General Medical Council

Introducing regulated credentials

Working with doctors Working for patients

About this **consultation**

We're considering a new process called credentialing and are consulting on our proposed model for this.

What is credentialing?

Credentialing is 'a process which provides formal accreditation 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…'*

Credentialing would be used to help protect patients and make sure that future healthcare developments are safe and effective. It will be particularly relevant for doctors who work in areas of medical practice that aren't covered by our existing standards for training and in new and emerging areas of medical practice.

Doctors who have met our standards and been awarded credentials in particular fields of practice will have this recorded in their entry on the List of Registered Medical Practitioners (the medical register).

* Postgraduate Medical Education and Training Board, *Credentialing Steering Group Report*, April 2010, available at www.gmc-uk.org/CSG_Report_April_2010.pdf_34123082.pdf.

Benefits of credentialing

In areas of medicine which fall outside recognised medical specialties the creation of UK recognised standards, and a system that we quality assure, would help to make sure that doctors have the appropriate competencies and capabilities. This would be particularly helpful in fields where regulation is limited and patients are vulnerable (such as cosmetic surgery).

We think there would be a number of other benefits.

- Recording doctors' credentialed areas of competence on our registers would improve the information available to patients, employers, commissioners of services and other professionals about doctors' capabilities.
- Making credentialing information publicly available on the registers would help groups such as staff and associate specialist (SAS) doctors whose capabilities are often not formally recognised in other ways.
- Giving formal recognition to doctors' capabilities in particular areas of practice would support workforce flexibility and doctors' career development as their practice changes over time.

You can find more detailed information about our credentialing proposals in our report, *Final report and recommendations of the GMC Credentialing Working Group* (2014), available at **www.gmc uk.org/about/council/25979.asp**.

What is the scope of this consultation?

Through this consultation, we are seeking feedback on the broad principles and processes for our credentialing model, including:

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

This consultation doesn't cover operational details for how any training associated with credentialing will be organised or funded. Nor does it cover the future arrangements for postgraduate training described in Professor Sir David Greenaway's 2013 Shape of Training report or its proposals for a system of credentialing to cover sub-specialty training.* But we want our model to be sufficiently flexible to accommodate those proposals in future, as and when they are brought forward by the UK Shape of Training Steering Group. We'd welcome your views on whether our planned model achieves this.

* See the Shape of Training report, *Securing the future of excellent patient care*, October 2013, available at www.shapeoftraining.co.uk/static/documents/content/Shape_of_training_FINAL_Report.pdf_53977887.pdf.

How do I take part?

There are 17 questions in the consultation document. You do not have to answer all of the questions if you prefer to focus on specific issues.

The consultation is open until **4 October 2015**.

You can answer the questions online on our consultation website: **https://gmc.e-consultation.net/econsult/default.aspx**.

Alternatively, you can answer the questions using the text boxes in this consultation document and either email your completed response to us at educationconsultation@gmc-uk.org or post it to us at:

Education Policy team (credentialing)
General Medical Council
Regent's Place
350 Euston Road
London
NW1 3JN

What will happen next?

We'll analyse the responses to the consultation and consider any changes to our proposed approach in the light of these. We'll report the outcome of this consultation, along with recommendations on next steps, to our Council – our governing body – in February 2016. Council will decide how to proceed, and at what pace if they agree with the model.

Some elements of our credentialing model, such as the use of revalidation as the means for keeping credentials up to date, will need legislation. We don't yet know when the required law changes will be in place, but it won't be before 2017 at the earliest.

But subject to Council's decision, it may be possible to introduce arrangements for approving, awarding and recording credentials on the medical register without further legislation. If so, we hope to be able to pilot the introduction of credentialing for one or two areas of practice in late 2016. Credentialing will be rolled out gradually. We'll prioritise areas of practice where the needs of patients, employers and commissioners of services are greatest.

How credentialing **will work**

What do we mean by a regulated credential?

Credentialing will give formal recognition of doctors' capabilities in particular areas of practice.

We will set standards and requirements that any proposed credential must meet. Organisations that want to develop credentials in a particular field will need to make sure that the content, outcomes and assessment methods for gaining the credential meet those standards before we approve it.

Doctors will then be able to gain the credential by demonstrating that they have the necessary knowledge, skills and performance in the relevant field. If they are successful, this will be recorded in their entry on the medical register. Patients and the public, employers, commissioners of services and other professionals will be able to see whether a doctor working in a particular field of medicine is credentialed in that field.

