

*To note*

## **Report of the Credentialing Working Group**

### **Issue**

- 1** In 2012 Council agreed that the GMC should develop a regulatory framework for credentialing. In March 2013 the Strategy and Policy Board agreed that a working group made up of those with a key interest in this area should be established to take this work forward.
- 2** The Credentialing Working Group met on seven occasions between July 2013 and September 2014. This paper reports its conclusions and notes our proposed next steps.

### **Recommendations**

- 3** Council is asked to note:
  - a** The Report of the Credentialing Working Group.
  - b** The intention to consult on the proposed regulatory framework for credentialing in quarter 2 of 2015.

# Report of the Credentialing Working Group

## Issue

### *Background*

#### 4 Credentialing is:

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

- 5 Following the merger of the Postgraduate Medical Education and Training Board (PMETB) with the GMC in 2010, the GMC agreed that the feasibility of credentialing should be piloted in three areas of practice where there was no formal specialty recognition leading to a Certificate of Completion of Training (CCT) or sub-specialty. The three areas to be piloted were breast disease management, forensic and legal medicine, and musculoskeletal medicine. In the light of the pilots, in July 2012 Council agreed in principle that a regulatory framework for credentialing should be established, subject to the outcome of further developmental work.
- 6 Since Council's 2012 decision, other developments have pushed the idea of credentialing medical practice up the regulatory agenda. First, and most significantly, credentialing is a key component of the new architecture for GP and specialist training proposed by the 2013 *Shape of Training Review*. The four UK Departments of Health welcomed the report and, through their UK Shape of Medical Training Steering Group, have been considering the recommendations in more detail by sponsoring a series of workshops. The GMC, together with the Academy of Medical Royal Colleges (AoMRC), led the credentialing element of that work, building on the work already undertaken by the Credentialing Working Group.
- 7 Second, the UK Government's 2013 response to Sir Bruce Keogh's review of the regulation of cosmetic interventions identified medical credentialing as one of the ways of enhancing patient protection through the establishment of regulated standards of practice. Again, the GMC was identified as leading the development of this work. Since then, we have been working closely with the Royal College of Surgeons of England as it begins to develop standards in this area which are intended to lead to the creation of regulated credentials.

<sup>\*</sup> PMETB Credentialing Steering Group Report, 2010

- 8** Third, the completion of the credentialing pilots has raised expectations among those involved that we will press ahead with credentialing. Other organisations have also been watching these developments with interest, and we have had a number of approaches from bodies keen to establish credentials regulated by the GMC.

*Credentialing Working Group Report and next steps*

- 9** The final Report of the Credentialing Working Group is at Annex A. We now need to decide whether we wish to proceed with credentialing and, if so, on what basis and over what time frame.
- 10** The Group has fulfilled its brief in developing a framework for how credentialing could be regulated, but we are not yet in a position to implement. A number of other elements need to be put in place.
- a** Implementation of all the Group's recommendations will require legislation to provide statutory underpinning. However, it should be possible to make progress by introducing some aspects of credentialing as an extended pilot (see paragraphs 96-97 of the Group's Report).
  - b** Although the Departments of Health have welcomed the *Shape of Training* report, there is as yet no detailed plan or government commitment to implementation. Credentialing will be a key component of any plan to take forward the *Shape of Training* reforms.
  - c** Should we wish to proceed there is a layer of policy and operational detail (including IT and registration systems) still to be developed to support the proposed credentialing framework. This work will also need to be linked to the developing thinking in our current review of the online List of Registered Medical Practitioners.
  - d** Although the Group's model proposes that most of the financial burden of credentialing would fall on those bodies which wish to establish a credential, there will be resource implications for the GMC which we will need to quantify once the further policy and operational elements have been worked through in more detail. This will guide how, and how quickly, we wish to proceed.
- 11** Although the idea of credentialing is gaining momentum, it would be a significant development of our regulatory activity and one which is likely to be controversial in some quarters. The British Medical Association (BMA) has reservations although BMA Staff and Associate Specialist (SAS) doctors have expressed support for the idea\*. We plan to undertake a public consultation on our credentialing proposals, next

\* Both BMA perspectives were represented within the Credentialing Working Group membership.

year. The precise timing and content of the consultation will be informed by the decisions by the four UK governments on the *Shape of Training* recommendations.

## Supporting information

### How this issue relates to the corporate strategy and business plan

- 12 Strategic aim 2: to *help raise standards in medical education and practice*. In particular, we have committed to review key education and training standards and take forward the recommendations from the Shape of Training review, subject to decisions by the four UK governments on that review. Credentialing is linked to both these commitments.
- 13 Strategic aim 4: to *work more closely with (amongst others) doctors and includes a commitment to explore ways of making the List of Registered Medical Practitioners more accessible and useful*.

### How the issues support the principles of better regulation

- 14 The Group's proposals support the principles of better regulation through: being proportionate and targeted in that they recognise that credentials should only be developed where four tests can be met: a need to enhance patient safety which cannot be adequately addressed through other, non-regulatory, means; a demonstrable service need; evidence of feasibility; and key interest support from the authoritative bodies in the field. A framework of processes has been recommended which will support a consistent and transparent approach to credentialing, and which largely mirrors existing mechanisms for the regulation of education and training. The public value case for credentialing is summarised in paragraphs 9-10 of the Group's Report at Annex A.

### How the action will be evaluated

- 15 Early piloting in 2012 allowed us to consider the feasibility of credentialing and a key interest workshop in 2013 helped us to consider some of the learning from those pilots preparatory to the work of the Group. Since the Credentialing Working Group completed its report we have also had the opportunity to begin to test its conclusions on some key audiences; first at the *Shape of Training Credentialing workshop* in September 2014 and, more recently, at a meeting of the medical royal colleges post-CCT fellowship committee. On both occasions the work was well received. This will be followed by public consultation on the proposals next year (with a supporting impact assessment) and then 'live' piloting.

### What engagement approach has been used to inform the work (and what further communication and engagement is needed)

- 16 Initial piloting was followed by a key interest workshop in 2013. During the subsequent work of the Group we have given presentations to a number of key interest groups and this has helped us to test our emerging ideas with different

audiences. We also shared the Group's discussion papers with interested groups so that they were aware of developing thinking. In addition, the work of the Shape of Training review involved extensive discussion of and consultation on the idea of credentialing and this has also helped to inform our views. Now that the Group has developed its framework we propose that this is the subject of further public consultation.

### **How the issues differ across the four UK countries**

- 17** Our regulatory model is one that applies across the UK. As part of that model, credentialing will also need to apply UK-wide through the application of consistent processes and UK wide standards for each credential. However, as with our regulation of medical education and training generally, we recognise that the delivery of credentials will reflect local needs and conditions. We note, for example, that the appetite for credentialing is particularly keen in Scotland and that certain credentials, such as rural medicine, will be more relevant in some parts of the UK than in others.

### **What equality and diversity considerations relate to this issue**

- 18** Credentialing is likely to be particularly relevant to groups such as SAS grade doctors which include a significant proportion of women and international medical graduates.
- 19** The Group noted that among the standards it had set for the content and assessment systems for credentials was a requirement for any GMC authorised credentialing body to be able to demonstrate the application of equality principles. This will be one of the standards against which their arrangements are quality assured by the GMC.
- 20** Further, in order to support the accessibility of credentials to different groups we have recommended that access should be linked to demonstration of the relevant competences rather than prior possession of a CCT as this would have excluded some groups from any possibility of credentialing (see Report recommendation 5).
- 21** However, while the GMC can make sure that its regulatory mechanisms are deployed to support equality and diversity considerations, access to the training, experience, CPD opportunities and resources that individual doctors will need to obtain credentials will be largely a matter for employers and outside the GMC's direct control.

### **Legislation**

- 22** As noted in this paper and in the Group's Report at Annex A, we would need legislation (probably in the form of the Law Commission Bill) to deliver a fully developed credentialing model. The Department of Health is aware of this requirement. In the meantime, we have recommended that we begin to flesh out and then pilot the education and registration processes that will be needed to support implementation.

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Report of the GMC Credentialing Working Group



# Report of the GMC Credentialing Working Group

## Executive summary

The idea of credentialing medical practice is not new, but it has been slow to take hold because of the lack of any consensus about what it means, what it should seek to achieve and how it would work. Even so, the momentum behind the idea has been growing.\* The GMC's Credentialing Working Group has attempted to address these questions and describe a model for how regulation can ensure that credentialing is developed in the interests of patients.

Credentialing can help to meet a number of different needs. It can provide a framework of standards and accreditation in areas where regulation is weak or non-existent; give better recognition of doctors' competences; improve workforce flexibility and professional mobility; and improve the information available to patients and the public about doctors' areas of competence. But the primary purpose for introducing regulation of credentialing must be to enhance patient protection.

Regulation must be proportionate to the problems it is intended to address. Therefore, regulated credentialing should only be introduced where it provides a means of enhancing patient protection which cannot be met in other ways; where there is a demonstrable service need; where it is practicable and feasible to develop a credential; and where there is clear support from the relevant organisations in the field. Not every specialty or type of medical practice will be suitable for credentialing.

