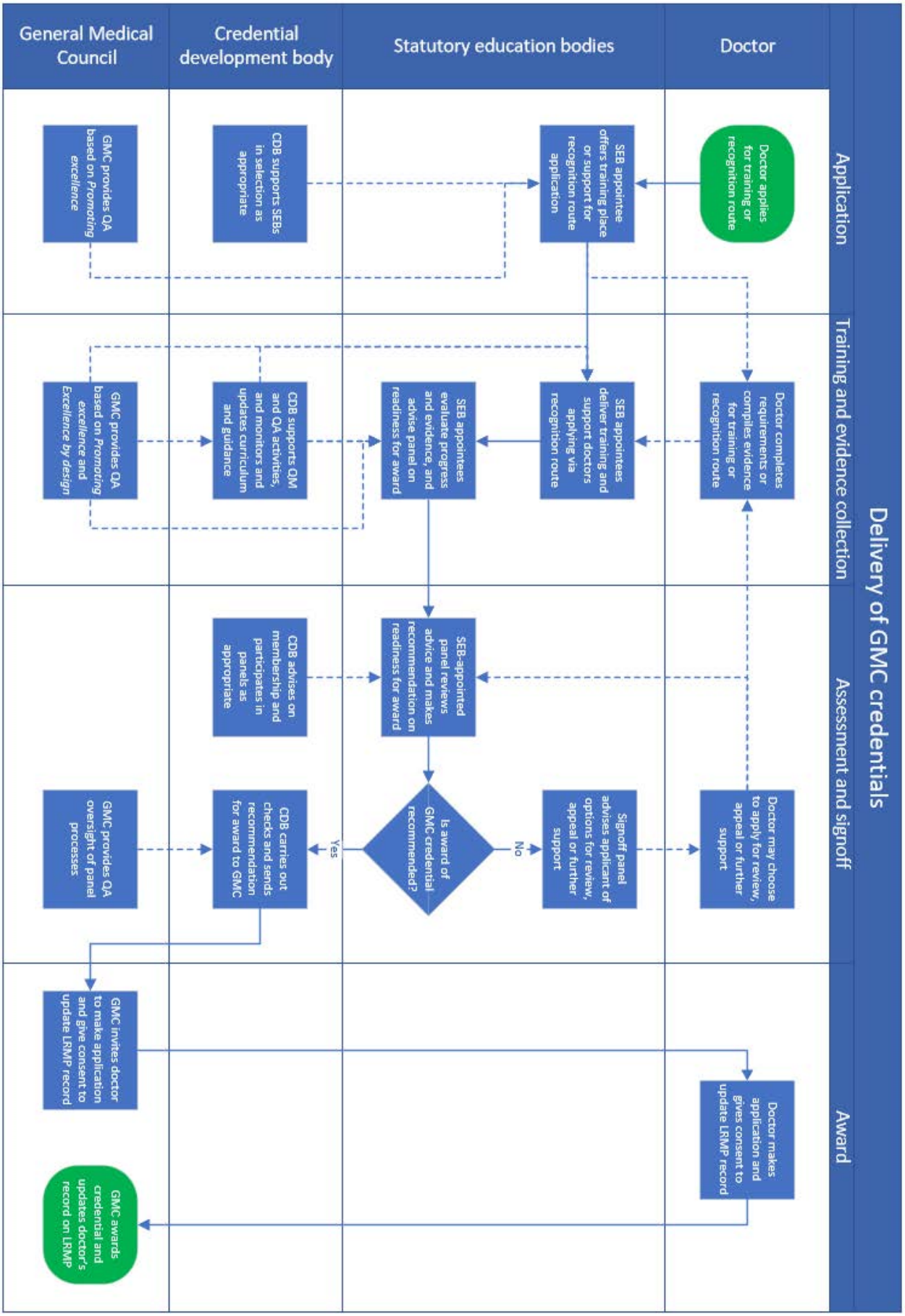
- Health Education and Improvement Wales (HEIW)
- NHS Education for Scotland (NES)
- NHS England (NHS E)

  (Health Education England (HEE) was merged with NHS England in 2023)
- Northern Ireland Medical and Dental Training Agency (NIMDTA)

UK Medical Education Reference Group

The UK Medical Education Reference Group (UKMERG) is currently the forum for the discussion and approval of matters relating to medical education and training. It has representation from organisations responsible for UK medical workforce planning and education, such as the four UK Departments of Health and the four statutory education bodies.