Examples of areas of medical practice that have been suggested as suitable to become credentials include things like:

- forensic and legal medicine
- breast disease management
- musculoskeletal medicine
- psychosexual medicine
- cosmetic surgery
- remote and rural medicine
- medical leadership and management.

Giving patients confidence in their care

Cosmetic surgery is an area of medical practice where regulation is limited and patients are vulnerable.* While some of the clinical and professional skills needed are covered in other areas of specialty training, there are currently no agreed standards. Establishing credentials for cosmetic surgery would help to address this and mean that patients, hospitals where cosmetic procedures are carried out, and insurers, could see on the medical register who has met and who is continuing to meet those standards.

* Department of Health, *Review of the Regulation of Cosmetic Interventions: Final Report*, April 2013, available at www.gov.uk/government/publications/review-of-the-regulation-of-cosmetic-interventions.

Why introduce regulated credentials?

Credentialing won't be suitable for every area of medical practice. However, appropriately deployed it can improve patient protection in a number of ways.

- In areas outside of specialties or where patients are particularly vulnerable, UK-recognised standards that are quality assured will help to make sure that doctors have the appropriate capabilities.
- We'll be able to improve the information on the medical register that is available to patients, employers, commissioners and others about doctors' capabilities.
- Some groups, such as SAS doctors, will be able to have their capabilities formally recognised on the medical register.
- Credentialing will offer a transparent way to show who has met agreed standards in a particular field.

It will also provide a framework to support potential future changes to postgraduate training as a result of the Shape of Training review.

Another potential advantage of credentialing is that by giving formal recognition to doctors' capabilities in particular areas of practice, it will support workforce flexibility and doctors' career development as their practice changes over time.

Being more transparent about GPs' extended roles

Credentialing could be used to help general practitioners (GPs) extend their roles to meet the changing ways healthcare is delivered in the UK. Currently special interest areas are not recognised on our GP Register. Our proposals would mean we'd be able to recognise GPs' credentialed areas on the medical register. These areas might include management and commissioning or particular clinical areas that are relevant to their patients such as dermatology.

Limiting credentialing to where it is needed

Credentialing must be proportionate to the problems we are trying to fix. Not every area of medical practice will be suitable for GMC-approved credentials.

Regulated credentials should only be introduced if the following criteria have been met.

- Patient need – there is a need to protect patients.
- Service need – a demonstrable service need exists.
- Feasibility – development of the proposed credential is practicable and feasible.
- Support from authoritative bodies – there is support for creation of the credential from organisations that are authorities in that field.

Meeting service needs in rural areas

The Scottish Government, Health and Social Care Directorate has identified the need to improve patient care in rural areas as a service priority.

A credential in rural medicine, drawing from competencies across different specialties might be attractive. If a credential was developed in this field we would expect the content, assessment systems and standards set to be applicable and transferable across the UK. But the way the credential is delivered (eg where, when, timing and funding) and the opportunities that doctors will have to meet the requirements will reflect the specific needs of people who live in rural areas in Scotland.

1 Do you agree with our reasons for introducing regulated credentials?

☐ Yes ☐ No ☑ Not sure

Do you have any comments?

Credentialing is a logical step to record suitable qualifications.
However, the level where credentials are appropriate is a very important decision.
The value of credentials to patients is by no means clear; there does need to be considerable discussion about this before any implementation.
The proposal that sub specialty training is transferred to a credential is sensible but the GMC has to be very sensible but it may be unhelpful if credentials became vast in number. (This would cause enormous increase in administration, both for entering details & maintaining them.)

2 Can you think of any disadvantages to our proposals for credentialing?

☑ Yes ☐ No ☐ Not sure

If so, how might we mitigate them?

There are a number of disadvantages to implementing credentials.
There will be considerable administrative costs by the GMC to enter & to maintain an accurate record of credentials for each doctor.
Although not really part of this consultation, there will be considerable extra administration by the GMC to assess, approve & review any teaching centres involved in the delivery of programmes which can be recognised for a credential.
There is a real risk that some doctors and some managers will decide that only doctors with a credential can undertake work in that area of practice. eg Many doctors see patients with musculo skeletal conditions, and the lack of a credential in this area may suggest that the doctor without the credential may deliver a lower quality service.
The Shape of Training Review indicated that doctors should become more generalists rather than more narrowly specialised, so there is a possibility that widespread credentials may work against he Shape of Training ideas.
Leadership & management are delivered by many doctors now and it would be a retrograde step if

3 Do you agree that regulated credentials should only be established if all of the four criteria we have identified (patient need, service need, feasibility and support from authoritative bodies) are met?