The need for proportionality means that credentialing should be aimed at the level of autonomous practice rather than doctors in training whose practice is already subject to supervision and regulation. Further, credentialing should define areas of practice rather than attempt to regulate specific procedures at a level of granularity which would soon become obsolete as medicine moves on and new treatments emerge.

Proportionality is also relevant to the regulatory effects of credentialing. Our preference is for a model which would enable the GMC's registers to show the areas of medical practice in which doctors have obtained and maintained credentialed competences. But this should not be a legal requirement to possess a particular credential in order to practise. We recognise, however, that in areas of practice where patients may be particularly vulnerable, some have called for a more restrictive model. It is important that whatever model is adopted it commands the confidence of both the public and the profession. The GMC should therefore consult before deciding the model which can most effectively meet the aim of enhancing patient protection.

One way in which credentialing can help to meet that aim is by using the system of revalidation to show on the GMC's registers that doctors are continuing to practise safely in their credentialed field. This will require some maturation of the current revalidation

\* Shape of Training: Securing the future of excellent patient care. Final report of the independent review led by Professor David Greenaway. 2013

model introduced in 2012 and development of the registers. However, this will enhance the transparency and value of the registers.

The GMC can provide the regulatory framework for credentialing. This report sets out processes for establishing a GMC approved credential and for doctors to then obtain and register those credentials. But the model will require expert bodies with the resources to develop and maintain individual credentials and assess whether applicants possess the required competences for those credentials. The medical royal colleges and faculties are well placed to do this, but there are likely to be others who may also wish to bring forward proposals for new credentials. Any organisation wishing to propose a credential must be able to demonstrate that it has the educational credibility, infrastructure, organisational sustainability and the business case for the credential.

The speed at which credentialing is able to develop will depend, in part, upon the appetite of credentialing bodies to bring forward proposals. A number of organisations have already approached the GMC about credentialing areas of practice which are not covered by recognised UK specialty training. The *Shape of Training* review has described how credentialing would fit with mainstream specialty training in the future and we wait to see how the UK Governments wish to take this forward. In the meantime, there are areas where regulated credentialing could already add value by enhancing patient protection.

## List of recommendations

The following recommendations should be read in conjunction with the paragraphs of the report to which they relate, as shown in parenthesis:

**Recommendation 1:** *The purpose of the regulatory framework for credentialing should be to ensure patient protection and that future healthcare developments are safe and effective (paragraphs 13-14)*

**Recommendation 2:** *Regulated credentials should only be introduced in those areas of medical practice where the GMC is satisfied that all four tests of need have been met (paragraphs 17-18)*

**Recommendation 3:** *Regulated credentials should define an agreed area of practice (rather than a single procedure), including any specific procedures encompassed within that area of practice (paragraphs 19-21)*

**Recommendation 4:** *A credential should signify that a doctor has attained the complete range of expertise within the scope of practice of that credential, ensuring they are judgement safe and accountable for their professional decisions in the credentialed field (paragraphs 22-25).*

**Recommendation 5:** *In principle, eligibility for a credential should not be dependent upon participation in a CCT programme or possession of a CCT, although there are likely to be individual credentials for which possession of specific knowledge and skills would contribute to demonstrating the competences necessary for the credential (paragraphs 26-28).*

**Recommendation 6:** *Credentialing should be consistent with the current indicative model of medical regulation. Possession of a credential should indicate attainment of competences in a designated area of practice but should not be a statutory requirement for practice in a particular field. The GMC should utilise all of the regulatory levers at its disposal to ensure the efficacy of the indicative model in protecting patients. It should also consult stakeholders on the proposed approach (paragraphs 29-36)*

**Recommendation 7:** *Any organisation or group of organisations proposing to bring forward a credential for approval by the GMC must demonstrate that they have the educational authority, infrastructure, organisational sustainability, expertise and resources to support the development and maintenance of the credential (paragraphs 37-42).*

**Recommendation 8:** *The cost of developing and maintaining the credential should fall to the authorised body or bodies which bring it forward for approval (paragraphs 37-42).*

**Recommendation 9:** *The GMC should set high level standards (Annex C) for the content and assessment systems of credentialing. This will allow the credentialing bodies to*

*determine the approach to content and assessment best suited to their area of practice consistent with GMC standards. GMC approval of the approach and the credentialing body's compliance with the relevant standards will be essential for recognition of a credential (paragraphs 43-45).*

***Recommendation 10:*** *The GMC's registers must be developed to include information about doctors' credentialed practice, showing whether a credential is 'historical' or 'active' as demonstrated through revalidation (paragraphs 46-50).*

***Recommendation 11:*** *The GMC should endorse the outline process for establishing credentials (paragraphs 51-58).*

***Recommendation 12:*** *The GMC should endorse the outline process for obtaining and maintaining credentials (paragraphs 59-73).*

***Recommendation 13:*** *Credentialing should be an evolutionary process. It should begin where there is evidence of patient protection and service need and readiness of professional bodies to meet that need (paragraph 93-95).*

***Recommendation 14:*** *The GMC should explore the opportunities for introducing elements of the credentialing model in advance of legislative change (paragraphs 96-97).*

***Recommendation 15:*** *The GMC's implementation of credentialing should include plans for the future evaluation of the process, its impact and efficacy (paragraphs 96-97)*

## Section 1: Background

- 1 Discussion about the credentialing of medical practice in the UK has been going on for at least 10 years. The GMC did not initiate these discussions, but began to explore the idea in 2006/7 as part of a review of the fitness for purpose of the specialist register.<sup>\*</sup> This was driven by a wish to improve the information about specialists that was available on the GMC's registers. Around the same time others, such as Lord Darzi and NHS Employers, were identifying credentialing as a means of providing better information about doctors' specialist capabilities and supporting a more flexible workforce.<sup>†‡</sup>
- 2 In December 2008 the Department of Health (England) invited the Postgraduate Medical Education Training Board (PMETB) to lead exploratory work on the concept of credentialing. The subsequent PMETB Credentialing Steering Group report set out the case for credentialing and some preliminary recommendations for how credentialing might be taken forward.<sup>§</sup> In 2010 Lord Naren Patel's Report *Recommendations and Options for the Future Regulation of Medical Education and Training* gave further support for credentialing, citing it as a way of enhancing the training and status of staff and associate specialist (SAS) grade doctors.<sup>\*\*</sup>
- 3 More recently, Professor Sir David Greenaway's 2013 report *Shape of Training: Securing the future of excellent patient care* includes credentialing as part of the recommended future architecture of specialist and general practice (GP) training.<sup>††</sup> And, with a slightly different focus, the Government's 2014 response to Sir Bruce Keogh's report on the regulation of cosmetic interventions supported credentialing as one of the ways of improving standards and regulation in cosmetic surgery.<sup>‡‡</sup>
- 4 Despite being so frequently mentioned in despatches, credentialing has made little headway. In part, this has been a matter of timing; the GMC's main priority until recently has been to introduce revalidation. But the more important obstacle has been the lack of consensus about what is meant by credentialing, what it is supposed to achieve and what problems it is intended to solve. Those on different sides of the debate have frequently been arguing on the basis of very different understandings and aspirations.

\* [http://www.gmc-uk.org/5a\\_\\_\\_Annex\\_B\\_Draft\\_Report\\_of\\_the\\_Specialist\\_Register\\_Review.pdf\\_25399658.pdf](http://www.gmc-uk.org/5a___Annex_B_Draft_Report_of_the_Specialist_Register_Review.pdf_25399658.pdf)

† Ref Next Stage Review

‡ NHS Employers position statement

§ [http://www.gmc-uk.org/CSG\\_Report\\_April\\_2010.pdf\\_34123082.pdf](http://www.gmc-uk.org/CSG_Report_April_2010.pdf_34123082.pdf)

\*\* [http://www.gmc-uk.org/4\\_\\_\\_Annex\\_B\\_\\_\\_Outcome\\_of\\_Consultation\\_on\\_the\\_Review\\_of\\_the\\_Future\\_Regulation\\_of\\_Medical\\_Education\\_and\\_Training.pdf\\_31275463.pdf](http://www.gmc-uk.org/4___Annex_B___Outcome_of_Consultation_on_the_Review_of_the_Future_Regulation_of_Medical_Education_and_Training.pdf_31275463.pdf)

†† Shape of Training final report, 2013, recommendation 16

‡‡ <https://www.gov.uk/government/publications/regulation-of-cosmetic-interventions-government-response>

- 5 Prompted by the early work and recommendations of PMETB's Credentialing Steering Group (and following PMETB's merger with GMC in 2010), the GMC sought to move the debate forward to a shared understanding of the meaning of credentialing, where it might bring benefits and, where appropriate, how it might fit within the wider system of medical regulation.
- 6 This began with support for three pilot studies looking at the feasibility of credentialing in areas of practice where there was no formal specialty recognition leading to a CCT or sub-specialty, and no regulation of standards. The areas were breast disease management, forensic and legal medicine (which we concluded had a strong case to be recognised as a specialty), and musculoskeletal medicine. The pilots were led, respectively, by the Association of Breast Clinicians, the Faculty of Forensic and Legal Medicine and the British Institute of Musculoskeletal Medicine. These bodies planned, undertook, resourced and evaluated the pilots in their specialty areas.\* The learning from these pilot studies has helped to inform our subsequent work.
- 7 In the light of the pilots, in July 2012 the GMC's Council agreed in principle that a regulatory framework for credentialing should be established, subject to the outcome of further developmental work.