Annex A: Delivery of GMC credentials process map



Annex B: Description of ARCP process in Gold Guide 9

ARCP: What is its purpose? (4.38-4.51)

This describes the purpose of the ARCP panel as a review of evidence presented by the trainee and their educational supervisor as a demonstration of progress against curriculum requirements, and to enable the trainee, PG Dean, and employers to document whether capabilities required by the curriculum are being gained at appropriate rate. It must include a review of the trainee's educational portfolio and educational supervisor's structured report.

It describes how the ARCP process is applicable to all postgraduate trainees and that panels should be held on an annual basis with 15 months the maximum interval, with greater frequency appropriate if there are performance or progression issues. It lists the functions of the ARCP, which are wide ranging, for example: as a mechanism for reviewing and recording evidence relating to performance; a means whereby evidence is coordinated into coherent record of progress; and providing advice to the Responsible Officer about revalidation.

It describes how the ARCP process is linked to the assessment strategies in GMC-approved curricula and assessment and the responsibilities of trainees and trainers to familiarise themselves with these, along with the responsibilities of different organisations when they change. Additional responsibilities of trainees, such as familiarising themselves with the GMC's Good Medical Practice and to take part in audit and quality improvement activity are also outlined.

ARCP: The educational supervisor's report (4.52-4.58)

This describes how evidence included in the supervisor's structured report should reflect the educational agreement between supervisor and trainee for the period of the review and its purpose is to provide a summary of progress, including collation of assessment outcomes and experiential activities required by the curriculum. It should account for any modifications to the educational agreement or remedial action taken, providing a summary comment regarding overall progress during the period under review and a recommended outcome.

It should be discussed with the trainee prior to submission to the ARCP panel. If this cannot take place, it is the duty of the supervisor to report the reasons to the panel in advance. The process is to be transparent, with trainees notified of any concerns about their performance, which will be documented in their portfolio and the implications discussed prior to ARCP, with the discussion and any agreed actions documented by trainee and supervisor.

ARCP: Collecting the evidence (4.59-4.66)

This section describes how evidence is collected for the educational portfolio, with each of the four nations making local arrangements for receiving portfolios and giving trainees and trainers six weeks' notice of the date by which it is required, with it to be made available to the panel two weeks prior to the ARCP. It describes the responsibilities of trainees regarding submission of required evidence and forms and the role of the ARCP in revalidation process. The evidence provided may also relate to other local issues and concerns such as clinical safety or perceived undermining and the responsibilities of different individuals in relation to this is described.

The ARCP panel (4.67-4.79)

This section describes the composition of panels. It should consist of at least three panel members appointed by the training committee (or an equivalent group) of which one must be either the Postgraduate Dean (or their nominated deputy), the Head of School, or a TPD.

The Chair of the Specialty Training Committee, TPDs, College/Faculty representatives (e.g., from the Specialty Advisory Committee), Educational Supervisors and Associate Deans/Directors are all appropriate panel members.

Where more than one specialty is being assessed (e.g., dual CCT), or where the trainee is on an integrated academic programme, the panel will include relevant specialist/ academic input.

Representatives of employer organisations can also sit on panels.

The Chair of the ARCP panel must ensure that there are no declared conflicts of interest.

It is good practice for the PG Dean to nominate a deputy to be present at any panel involving cases where it is possible that a trainee could have an ARCP Outcome which recommends additional training time is required, or where the trainee is released from the programme.

The panel should normally have input from a lay advisor and an external advisor who should review a random sample (indicative minimum 10%) of the outcomes and evidence supporting these, and any recommendations from the panel about concerns over performance. The lay advisor ensures process is followed correctly and does not comment on outcomes awarded or a trainee's progression. The external advisor may be a College/Faculty representative who is external to the programme and has expertise in the relevant curriculum being assessed. If either the lay advisor or the external advisor has concerns, these will be raised with the PG Dean for further consideration, who may decide to establish a new panel.

All members of the ARCP panel (including the lay and external advisors) must be trained for their role. This training should be kept up to date and refreshed, normally every three years.

Educational and named clinical supervisors should declare an interest if their own trainees are being considered by a panel of which they are a member. Where there are any concerns about satisfactory educational progress, they should withdraw temporarily from the process while their trainee is being considered and the panel should be constituted such that in that situation it remains quorate in accordance with panel composition as set out in paragraphs 4.67–4.79.

How the ARCP panel works (4.80-4.88)

This section describes how the ARCP panel reviews evidence to reach a judgement which is recorded as an outcome. It is convened by the statutory educational body and will normally be chaired by the Head of School, the Chair of the Specialty Training Committee, or one of the TPDs or Associate Deans/Directors.