☑ Yes ☐ No ☐ Not sure

Do you have any comments?

Credentials must only be agreed & approved when all of the evidence has been properly assessed. The evidence must clearly be very robust with a rigorous process for agreement.

What should the breadth of a credential be?

Each credential will cover a particular practice area or discipline. We won't recognise individual procedures as credentials because, as medicine develops, it is likely that they could become out of date relatively quickly.

But the precise breadth of each credential will depend very much on the field of practice involved. For example, a credential in medical education might cover a broad scope of practice, while more specialised clinical areas (such as breast disease management) might be narrower.

4 Do you agree that credentials should be developed for areas of medical practice rather than for individual procedures?

☐ Yes ☐ No ☑ Not sure

Do you have any comments?

There is perhaps an argument for either of these options but an 'area of medical practice' is a wide subject whereas a 'procedure' is well defined, and much easier to deliver. The area of patient care is also much easier to identify; eg an ERCP delivered by a endoscopic gastroenterologist. Patients will attend for a special procedure, rather than special advice. For procedure based credentials it is likely that the doctor will undertake the complex procedure frequently which then is likely to deliver a high quality patient outcome.

What level of practice will be recognised by a regulated credential?

Credentials will be set at a level that signifies that a doctor has attained the complete range of expertise within the scope of practice of that credential. The set level must be sufficient to make sure that they can practise safely and competently without supervision in the credentialed area within the context of clinical governance.

The level will be comparable to the level of competence expected of a doctor who has completed formal postgraduate training,* but not across the same breadth of practice.

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

Depending on the area to be credentialed, an individual credential could be set at a higher level of expertise. However, initially at least, we won't establish different credentials set at different levels within the same field – this is called tiered credentialing.

That is partly a practical matter of needing to introduce the credentialing model in the simplest way possible. But more fundamentally, the purpose of regulating credentialing is to approve a standard that demonstrates safe practice in a given field.

Who will be eligible for credentials?

Any doctor who can demonstrate the necessary capabilities would be eligible for a credential. In principle, eligibility shouldn't depend on having a Certificate of Completion of Training (CCT) or equivalent. But doctors will have to show they have relevant knowledge, skills and capabilities set for that credential at the required level. It may be that for some fields of practice, possession of a CCT or equivalent would contribute to demonstrating the specific and generic knowledge, skills and capabilities needed for the credential. The body that develops the credential will need to consider what is appropriate in each case.

* Doctors who have completed postgraduate training receive a CCT. Alternatively, a doctor can apply for its equivalent (a Certificate of Eligibility for Specialist Registration or a Certificate of Eligibility for General Practitioner Registration). They are then put on either our Specialist Register or GP Register.

† We are currently consulting on the generic professional capabilities framework. You can find out more information about this on our website.

5 Do you agree with our proposal for the level of a credential?

☐ Yes ☑ No ☐ Not sure

Do you have any comments?

Credentials should have only one level and should really be confined to specialists who deliver a very rare skill or rare level of expertise.

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

☐ Yes ☑ No ☐ Not sure

Do you have any comments?

Credentials should not have tiered levels. Patients would likely find this very confusing indeed. Lower levels of credentials may suggest a lower level of competence or a doctor who has less experience. The administration and record keeping of different levels of credentials would be a considerable extra demand on the resources of the GMC which may be reflected in higher fees for those on the Register.

7 Is it right that eligibility for a credential should not depend on doctors having a CCT or equivalent?

☐ Yes ☑ No ☐ Not sure

Do you have any comments?

Trainee doctors, SAS doctors & Specialty Doctors are not expected to practice independently and should be supervised by a registered specialist or registered GP.
There is no indication in this consultation document that this arrangement will be changing with the introduction of credentials.
Therefore, a credential could be achieved by a doctor without a CCT but that doctor would have to be supervised by a specialist or GP who presumably also has the credential. This is unclear in your paper.

Will doctors have to hold credentials to practise?

The aim of credentialing is to help protect patients. We must do this in a way that is effective but proportionate, and that avoids unintended and undesirable consequences.

Doctors must be registered and licensed by us in order to practise in the UK. The law doesn't stop them from working in specific specialities or fields. Instead, our guidance, *Good medical practice*, requires doctors to work within the limits of their competence. We ask doctors to show on a regular basis, through revalidation, that they remain up to date and fit to practise in the work that they do. If doctors fail to recognise and work within the limits of their competence, we may take action against them under our fitness to practise procedures.

The advantage of this approach is that it allows medicine to be practised in a way that is flexible and responsive to medical developments and healthcare needs, without limiting workforce flexibility. It puts professional responsibility on the doctor, and on those contracting doctors' services, to make sure they are fit for the role they are asked to carry out.