## **Section 2: GMC Credentialing Working Group (CWG)**

- 8 That further development work has been taken forward by a GMC appointed working group which comprised a range of expert and stakeholder interests. The members of the CWG are listed at Annex A. The group's terms of reference are at Annex B. In essence, the task of the group was to make proposals for how credentialing should be regulated. This report sets out the group's conclusions.

## **Section 3: Understanding the problem**

- 9 As PMETB's Credentialing Steering Group has previously identified, credentialing creates opportunities to enhance regulation in ways that bring benefits for patients and the public, employers, commissioners, and the profession.† Although no magic bullet, credentialing will help to address different problems for different groups. For example:
  - Outside of recognised medical specialties there are areas where regulation is weak or non-existent and patients can be vulnerable. By establishing a framework for nationally recognised standards in these areas, and a system of accreditation

\* ([http://www.gmc-uk.org/7b\\_Credentialing\\_Pilot.pdf\\_49294057.pdf](http://www.gmc-uk.org/7b_Credentialing_Pilot.pdf_49294057.pdf))

†[http://www.gmc-uk.org/CSG\\_Report\\_April\\_2010.pdf\\_34123082.pdf](http://www.gmc-uk.org/CSG_Report_April_2010.pdf_34123082.pdf)

which is quality assured by the GMC, credentialing can help to ensure that doctors practising in these areas have the appropriate competences.

- The *Shape of Training* report proposes a new architecture for postgraduate medical education in which specialty training will be more broadly based than at present. Specialty and sub-specialty expertise will nevertheless still be required to meet the health needs of patients. As medical royal colleges and faculties re-examine their specialty curricula to reflect this broader specialty focus, credentialing will provide continued support for those sub-specialty needs once formal postgraduate training is complete. Credentialing is therefore essential to the implementation of the *Shape of Training* agenda.
- Staff and Associate Specialist (SAS) grade doctors deliver much of the healthcare in the NHS, often working with a high degree of autonomy in their specialist field. Yet because many of these doctors are not on the specialist register (which was designed for a different purpose) their capabilities are not formally recognised. This does not mean they are not meeting the standards that apply in their area of practice, but lack of recognition means that neither patients nor employers can be assured that they have met national standards in their field. This can also limit the professional mobility of these doctors. For those who can demonstrate the required standards, credentialing offers both patients and employers greater assurance of their competences and a more flexible workforce.
- With changing modes of healthcare delivery, and as doctors' scope of practice changes (for example general practitioners with extended roles), credentialing offers a transparent means of demonstrating adherence to nationally agreed standards.
- Recording credentialed areas of competence on the GMC's registers improves the information available to patients, the public, employers and commissioners of services. It can also complement revalidation by showing, more transparently than at present, the fields in which doctors are continuing to meet credentialed standards.

**10** How well credentialing is able to address these problems depends in part upon the regulatory framework that supports it, but also on the readiness of employers and commissioners of services, educational bodies, and the profession, to exploit the opportunities that it presents for them. The further development and implementation of credentialing must therefore engage all of these interests. But the focus of this report is on the first element; the regulatory framework.



## Section 4: What we mean by credentialing

- 11 We have taken as our starting point the definition of credentialing developed by PMETB's Credentialing Steering Group in 2010:

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

- 12 Beneath this high level definition lie a series of questions about issues such as the level of practice at which credentialing takes place, the depth and breadth of credentials, and who they are aimed at. We could only begin to address these questions once we had clarity about the regulatory purpose of credentialing.

## Section 5: The purpose of regulated credentialing

- 13 There already exist a plethora of diplomas, certificates and modules set at different levels and awarded by different bodies providing ‘accreditation of attainment of competences’ in different disciplines. These are credentials by any other name. But they do not require the involvement of the regulator.
- 14 Consistent with the statutory purpose of the GMC,<sup>\*</sup> credentialing should only be subject to national regulation where this can add value by enhancing patient protection. It will do this by setting standards in the areas to be credentialed, approving the arrangements by which individuals are assessed as meeting those standards, and by providing clear information on the GMC registers about which individuals have met and maintained those standards.

**Recommendation 1:** The purpose of the regulatory framework for credentialing should be to ensure patient protection and that future healthcare developments are safe and effective.

- 15 The working group recognised that although the principal purpose of credentialing is patient protection, it will serve a number of supplementary functions. For employers, commissioners of services and the public it should provide better information on the registers about doctors’ areas of competence; for providers it may facilitate workforce flexibility; for groups such as SAS doctors it can support recognition of their capabilities and professional mobility.
- 16 If the purpose is patient protection, credentialing should also enable areas of practice where patients are vulnerable and regulation is weak to be brought within the scope

\* To protect, promote and maintain the health and safety of the public.

of regulation. Cosmetic surgery is one such example. Following the recommendations of the Keogh review into the regulation of cosmetic interventions, the Royal College of Surgeons of England is developing a set of standards in cosmetic surgery with the intention that these should, in due course, form the basis of a GMC regulated credential.

### *Limiting regulatory intervention to where it is needed*

**17** Not every field of practice will be suitable for credentialing and the GMC should not attempt to establish credentials for every specialty, discipline, scope of practice or procedure. The GMC will need criteria and evidence for evaluating proposals to establish a GMC regulated credential. These should fall under four broad headings, all of which must be satisfied before work to develop a credential begins:

- A need to ensure patient protection which cannot be met through other means
- A demonstrable service need
- Feasibility of developing and maintaining the credential
- Support for the credential from a recognised authoritative body in the field.

**Recommendation 2:** Regulated credentials should only be introduced in those areas of medical practice where the GMC is satisfied that all four tests of need have been met.

**18** Suggestions for the sort of evidence that the GMC should take into account in deciding whether the criteria have been met are at Annex C.

### *Credentialing of procedures or areas of practice*

**19** One of the criticisms often levelled at credentialing is that it is little more than stamp collecting for accredited procedures. Slicing and dicing medical practice into thousands of different regulated procedures does not fit well with the idea of care for the whole patient. The GMC's registers would rapidly become cluttered with information about doctors' competence to perform individual tasks, procedures which would soon become obsolete as medicine moves on and new treatments emerge. Credentialing in this way would make the GMC registers less, rather than more, meaningful.

**20** The working group concluded, therefore, that a credential must describe a defined area of practice rather than a specific procedure. That area of practice may be more or less broad depending on the discipline, and may include among the competencies required to demonstrate the credential the ability to perform particular procedures.

**21** In some fields it may be appropriate to develop more than one credential. For example, a single credential covering the full range of musculoskeletal and

rheumatological interventions might not be feasible or reflective of actual medical practice. This might also apply to aspects of orthopaedic and reconstructive surgery. It would be for an authoritative body in the field to determine the appropriate scope for the area of practice to be credentialed, just as it is currently for specialty and sub-specialty practice.

**Recommendation 3:** Regulated credentials should define an agreed area of practice (rather than a single procedure), including any specific procedures encompassed within that area of practice.

### *Setting the level for credentialing*

- 22** The credentialing debate has often revolved around the level at which credentials should operate; whether they should accredit modules of pre-CCT training, or post-CCT expertise, or, indeed, whether it is desirable to develop credentialing at several different levels. The issue for the working group was to decide the level, or levels, at which a regulated credential could add value.
- 23** The CWG saw no regulatory value in developing credentials for doctors in specialty training leading to a CCT as this is already a supervised and highly regulated group. There would be no added benefit in terms of patient protection. Deconstructing specialty training in this way would also run counter to the thrust of the *Shape of Training* report which has recommended broader based specialty training in the early years of training.
- 24** The CWG also felt that to allow regulated credentials to be established at a number of different levels, whether within a single field, or more generally, risked creating confusion in the minds of employers, commissioners of services, patients and other health professionals about what possession of a credential meant. In the same way that award of a specialty CCT signifies attainment commensurate with the level of a day-one consultant, there should be similar clarity about regulated credentials. A credential would not usually cover the breadth of a CCT specialty, but would denote at least a comparable level of competence within a narrower field.
- 25** The *Shape of Training* report discusses the development of credentialing programmes 'once doctors have completed their postgraduate training' and for 'doctors who are not in a formal training programme'.<sup>\*</sup> This clearly points to the regulation of credentialing at the level of autonomous practice, albeit within a system of clinical governance.

**Recommendation 4:** A credential should signify that a doctor has attained the complete range of expertise within the scope of practice of that credential, ensuring

<sup>\*</sup> Shape of Training final report, 2013, page 46.

they are judgement safe and accountable for their professional decisions in the credentialed field.