The trainee must not be present. However, following the ARCP, there will be a meeting with the trainee to inform them of and explain the outcome, and to agree objectives and learning plan.

Any concerns that emerge about a trainee's fitness to practise must be reported to the Postgraduate Dean/Medical Director, as Responsible Officer, for further advice and guidance.

Where the TPD, Educational Supervisor or named academic supervisor has indicated that a specific sub-set of outcomes may be appropriate – development required without additional training time, development required with additional training time, or release from programme – the trainee must be informed of the possible outcome prior to the ARCP panel meeting.

If those outcomes are recommended by the panel, the trainee must meet with either the ARCP panel or a senior educator involved in their training programme at the earliest opportunity. The purpose of this meeting is to discuss the recommendations for focused or additional remedial training.

At the ARCP, the end of programme/CCT date should be reviewed and adjusted, if necessary.

Outcomes from the ARCP (4.89-4.98)

This section outlines the outcomes the panel can recommend and the principles for awarding to trainees in different circumstances (e.g., outcomes required for specialty and sub-specialty, or both specialties in the case of dual trainees.).

When the panel recommends an outcome requiring additional training time or release from programme, the PG dean will confirm this in writing to the trainee, including where relevant their right to review or appeal the decision.

Additional or remedial training (4.99-4.115)

This section describes how the ARCP panel may identify the need for additional, focused or remedial training, which may extend the indicative programme end date. If it recommends focused training towards specific capabilities, then timescales should be agreed with the trainee. If remedial training time is required, the panel should indicate the objectives and proposed timescales. The PG Dean will determine the framework for delivery of the remedial training, with placements planned by the TPD and arranged with full knowledge of the employer.

Additional training must be agreed with the trainee, trainers, and employer. The guide sets out the principles for how this situation is managed and communicated and sets out the maximum limits to extensions. There are principles governing how that time is allocated (e.g., whether it is used as a single block) and examples of exceptional circumstances for extension.

Pausing training for reasons other than statutory leave (4.116-4.118)

This section describes how decisions to pause training should normally be taken outside the ARCP process and agreed with the trainee as early as is reasonably practical and approved by the PG Dean. The SEBs should have a process for obtaining suitable evidence and deciding whether to pause, which will also lead to adjustment of programme end dates.

Notification of ARCP outcome (4.119-4.122)

This section lists the persons to be notified of ARCP outcomes, which includes the trainee, TPDs, Educational Supervisors, Medical Directors, and the relevant College/Faculty. The SEBs submit ARCP outcomes to the GMC which supports reporting on progression. All trainees should receive standard written guidance relevant to outcomes, which as appropriate should detail extensions, remedial or focused training, and reference review and appeal processes.

Form R and the Scottish Online Appraisal Resource (4.123-4.130)

This describes the different forms relating to revalidation across the four nations, which need to be updated annually and returned prior to the ARCP. Failure to submit the form can result in a change to their ARCP outcome and referral to the GMC for non-engagement with revalidation.

Quality assurance of the ARCP (4.131)

This section describes the role of lay advisors and external advisors in quality assuring the ARCP process. The lay advisor reviews process and evidence supporting decisions as well as any recommendations from the panel about concerns over performance and training progression. The external advisors should review a minimum random 10% of the outcomes and evidence

supporting these as well as any recommendations from ARCP panel about concerns over performance and training progression.

The role of the Postgraduate Dean in the ARCP (4.132-4.136)

This section describes how the PG dean has responsibility for management of the process, including the provisions for review and appeals.

It notes that with the agreement of COPMeD the ARCP process for smaller specialities may be coordinated nationally although it must remain the overall responsibility of a designated dean (usually the UK lead dean for the specialty).

The PG dean is the statutory responsible officer for revalidation in relation to doctors in GMC approved postgraduate training programmes, and they must make revalidation recommendations to the GMC with information to inform this decision coming from the ARCP.

The PG Dean should maintain a record for each trainee in which ARCP outcomes are stored and the record of progression of each trainee (including supporting documentation) must be available to any ARCP panel at which the trainee is reviewed. The PG Dean's staff will provide administrative support for the panel.

Where concerns about a trainee have been raised with the PG Dean then the PG Dean should liaise directly with the Medical Director and the educational lead, or the GP trainer and TPD where the trainee is employed to investigate and consider further action.