## Section 6: Accessibility

- 26** The speed and scale at which any future credentialing system evolves will depend on funding and workforce development needs and the opportunities that are created for individual doctors to access the time, resources and, where appropriate, training necessary to obtain credentials. Although we touch on these issues later in this report, they go beyond the remit of the CWG to make proposals for the *regulatory framework* for credentialing.
- 27** Nevertheless, in view of what we have said about the level of attainment signified by credentialing, it is relevant for us to note that credentialing should not be limited to those doctors who have already attained a CCT. Although *Shape of Training* refers to specialty and subspecialty training being undertaken through post CCT (in future CST) credentialed programmes, the report is also very clear that credentialing will give opportunities to SAS doctors and others who may not have completed formal postgraduate training.\* Furthermore, as illustrated by the pilot studies we have already undertaken, some of the areas where credentialing may add most value are in those specialties for which CCTs do not exist.
- 28** The question of whether credentials are pre or post CCT, or wholly outwith the CCT, is therefore largely irrelevant. What matters is whether there is a demonstrable need for a regulated credential in a particular field, whether appropriate competences and assessment systems for the credential can be developed at the required standard, and whether an individual has met the competences for that credential. This does not preclude authorised credentialing bodies (see section 8 below) from setting entry criteria for individual credentials.

**Recommendation 5:** In principle, eligibility for a credential should not be dependent upon participation in a CCT programme or possession of a CCT, although there are likely to be individual credentials for which possession of specific knowledge and skills would contribute to demonstrating the competences necessary for the credential.

## Section 7: The regulatory effects of credentialing

\* Shape of Training final report, 2013, pages 46-7

## *Indicative versus mandatory credentialing*

- 29** In order to practise medicine in the UK a person must be registered and licensed as a doctor with the GMC. However, the law does not restrict doctors to working in a particular field of practice or specialty. Instead, the GMC's guidance, *Good Medical Practice*, imposes a duty on all doctors to 'recognise and work within the limits of their competence'. The system of medical revalidation introduced in 2012 then requires doctors to demonstrate on a regular basis that they remain up to date and fit to practise in the field(s) in which they are working. Doctors who fail to recognise and work within the limits of their competence may face action by the GMC under our fitness to practise procedures.
- 30** Doctors who have completed specialist training are eligible for inclusion in the GMC's specialist register. The specialist register indicates the specialty in which the doctor's specialty training was completed, but it does not legally restrict the doctor to working only in the indicated specialty. Nor does it prevent other licensed doctors who are not on the specialist register from working in those same fields of medicine.
- 31** Thus, our regulatory system is said to be 'indicative' rather than 'restrictive' in that it indicates to patients, the public, employers and commissioners who is licensed and who has completed training in a particular specialty, but does not legally restrict who can work in a specialty. It is for employers, commissioners of services and those granting admitting rights to hospitals to decide whether an individual is fit for the purpose of the particular job they are required to undertake.
- 32** The advantage of this approach is that it allows medicine to be practised in a way which is flexible and responsive to medical developments and healthcare needs, without limiting workforce flexibility. But it does put a professional responsibility on the doctor, and on those contracting the doctor's services, to make sure that they are fit for the role they are being asked to undertake.
- 33** The CWG has concluded that credentialing should follow the 'indicative' model and operate in exactly the same way as the rest of the GMC's registers. It would be anomalous to introduce requirements relating to credentialing (or a particular field of credentialed practice) which were fundamentally different from the requirements for other aspects of licensed medical practice.
- 34** Nevertheless, the CWG recognised that some of the fields of practice where credentialing will develop are those in which patients are likely to be particularly vulnerable. The RCS, for example, has drawn attention to the lack of formal governance structures surrounding cosmetic surgery in the independent sector to provide a check on unscrupulous practitioners, and the extent to which patient choice may be determined by price with limited information currently available on safety and quality.

- 35** These are legitimate concerns and the GMC should look at how it might use other regulatory levers to enhance patient protection. This could be indirectly through working with other agencies, such as the system regulators, or directly by enhancing the information available on the GMC registers and utilising the powers currently available for the revalidation of doctors. The GMC would be able, for example, to use evidence of risk as grounds for varying the basis upon which a doctor working in a credentialed field of practice, but without a credential, is revalidated. This might involve more frequent revalidation or requiring additional information in support of the doctor's revalidation.
- 36** We accept, however, that some stakeholders believe that only by making possession of the relevant credential a legal requirement for practice in a credentialed field would patients be adequately protected. We feel that mandatory credentialing of this kind would be disproportionate and likely to have profound and unintended consequences for medical practice. But in order that any future credentialing model commands the confidence of stakeholders the GMC should consult on the proposed approach.

**Recommendation 6:** Credentialing should be consistent with the current indicative model of medical regulation. Possession of a credential should indicate attainment of competences in a designated area of practice but should not be a statutory requirement for practice in a particular field. The GMC should utilise all of the regulatory levers at its disposal to ensure the efficacy of the indicative model in protecting patients. It should also consult stakeholders on the proposed approach.

## **Section 8: Authorised credentialing bodies**

- 37** The GMC should be responsible for deciding which credentials are regulated, awarding credentials to individual doctors, recording and maintaining those credentials on its register, and for quality assuring the overall process by which credentials are developed, approved and assessed.
- 38** The GMC is not, however, well placed to initiate, develop and maintain the content and assessment systems for the credentials themselves. This should be the job of 'authorised credentialing bodies' in much the same way as medical specialties and specialty curricula are developed by the medical royal colleges and faculties and training and then submitted to the GMC for approval. The cost of developing and maintaining the credential (so that it continues to reflect changes in the credentialed field of practice) should fall to the authorised body which brings it forward for approval.
- 39** The colleges and faculties are the organisations most likely to be in a position to develop credentials in their specialty areas as they have the experience, expertise, resources and infrastructures already in place. They might do this individually or in partnership with others.

- 40** But the pilot studies have shown that bodies other than colleges and faculties have an interest in developing credentials. This could extend to universities and other academic institutions, professional associations or employers responding to a service need. There is no reason why credentialing should be limited to clinical disciplines associated with particular colleges or faculties.
- 41** A credential may arise from a specific local need; for example, rural medicine in Scotland. But the GMC is a UK wide regulator and so the content, assessment systems and standards set for the credential by the authorised credentialing body must have UK-wide currency, even if the way the credential is delivered reflects local circumstances. This is no different from recognised specialty and sub-specialty training today.
- 42** With a range of bodies able to propose the creation of a credential, the GMC must be satisfied not only of the need for the credential but of the credibility and capability of the body that wishes to establish the credential. The GMC already performs an analogous function with the establishment of new medical schools.

**Recommendation 7:** Any organisation or group of organisations proposing to bring forward a credential for approval by the GMC must demonstrate that they have the educational authority, infrastructure, organisational sustainability, expertise and resources to support the development and maintenance of the credential.

**Recommendation 8:** The cost of developing and maintaining the credential should fall to the authorised body or bodies which bring it forward for approval.

## **Section 9: Standards and assessments**

- 43** The GMC's role is to set the high level standards within which all credentials are developed and maintained. The task of the authorised credentialing body is to demonstrate to the GMC how the content, competences and assessment systems for the proposed credential will meet those standards. Different bodies will do this in different ways for different credentials. The GMC will quality assure the approaches used in order to satisfy itself that standards are being met.
- 44** However, the way opportunities for training and/or experience are created and managed to enable candidates to meet the required outcomes for the credential should not be a matter for regulation by the GMC. This approach allows credentialing to develop in a way which is flexible. We recognise that the corollary of this is that employers and commissioners of services are likely to facilitate opportunities for experience or training towards a credential only where they have an identified need. Others will not do so and doctors wishing to acquire a credential may need to obtain the necessary competences in other locations.
- 45** The draft standards for the content and assessment of credentials at Annex C reflect this overall approach. The draft standards are aligned, as closely as possible, with the

GMC's existing *Standards for curricula and assessment systems*. This will help to give the credentialing process a consistency and robustness that is comparable with the arrangements for recognised specialty training.

**Recommendation 9:** The GMC should set high level standards (Annex D) for the content and assessment systems of credentialing. This will allow the credentialing bodies to determine the approach to content and assessment best suited to their area of practice consistent with GMC standards. GMC approval of the approach and the credentialing body's compliance with the relevant standards will be essential for recognition of a credential.

## Section 10: Registration and Revalidation

- 46 One of the aims of credentialing is to provide better information on the GMC's registers about doctors' capabilities. It follows that the award of a GMC recognised credential should be reflected in the registers. This would signify that a doctor has been accredited as having demonstrated the standards relevant to that field of practice.
- 47 Unlike the specialist and GP registers which provide a purely historical record of attainment which does not necessarily reflect an individual's current practice or areas of competence, credentialing should provide a more contemporary statement of a doctor's status. It should be possible to remove credentials from the registers either at the request of the doctor concerned or where the doctor is no longer meeting the requirements for the credentialed area of practice. This need not be seen as a negative step. It may simply reflect developments in a doctor's practice; for example, a move from clinical practice into medical management or education and training.
- 48 Building on the systems that are already in place, revalidation should be the mechanism for maintaining a registered credential. As part of revalidation, all doctors are required to bring information about their practice to their annual appraisal. For a doctor working in, for example, anaesthesia, this would include information about their practice in that specialty. The medical royal colleges and faculties (in this example, the Royal College of Anaesthetists) issue guidance about what information an appraiser should expect from a doctor in the specialty. Exactly the same approach should therefore apply for a credentialed doctor and the relevant credentialing body.
- 49 Where a credentialed doctor did not bring to appraisal information relating to their practice in the credentialed field over the course of the revalidation cycle their credential in the register would be shown as 'historical' rather than 'active'. This would not mean that they could not revalidate. Their practice may simply have diversified into other areas so that it is not possible or relevant for them to show that they have remained up to date in the credentialed field. The designation of a credential as 'historical' or 'active' would therefore imply no judgement about a doctor's overall fitness to practise. It would simply indicate whether they had been practising in the credentialed field during the revalidation cycle and provided



appropriate information in support of their fitness to practise in that specific field. A 'historical' credential could be re-activated by providing appropriate information during the next revalidation cycle.

- 50 We recognise that the GMC's registers are not currently configured to support the maintenance of credentialing through revalidation in the way that we propose. We also understand that if this model is adopted for credentialing it will have implications for the way doctors' practice is reflected in the registers more generally and for the future development of revalidation. We note, however, that the GMC is currently reviewing the utility of the registers. Furthermore, the legislative reforms in the Law Commission's proposed *Regulation of Health and Social Care Professions Etc Bill* would facilitate the recording of credentials on the registers.\* We are strongly of the view that this would be a small, but important, step towards enhancing the utility of the registers for patients and the public, employers and commissioners of services.

**Recommendation 10:** The GMC's registers must be developed to include information about doctors' credentialed practice, showing whether a credential is 'historical' or 'active' as demonstrated through revalidation.

### **Section 11: Process for establishing a credential**

- 51 The diagram at Annex E describes the process for establishing a credential.
- 52 Box 1: The identification of the need for a credential may come from a variety of different sources: for example, patients or the public a college or specialist society, interested clinicians, employers, or government,.
- 53 Box 2: For the credential to be developed it will need the support of the authoritative body in the field, referred to as the 'authorised credentialing body'. Typically, though not in all cases, this will be a medical royal college or faculty.
- 54 Box 3: If a body wishes to establish a regulated credential it will make a proposal to the GMC. The GMC's initial task is to decide whether the criteria for establishing a credential have been met: patient protection, service need, feasibility, and support from the appropriate authoritative body or bodies in the field (the authorised credentialing body).
- 55 Boxes 4 and 5: If the initial criteria are met, the authorised credentialing body would undertake work (using expert, service and lay input) to develop the content, competences and assessment methodologies to support the credential, and undertake piloting. The credentialing body would then submit its proposal to the GMC for approval.

\* [http://lawcommission.justice.gov.uk/docs/lc345\\_regulation\\_of\\_healthcare\\_professionals.pdf](http://lawcommission.justice.gov.uk/docs/lc345_regulation_of_healthcare_professionals.pdf)

- 56 Box 6: The GMC would assess the proposed credential against generic, high level standards for the content and assessment of credentials (see section 9 of this report).
- 57 Box 7: If the GMC approves the credential, the credentialing body would be responsible for the ongoing maintenance of the credential, updating the credential content and assessment systems over time with approval from the GMC.
- 58 Box 8: If the GMC is not satisfied that the credential meets the required standards, the credentialing body will be informed so that further work can be undertaken.

**Recommendation 11:** The GMC should endorse the outline process for establishing credentials.

## **Section 12: Process for a doctor obtaining a credential**

- 59 Once a GMC approved credential has been established, doctors would be able to apply to obtain the credential and have it recorded against their register entry. The diagram at Annex F describes the process.
- 60 Box 1: The doctor wishing to obtain a credential in a particular field would first contact the authorised credentialing body for that credential.
- 61 Box 2: The credentialing body would advise the doctor of the requirements for the credential as approved by the GMC.
- 62 Box 3: The doctor must assemble evidence that they have satisfied the requirements for the credential. Depending on those requirements and the doctor's experience and previous training, they may need to undertake further specific training. Alternatively, they may be able to draw on evidence from their current or previous practice. For example, it is likely that elements of previous CCT training could be transferable and used to evidence some parts of a credential (as indeed elements of individual credentials should be transferable between credentials).
- 63 Boxes 4 and 4a: The authorised credentialing body is responsible for setting the content and assessment methodology for the credential and would need to assess whether an individual has met the credentialing requirements (box 4). It may wish to do this directly, or using local assessors (box 4a). However, its processes must comply with the high level standards set by the GMC and be subject to quality assurance by the GMC.
- 64 Box 5: It is for the authorised credentialing body to recommend to the GMC whether a credentialing candidate has demonstrated the required standard and the credential should be awarded. If the standard has not been met the credentialing body would advise the doctor accordingly (box 6).

- 65** Box 6: As with any educational assessment, there will be some who are unsuccessful. It may be, for example, that a candidate is practising competently within a relatively narrow field but does not have the full range of competences required for the credential. Candidates may wish to defer applying for a credential until they are confident that they can demonstrate the required competences. Failure to meet the standard necessary to obtain the credential would not normally imply that the individual's fitness to practise is impaired. Only in exceptional cases should the assessment reveal the sort of profound deficiencies that would warrant referral by the authorised credentialing body to the GMC.
- 66** Box 7: If the doctor has not met the required competences they should be notified and advised of the deficiencies they need to address before re-applying.
- 67** Box 8: The authorised credentialing body should have in place an appeal mechanism to enable the doctor to appeal its decision.
- 68** Box 9: If the authorised credentialing body is satisfied that the requirements for the credential have been met, it will make a recommendation to the GMC. It is for the GMC to decide whether to accept the recommendation of the credentialing body and formally award the credential, exactly as it does with the CCT currently.
- 69** Box 10: If the GMC accepts the recommendation the credential would be recorded on the doctor's register entry.
- 70** Box 11: Evidence submitted for appraisal in support of revalidation would be the means of maintaining the doctor's credential on the register.
- 71** Box 12: Even if there has been a recommendation to the GMC that the credential should be awarded, the GMC may reject the recommendation. This could be, for example, because the GMC has information about the individual which is pertinent to the award of the credential but not known to the credentialing body, or because quality assurance reveals flaws in the credentialing process. If the GMC does not accept the credentialing recommendation, no credential will be awarded.
- 72** Box 13 and 7: Should the GMC not accept the positive recommendation from credentialing body, the credentialing body and the doctor should both be informed.
- 73** Box 14: If the doctor is refused a credential by the GMC following a positive recommendation or a credential, once awarded, is subsequently removed from the register so that it is no longer seen as an 'active' credential, this should be subject to a right of appeal by the doctor to a GMC Registration Appeals Panel.

**Recommendation 12:** The GMC should endorse the outline process for obtaining and maintaining regulated credentials.

## Section 13: Quality assurance

- 74** The processes for establishing and awarding credentials should be subject to quality assurance by the GMC, building on its existing Quality Improvement Framework for postgraduate medical education.
- 75** The GMC will require the authorised credentialing body to show that it has effective processes in place for setting the appropriate standards and outcomes, and for assessing candidates against those standards.
- 76** Responsibility for quality management of the credential should rest primarily with the authorised credentialing body. The body bringing forward the credential for approval by the GMC must be able to demonstrate that any proposed training placements/posts or sites which form part of the credential (where that is applicable) are able to deliver the required outcomes.

## Section 14: Grandfather rights

- 77** 'Grandfather rights' refer to the arrangements by which individuals or organisations undertaking a particular activity are exempted from new rules relating to that activity, either for a limited period or indefinitely. It is a recognised feature of implementing major system changes which is intended to enable someone to continue to practise under their existing rights after new rules for that activity have been introduced.
- 78** There are three groups to whom grandfather rights may be relevant:
- Those who are already practising in a field for which a credential is subsequently established
  - Those in the authorised credentialing body who have developed the credential and will oversee its implementation
  - Those doctors with a sub-specialty recorded on the GMC's specialist register.
- 79** Subject to the outcome of public consultation, we propose that credentialing should be used to indicate accredited competences in the registers, rather than a legal requirement for practice in a particular field (see section 7). This approach would not require doctors who are already practising in a credentialed field to be 'grandfathered' into the credential in order to continue to practise. Those wishing to obtain the credential (as it becomes the expected standard in the field) would therefore need to apply to the authorised credentialing body and demonstrate the required competences.
- 80** To ensure the credibility of a credential those responsible for developing it and assessing other candidates must, themselves, hold the credential. This means they must have demonstrated the competences and undergone the assessments or other

evaluations associated with the credential. They cannot simply be 'grandfathered' in. However, initially at least, they would need to be assessed by peers who are not themselves credentialed and a recommendation made to the GMC in accordance with the processes outlined in this report. In these cases it will be particularly important to be able to show that due process has been followed and standards met.

- 81** The position of doctors with a sub-specialty currently recorded on the GMC's specialist register will depend on the way in which the *Shape of Training* recommendations are to be taken forward. This is considered further in section 15. However, if it is agreed that sub-specialties should be replaced by credentialing it would be possible to transpose all existing sub-specialties as credentials and grandfather all doctors with a registered sub-specialty into a newly established credential without affecting the practising rights of those concerned.