The following sub-sections include guidance for specific types of programmes:

The ARCP for specialised foundation programmes (4.137-4.140)

The ARCP for integrated clinical and academic training programmes (4.141-4.145)

Recording academic and clinical progress – academic assessment (4.146-4.152)

The ARCP for trainees undertaking Out of Programme Research (4.153-4.157)

Appeals of the ARCP outcomes (4.158-4.163)

This section describes how trainees are informed of panel decisions in the post-ARCP meeting and a trainee has a right to request a review and in some circumstances an appeal if certain outcomes have been recommended by the ARCP panel. If this request is made the PG Dean must not sign off the outcome documentation until the appeal or review has been completed.

Reviews and appeals (4.164-4.183)

This section describes the review and appeal processes. A review is a process whereby the panel is not formally reconvened, and which can be undertaken virtually, to take into account representations from the trainee, whereas an appeal involves a decision being considered by a different decision-maker. These processes may find the original ARCP outcome to not be justified. This includes principles around when appeals can be heard, how they are run, and how outcomes are notified.

Annex C: Developing credential-specific guidance

The aim of credential-specific guidance (CSG) will be to help doctors applying for a credential via the recognition route to gather evidence appropriate to their background and the specific credential. It may be used by signoff panels but is not binding for panel decisions. It may be accompanied by application and evaluation documents to further support the process.

These principles and examples have been agreed in partnership with the statutory education bodies and the early adopters, to help guide development of CSG.

Principles for evidence requirements

Evidence must:

- demonstrate current or recent competence in the area of practice of the credential
- be aligned to the curriculum and high-level outcomes, and show the applicant has achieved the capabilities in practice (CiPs) by experience gained in practice
- be reliable.

Evidence requirements and decisions must:

- Be based on knowledge, skills and experience needed to meet the credential outcomes
- Prioritise the provision of safe patient care
- Be proportionate, with consideration given to the potential burden to applicants and assessors. For training programmes which share the credential outcomes, and for current longstanding experience, evidence requirements should be minimal
- Ensure a consistent standard is met across applicants and across the UK
- Ensure fairness among applicants who have gained skills via different pathways
    - Equality, diversity and inclusivity principles must be considered to avoid discrimination
    - This should include consideration of our guidance and criteria on breaks in practice
    - Accessibility should be considered so that all candidates are able to achieve the evidence requirements.

Early adopter partners suggested that as well as using the principles and the examples below, it would be helpful to seek input from the lead dean. They suggested that stakeholder engagement was also key to developing the CSG, to ensure applicants are able to navigate the process.

Other useful tips included considering the role of primary and secondary evidence as appropriate for the specific credential, and how to manage applicants' expectations about what holds value.

Examples of experience and appropriate evidence

Examples of experience	Evidence which may be appropriate
Completed a certificate of completion of training (CCT) in cases where this covers the area of practice • Consultant anaesthetist who completed pain specialist training as part of CCT Completed alternative training or fellowship in UK with the same learning outcomes • IR trained in mechanical thrombectomy via an IR training pathway in any of the four nations in the UK • Consultant psychiatrists who completed a pilot credential in liaison psychiatry, if outcomes align with the final approved curriculum for the GMC credential Completed similar training outside the UK with the same learning outcomes Gained relevant knowledge, skills and experience while working in the area of practice of the credential • Rural and remote health doctors	• Evidence of CCT qualification in cases where this covers the area of practice • Evidence of alternative qualification that demonstrates achieving the outcomes • A self-assessment rating against the capabilities (CiPs) and procedural skills, verified, or alongside other evidence • Referees who can attest to current roles and scopes of practice • A letter of corroboration from a responsible officer (RO) confirming engagement with appraisal and revalidation and up-to-date experience • Primary evidence of knowledge, skills and experience gained via learning or work • Evidence of patient outcomes • Audit outcomes from practice • Where appropriate, a structured interview with panel members may be used to seek clarification on scope of practice, but this would not apply in most cases and would need to be justified

The early adopters noted that the amount of evidence needed may depend on the applicant and could be quite simple for some, such as an applicant who has done an exam in the past and is currently in practice, but for others it may be more complex. They are also considering how panels will want to see evidence presented, and advising applicants on how much material is appropriate.

The early adopters are exploring how references and the appraisal process may support applicants who may be highly experienced, particularly in the 'first wave'. They are considering the use of a structured form to support referees to sign off each CiP. They are also thinking about who would be appropriate referees, with some credentials needing someone with first-hand experience of the applicant's roles and scope of practice, while others may need a lead referee in an oversight role getting input from people involved in a process of onward care.