### **Section 15: Credentialing and the *Shape of Training* review**

- 82** Our work on credentialing pre-dates the *Shape of Training* review. In developing our regulatory framework much of our focus has been on examples drawn from outside recognised training specialties. At the same time, we have sought a regulatory model which could be applied to any area of medical practice. We note that the credentialing proposals within the *Shape of Training* report are entirely consistent with our proposed model, and the ground we have prepared should facilitate the introduction of the *Shape* recommendations.
- 83** There are, nevertheless, some decisions about credentialing that cannot sensibly be made in isolation from the work now being taken forward by the four UK governments towards implementing the *Shape of Training* proposals. These include, but are not limited to, decisions about the future relationship between credentialing and sub-specialty training; the transferability of competences across credentials; how credentialing is funded; the management and delivery of training to support credentialing; and the pace at which it is introduced. Even so, in considering the regulatory framework the CWG has had to form preliminary views on some of these issues and they are offered here in the hope that they will help to advance the debate.

#### *Credentialing and sub-specialties*

- 84** The CWG considers that credentialing and sub-specialties cannot co-exist. Both are concerned with the demonstration of competences in a particular field at a level necessary for autonomous practice. At present a sub-specialty will always fall within a recognised specialty but a credential is more likely to be established outside a recognised specialty. However, there is currently a moratorium on establishing new sub-specialties and a number of organisations are looking to credentialing as an alternative to sub-specialty recognition. There is already, therefore, some general perception of equivalence between the two concepts. In terms of professional,

service and, more importantly, public perception, we feel that it would be confusing to run a mixed economy in which credentials and registered sub-specialties co-exist.

- 85** These factors, coupled with the conclusions from *Shape*, suggest that sub-specialties should be replaced by credentialing. The criteria and processes for approval of credentials outlined in this report should in future be applied both to credentials and what we currently understand as sub-specialty training.
- 86** The management of the transition from sub-specialties to credentials will depend on how the UK governments decide to implement the *Shape of Training* agenda. However, the simplest and cleanest mechanism would be to re-designate existing specialties as credentials. We recognise that some sub-specialties will change significantly to accommodate the new training architecture resulting from the *Shape* proposals. Over time the authorised credentialing body for the sub-specialty area would be asked, as part of routine quality assurance, to demonstrate that they are meeting the new credentialing criteria in order to retain GMC recognition.
- 87** As sub-specialties are re-designated as credentials, doctors on the specialist register who already have a sub-specialty against their name should have the sub-specialty re-designated as a credential in the same field. This will provide clarity for those consulting the registers. Since any legal privileges derive from the fact of a doctor's inclusion in the Specialist Register (which would remain unchanged), rather than from possession of a particular registered sub-specialty, there should be no adverse impact upon a doctor's practice or entitlements.

#### *The costs of and funding for credentialing*

- 88** The way in which the management and delivery of training opportunities for credentialing should be funded is for those implementing the *Shape of Training* agenda to determine. The start-up and ongoing costs will also be determined by the approach to implementation taken by *Shape*. However, the CWG offers the following observations.
- 89** We envisage that the cost of developing and maintaining a credential for approval by the GMC, and overseeing the assessment of candidates (and appeals against assessment recommendations), would be borne by the authorised credentialing body that is bringing forward the proposal. Any proposal would, therefore, include evidence that there is a demand, that the credential will be viable to maintain, and that the credentialing body or bodies involved have the resources and infrastructure to develop and maintain it.
- 90** The GMC already bears the cost of approving and quality assuring undergraduate and postgraduate medical education and training, and has the staff and systems in place to carry out those functions. This should be extended to incorporate the approval and quality assurance of credentialing.

- 91** Using revalidation as the means of maintaining credentials on the register should involve negligible changes and additional burdens for the GMC, appraisers or responsible officers, although it may involve some development of responsibilities. There would, however, be an increase in the number of appeals made to GMC Registration Appeals Panels, although the rate would depend upon the scale and speed with which credentialing is rolled out and the regulatory effect of an adverse decision.
- 92** Changes would be required to the GMC's online register, but this will need to be assessed as part of any wider package of changes arising from the GMC's current review of the registers more generally.

## **Section 16: Implementation and prioritisation**

- 93** We noted at the start of this report that credentialing has been discussed for a number of years without tangible progress. While the *Shape of Training* proposals have helped to bring credentialing onto the mainstream agenda, we should not wait until that agenda is fully resolved. Credentialing is fundamentally about using regulation to enhance the protection of patients and it is clear that there are areas of medical practice where credentialing can add value regardless of *Shape of Training*.
- 94** The CWG has not been tasked with developing an implementation plan for credentialing. However, it considers that the guiding principle for that plan should be for the introduction of credentialing to be driven by evidence of need and the readiness of professional organisations able to meet that need. The GMC should not wait until there is comprehensive coverage of credentials across all specialty areas or fields of practice. Indeed, not all areas will be suitable.
- 95** Introducing credentialing gradually, as readiness allows, acknowledges that there is value in making a start, while also recognising that the process will be evaluated, refined and improved over time.

**Recommendation 13:** Credentialing should be an evolutionary process. It should begin where there is evidence of patient protection and service need and readiness of professional bodies to meet that need.

## **Section 17: Legislation**

- 96** The GMC is a creature of statute. Its regulatory powers are determined by the Medical Act 1983 (as amended). Those powers do not currently cover credentialing. The Law Commission's *Regulation of Health and Social Care Professions Etc Bill*, published in April 2014, would provide the legislative vehicle to enable full implementation of the credentialing model. We note that the GMC, along with other regulators, is seeking assurances from Government about early implementation of the Bill following the 2015 general election. However, at the present time we cannot be sure when parliamentary time will be made available.

**97** In the meantime, the GMC should consider whether there are aspects of the credentialing model described in this report which could be applied on a voluntary basis. Legal advice provided for the CWG indicates that although it is not currently possible to introduce a full credentialing system, some progress might be possible. This could include developing and approving the standards for the award of individual credentials and the recording of those credentials against a doctor's register entry.

**Recommendation 14:** The GMC should explore the opportunities for introducing elements of the credentialing model in advance of legislative change.

**Recommendation 15:** The GMC's implementation of credentialing should include plans for the future evaluation of the process, its impact and efficacy.

## **Section 18: Conclusions and next steps**

**98** Credentialing has been long in discussion. During that time the need for, and the momentum behind, credentialing has grown. Indeed, forms of credentialing are already taking place. Regulation is now needed to provide the framework of nationally recognised standards, the consistency of process and the transparency that will ensure credentialing develops to enhance patient protection.

**99** This can best be achieved through a regulatory framework which is flexible and responsive to the changing needs of patients and the health service, and which facilitates recognition of doctors' competence. However, it must do this without imposing bureaucratic restrictions on medical practice that would hinder specialty development and hamstring professional mobility. We believe that the model described in this report achieves that balance.

**100** Not every specialty or field of practice will be suitable for regulated credentialing. It would be wrong for the GMC to attempt to impose credentialing where it will not add value for patients and the public. Rather, the development of credentialing must be driven by the needs of patients and the public, employers and commissioners of services. There are areas of practice where those needs are already pressing. We hope, therefore, that the GMC's Council will endorse this report and commit to the earliest practicable implementation of its proposals.



## Membership of the Credentialing Working Group

Professor Stuart Macpherson – Chair

Professor Alison Carr – Academy of Medical Royal Colleges

Dr Liz Edwards – Association of Breast Clinicians

Dr Vicky Evans – Faculty of Forensic and Legal Medicine

Professor Derek Gallen – Conference of Postgraduate Medical Deans of the UK

Dr Andy Heeps – Academy of Medical Royal Colleges

Dr Judith Hulf - GMC

Dr Naila Kamal – Academy of Medical Royal Colleges

Dr Aileen Keel – Scottish Government

Dr Muj Husain (observer)

Ms Sally Malin – Lay representative

Dr Ben Molyneux - BMA

Dr Vicky Osgood - GMC

Mr Peter Russell – NHS Employers

Dr Radhakrishna Shanbhag - BMA

Professor Nigel Sparrow – Academy of Medical Royal Colleges

Dr John Tanner – Institute of Musculoskeletal Medicine

Professor Ian Wall – Faculty of Forensic and Legal Medicine

## Establishing a Regulatory Framework for Credentialing: Working Group Terms of Reference

### Background

- 1 In December 2008 the Department of Health (England) invited PMETB to lead exploratory work on the concept of credentialing. A PMETB-led Steering Group (which included GMC representation) was established to take forward this work. The Credentialing Steering Group (CSG) defined credentialing as:

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

- 2 The CSG published its report in April 2010.\* The key conclusions were:
  - Credentialing has significant potential for benefit because there is a strong need to articulate the nature of a doctor's practice and whether this meets national standards.
  - Credentialing has the potential to complement revalidation for doctors providing specialist services.
  - Credentialing could potentially provide trainee doctors with more flexibility to stop training at different stages, although this may be of interest to only a minority of doctors.
  - Credentialing must be seen to be objective, reproducible, credible, validated and appropriate.
  - There should be a further phase of work, a 'bottom up' approach determining the need for and benefits of credentials including the development of pilots.

\* [http://www.gmc-uk.org/CSG\\_Report\\_April\\_2010.pdf\\_34123082.pdf](http://www.gmc-uk.org/CSG_Report_April_2010.pdf_34123082.pdf)

- 3 Following the merger of PMETB with the GMC in 2010, the GMC agreed that the feasibility of credentialing should be piloted in three areas of practice where there was no formal specialty recognition leading to a CCT or sub-specialty.\* The three areas to be piloted were breast disease management, forensic and legal medicine, and musculoskeletal medicine. In the light of the pilots, in July 2012 the GMC's Council agreed in principle that a regulatory framework for credentialing should be established, subject to the outcome of further developmental work.

## Task

- 4 To:
- a Define the purpose and characteristics of a model for regulated credentialing
  - b Describe the regulatory and related processes necessary to support delivery of the credentialing model.

## Principles to underpin the approach

- 5 The credentialing model must have regard to the following key principles:
- **Patient and public interest:** The primary and overriding consideration in the design of the credentialing model must be to ensure that patients and the public can have confidence in standards attained and maintained by credentialed doctors and understand their scope of practice.
  - **Consistency and objectivity:** The approach to credentialing must be capable of general application across different disciplines.
  - **Equality:** Any proposed model must have regard to considerations of equality and diversity.
  - **Flexibility:** The approach must support flexibility and professional development within the future workforce and potential changes to the healthcare systems of the UK.
  - **Proportionality:** The approach developed must have regard to, and where possible, use existing regulatory structures. The approach taken should be proportional to the likely benefit to the public.

## Themes and issues

- 6** In describing the model for future credentialing, the working group will address such issues as it considers pertinent, but this must include the following:
- Describing the purpose and characteristics of credentialing.
  - Describing the standards for credentialing and the levels of practice signified.
  - Describing the criteria to be applied for the recognition of credentials and how they should be prioritised.
  - Describing the powers and privileges attached to holding a credential.
  - Describing the future relationship between credentialing, existing specialties, sub-specialties, GP special interests and the specialist register.
  - Describing the mechanisms for developing, approving, quality assuring and maintaining credentials.
  - Set out proposals for how the development of credentials in different areas of practice should be funded and the costs of awarding credentials met.
  - Describe the relationship between credentialing and revalidation.
  - Set out proposals for how information about doctors credentials should be made transparent and accessible to patients, the public, employers and other key interests.
  - Identify any legislative changes necessary to implement the proposed credentialing model.
  - Identify the priority areas for developing credentialing.

## Outputs

- 7** The output of the credentialing project will be a report to the Strategy and Policy Board setting out recommendations in relation to the themes and issues referred to in paragraphs 4-6 above, and on such other matters as it identifies as necessary for the introduction of regulated credentialing.
- 8** Subject to the report being endorsed by the Board, its conclusions will form the basis of a public consultation by the GMC.

## **Process: working group membership**

- 9** The credentialing project will be undertaken by a working group drawn from members of the GMC executive (Education and Standards, and Registration and Revalidation) and representatives from key interests as listed below:
  - a** Working group chair appointed by the GMC's Strategy and Policy Board.
  - b** Two representatives from the Academy of Medical Royal Colleges.
  - c** One representative from employers.
  - d** One representative from the Postgraduate Deaneries.
  - e** Two representatives from SAS grade doctors.
  - f** One representative from each of credentialing pilot groups.
  - g** One trainee representative.
  - h** One patient/public representative
  - i** One representative from each of the UK administrations
- 10** The group may seek information and expertise from additional sources, as required.

## **Working methods**

- 11** To be determined by the working group.

## **Accountability**

- 12** The review group will report to the Strategy and Policy Board of the GMC.

## **Timescales**

- 13** The working group is expected to report to the Strategy and Policy Board 12 months from the date of its inception.

## Evidence to support the criteria for establishing a credential

The following types of evidence may help to demonstrate the case for establishing a credential. They are indicative, not mandatory, and nor are they exhaustive:

### *Ensuring patient protection*

- 1 Examples supporting the need for patient protection would include:
  - The lack of existing regulation and professional standards for the field (for example through a pre-existing CST),
  - The nature of the setting in which the activity is undertaken (for example, within the clinical governance structure of the NHS or wholly unsupervised in the independent sector),
  - The relative vulnerability of the patient group and evidence of the risk of harm to patients.
  - Evidence of a lack of qualified staff to deliver the service
  - Evidence of broader public interest in accessing better information about professional standards in the field
  - Evidence that other measures short of regulation cannot, or have not, addressed the risks to patients
  - Report of a national inquiry or review
  - Complaints data or serious untoward incidents.
- 2 Evidence might be sought from a range of organisations including (but not limited to) the authorised credentialing body seeking to establish the credential, NHS England and Health Education England or the devolved administrations.

### *Meeting service needs*

- 3 Evidence of service needs should reflect the existence of a national, rather than simply a local Trust or Board level, demand for regulation in the proposed field. This

may this come from the bodies providing or commissioning services or from government (including the devolved administrations).

- 4 The information and evidence which might help to demonstrate the service need in the area to be credentialed could include such things as:
  - Demographic and health systems data about the patient groups within the field to be credentialed
  - Confirmation from patient groups and the service of the need for better information about doctors' areas of competence
  - Confirmation that the proposed credentials are supported by the service/government and how they will enhance provision of care
  - A demand for services from doctors working in the field to be credentialed
  - Confirmation that the service would be able to support doctors in gaining the relevant competences required for the credential
  - Support from the relevant systems regulators or other standard setting bodies (such as the Forensic Science Regulator)

#### *Feasibility of defining, developing and maintaining the credential*

- 5 For a credential to be viable there will need to be both a sufficient population of potential practitioners and, where the credential relates to clinical care, a sufficient patient population. There would also need to be a sufficient trainers and assessors and appropriate support structures. The authorised body should be required to demonstrate the financial, clinical and educational sustainability of the credential including:
  - Clear definition of the credentialed field consistent with GMC requirements regarding the scope and level of credentialed practice
  - Evidence that the authorised credentialing body (or endorsing college) has, or has access to, the resources and expertise necessary to develop and maintain the credential. This might include evidence that maintenance of the credential would be properly managed and supported and not wholly dependent upon the energies of one or two evangelical individuals
  - Support from a medical royal college or faculty or devolved administration
  - Collaboration or support from other specialist groups involved in the field
  - Evidence of a patient population in respect which the credential would be relevant (although the size of the patient population should not itself be a determining factor as there may be a pressing case to address the needs of a small patient population).

- Evidence of a professional population seeking or expected to seek the credential. In other words, a market for the credential.

*Support from a recognised authorised credentialing body in the field*

- 6** It should be for the GMC to determine whether an organisation(s) wishing to establish a credential is an authoritative body for the proposed area of practice and capable of maintaining the credential. The GMC may wish to take advice from other stakeholders, but must be mindful of potential conflicts of interest.
- 7** Only if an authoritative body(ies) was able to satisfy the four entry criteria set out above would it proceed to the next stage of developing the content and assessment methodology of the credential for the GMC to evaluate and approve.



## Standards for the content and assessment systems of credentials

### Content

#### Standard 1\*

The credentialing body must state how the credential was developed and consensus reached on the content of the credential and the competences to be demonstrated.

Development of the credential must involve external input from patients/lay people, employers/service as well as specialty and educational expertise.

The credential must set out the general, professional and specialty-specific content to be mastered, including:

- (i) The acquisition of knowledge, skills, and attitudes demonstrated through behaviours, and expertise
- (ii) Recommendations on the sequencing of learning and experience should be provided, if appropriate
- (iii) The general professional content should include a statement about how *Good Medical Practice* is to be addressed.

The content should describe how doctors will demonstrate that they have met the generic professional capabilities relevant for the credential.

Content areas should be presented in terms of what the credentialed doctor will know, understand, describe, recognise, be aware of, and be able to do.

#### Standard 2\*

\* Adapted from *Standards for curricula and assessment systems*, Standards 1 and 3

Assessments must systematically sample the entire content of the credentialed area, with reference to the common and important clinical problems that the credentialed doctor will encounter in the workplace and to the wider base of knowledge, skills and attitudes demonstrated through behaviours that doctors require.

Assessment systems must ensure that only those who have demonstrated the required competences and attributes at the appropriate level are able to obtain the credential.

The blueprint detailing assessments in the workplace and any examinations required for the credential will be referenced to the relevant curriculum and *Good Medical Practice* and must be accessible to candidates for the credential as well as assessors/examiners.

### Assessment system methods

#### Standard 3<sup>†</sup>

The choice of assessment method(s) should be appropriate to the content and purpose of that element of the credential.

Methods will be chosen on the basis of validity, reliability, feasibility, cost effectiveness, opportunities for feedback, and impact on learning.

The rationale for the choice of each assessment method will be documented and evidence based. The methods used must be appropriate to the competences being measured.

The assessments must explicitly link to the learning objectives and to the competences required for the credential.

#### *Large scale competence tests*

Approaches to the development and piloting of test items/clinical skills assessments for national tests of competence will be documented and available for external quality assurance. Studies to establish the validity of new methods will be undertaken.

Systematic data collection will support routine reporting on the reliability of tests of competence in high stakes pass/fail examinations. These statistics will be in the public domain.

\* Adapted from *Standards for curricula and assessment system*, Standard 4

† Adapted from *Standards for curricula and assessment systems*, Standard 8

*Summative assessments of performance* \* (formerly referred to as workplace based assessments – for example, direct observation of consulting, 360 assessment and case-based discussions)

Assessments must be subject to reliability and validity measures

Evidence must be collected and documented systematically

Evidence must be judged against pre-determined published criteria where available

The weight placed on different sources of evidence must be determined by the blueprint and the quality of the evidence

The synthesis of the evidence and the process for judging it must be made explicit.

*Methods for assessments of performance (workplace based assessments)*

Methods for assessments of performance are likely to develop over time. Not all methods will be suitable for all specialties. Credentialing bodies will need to determine the appropriate methods for their field of practice.

Some examples of current methods include (but are not limited to) systematic observation of clinical practice, direct observation of procedures, consulting with simulated patients, case record review (including OPD letters), case-based discussions, oral presentations, 360 degree peer assessment, patient feedback surveys, audit projects and critical incident review.

The credentialing body must maintain a thorough and effective system for delivery and monitoring of all assessment systems for which they have responsibility.

## Assessors

### Standard 4<sup>†</sup>

Assessors and examiners must:

Have relevant qualifications and experience

Undertake appropriate training.

\* Further information on assessments of performance can be found in *Learning and assessment in the clinical environment: the way forward – November 2011* [http://www.gmc-uk.org/Learning\\_and\\_assessment\\_in\\_the\\_clinical\\_environment.pdf](http://www.gmc-uk.org/Learning_and_assessment_in_the_clinical_environment.pdf) 45877621.pdf

<sup>†</sup> Adapted from *Standards for curricula and assessment systems* Standards 9 and 10

Assessors/examiners will be recruited against criteria for performing the tasks they undertake.

The roles of assessors/examiners will be clearly specified and used as the basis for recruitment and appointment.

Assessors/examiners must demonstrate their ability to undertake the role

Assessors/examiners should only assess in areas where they have appropriate competence.

The relevant professional experience of assessors should be greater than that of candidates being assessed.

Equality and diversity training will be a core component of any assessor/examiner training programme.

### Assessment feedback

#### Standard 5<sup>\*</sup>

The policy and process for providing feedback to candidates following assessments must be documented and in the public domain.

The form of feedback to the candidates must match the purpose of the assessment.

The measurement of candidate performance must be an integral part of the wider process of monitoring and evaluation, and must use objective criteria.

Sometimes it may be appropriate to provide no feedback other than the test result. If this is a policy decision then reasons should be stated.

### Standards for classification of candidates' performance/competence

#### Standard 6<sup>†</sup>

The methods used to set standards for classification of performance/competence must be transparent and in the public domain.

Standards in tests of competence required for the credential will be set using recognised methods based on test content and the judgments of competent assessors.

<sup>\*</sup> Adapted from *Standards for curricula and assessment systems* Standard 11

<sup>†</sup> Adapted from *Standards for curricula and assessment systems* Standard 12

Where the purpose of the test is to provide a pass/fail decision, information from the performance of reference group peers should inform, but not determine, the standard.

The precision of the pass/fail decision must be reported on the basis of data about the test. The purpose of the test must determine how the error around the pass/fail level affects decisions about borderline candidates.

Reasons for choosing either pass/fail or rank ordering should be described.

Standards for determining successful demonstration of the credentialed competences to the required level should be explicit.

Assessment regulations must clearly specify requirements for the procedure for the right of appeal.

### Standards for classification of candidates' performance/competence

#### Standard 7\*

Documentation will record the results and consequences of assessments and the candidate's progress through the assessment system.

Information will be recorded in a form that allows disclosure and appropriate access, within the confines of data protection and freedom of information.

Uniform documentation will be suitable not only for recording progress through the assessment system but also for purposes of registration and performance review.

Documentation should provide evidence for revalidation and compliance with *Good Medical Practice*.

Documentation should be comprehensive and accessible to the candidate.

### Credential content development review and updating

#### Standard 8†

Plans for review and updating of the credential, including its content, assessment systems, evaluation and monitoring must be set out.

The schedule for updating the credential, with rationale, must be provided including reference to governance arrangements where appropriate.

\* Adapted from *Standards for curricula and assessment systems* Standard 13

† Adapted from *Standards for curricula and assessment systems*, Standard 14

Mechanisms for involving relevant specialty and educational expertise, as well as patients, lay persons, employers and commissioners of services, in updating the credential must be in place and operational.

Any proposed new credential must undergo pilot testing of the content and assessment systems involved.

## Resources

### Standard 9\*

Resources and infrastructure will be available to support the required assessments.

Resources will be made available for the proper training of assessors and examiners.

Resources and expertise will be made available to develop and implement appropriate assessment methods.

Resources will support the assessment of candidates at national and local levels.

Appropriate infrastructure at national level will support the assessment process.

## Lay, patient and service involvement

### Standard 10†

There will be lay, patient and employer/service input in the development of the content of the credential and implementation of assessments.

Lay, patient/carer, service opinion will be sought in relation to appropriate aspects of the development of the credential and the development, implementation and use of assessments for classification of candidates.

Lay people may act as assessors/examiners for areas of competence they are capable of assessing for which they will be given appropriate training.

## Equality and diversity

### Standard 11‡

The credentialing system and supporting assessments must be fair and based on principles of equality.

\* Adapted from *Standards for curricula and assessment systems*, Standard 15

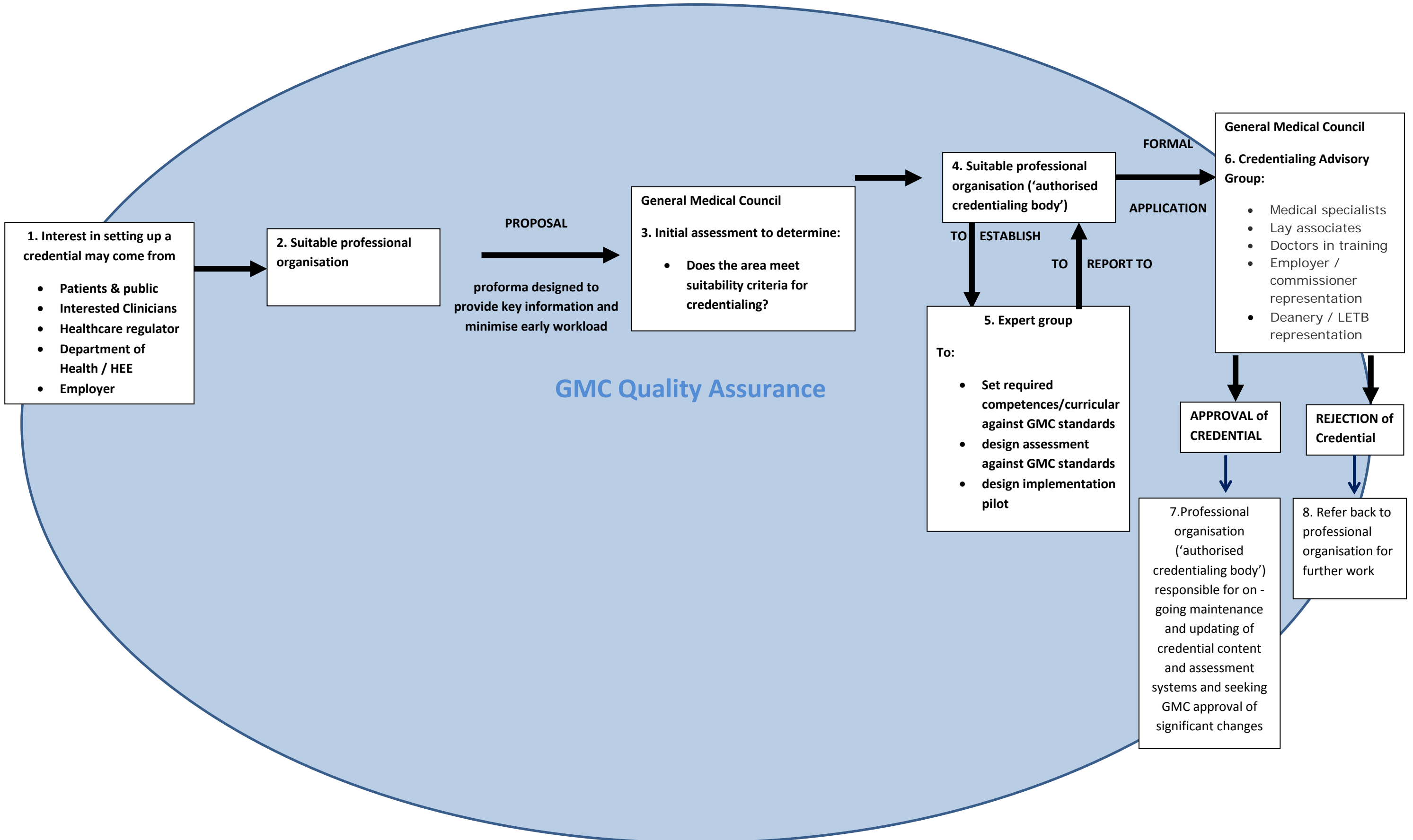
† Adapted from *Standards for curricula and assessment systems*, Standard 16

‡ Adapted from *Standards for curricula and assessment systems*, Standard 17

The credentialing body must provide a statement of the credential's compliance with equal opportunities and anti-discriminatory practice.

## Outline process for approval of Credentials





## Outline for acquiring a Credential

# Outline for acquiring a credential

## Annex F