We think that credentialing should operate in the same way and that it would be inconsistent and unhelpful to have restrictions for credentialed areas of medical practice that do not apply in other areas. For example, doctors may want to develop their careers in credentialed areas but need to first build up the necessary experience and expertise before they apply for the credential. We wouldn't want to limit doctors legally through credentials from professionally developing in new fields. We therefore propose that doctors shouldn't be prevented from working in a field for which a credential exists just because they don't have the relevant credential.

The fact that a doctor without a credential is working within an area of practice for which a GMC-approved credential exists does not, of course, mean they aren't competent in the particular job they are doing. It may be, for example, that their work covers only part of the range of competences that would be necessary to obtain the full credential and that they are perfectly competent within the scope of practice required of them. It is the responsibility of the employer or commissioner of their services, or the hospital granting admitting rights, to make sure they are fit for the job they are to do.

But where a credential has been created for a particular area of practice, our register will show whether a doctor holds that credential. We expect that patients, employers, insurers, and other regulators (such as the Care Quality Commission in England) will want to take account of this.

Credentials may be used in different ways.

- Employers may look for doctors who have the relevant credential as an assurance that they have met and are continuing to meet relevant standards in a particular field.

- When systems regulators are inspecting hospitals, credentials will be a way of satisfying themselves that the doctors employed there have the necessary training and skills in a particular field.

- In areas of medical practice where doctors are at higher risk of entering our fitness to practise procedures, we may wish to use revalidation to carry out closer scrutiny of those without the relevant credential to check they are practising safely.

We feel that this approach will enhance patient protection while also being practical and proportionate.

However, some people have told us the law should go further because there are areas of medical practice (such as cosmetic surgery) where patients are particularly vulnerable. They argue that in these cases patients must be protected by changing the law so that only doctors with credentials in the relevant field are allowed to work in that area. We have summarised the pros and cons of the two approaches in the tables on the next pages.

PROS

Legal requirement for credential	No legal requirement for credential, but using the medical register to show who has met relevant standards
■ Certainty for patients, the service and the profession about those practising autonomously in a credentialed field. ■ Public confidence that patients are protected. ■ Drive up standards in the credentialed fields.	■ Provides a clear statement on the registers that those possessing a credential have demonstrated competences in their field. ■ Drive up standards in the credentialed fields. ■ Flexibility for the service and for doctors to develop roles. ■ Consistent with our approach to regulation more generally. ■ Removes uncertainty about whether doctors are working within the scope of their registration.

CONS

Legal requirement for credential	No legal requirement for credential, but using the medical register to show who has met relevant standards
■ Introduce inflexibility into medical practice for the service and professionals if doctors cannot develop their roles without a credential. ■ Not all areas of practice will be credentialed, leaving uncertainty about doctors in areas without credentials. ■ Difficulty of getting the legislation required for credentialing if it imposes additional burdens on professionals and the service. ■ Inconsistent with our approach to other aspects of regulation. ■ Impractical to monitor the day-to-day practice of all doctors to check they are working within the scope of their registration. ■ Risk of doctors inadvertently working across the boundaries of a credentialed field in a way which would leave them technically unregistered. ■ Additional resource burdens for the service and regulators.	■ Risk that in fields dominated by commercial interests it will simply impose a burden on the conscientious while the unscrupulous will carry on regardless. ■ Perception that an indicative register of credentials will protect patients less. ■ Could be perceived as less effective at driving up standards. **However, these risks can be mitigated in a number of ways.** ■ Insurers, commissioners and providers expect doctors have relevant credentials making it more difficult to practise in a credentialed field without one. ■ Systems regulators would see credentialing as evidence that providers are using suitably trained individuals who are meeting standards set by the GMC. ■ The basis upon which doctors are revalidated could be varied depending on whether a doctor has the relevant credentials in their field.

8 Do you agree with our proposal that doctors should not be legally required to hold credentials?

☑ Yes ☐ No ☐ Don't know

Do you have any comments?

Page 14 states'..a doctor without a credential is working within an area of practice for which a GMC approved credential exists, does not of course mean that they aren't competent in the particular job they are doing.' This is certainly agreed & reflects the current situation. The table on page 16 'Pros' suggests that a credential 'Removes uncertainty about whether doctors are working within the scope of their registration.'
It is not impossible that doctors with a credential in a particular field can deliver poor practice. Annual appraisal & 5 yearly revalidation should identify poor practice as they cover the entire practice of a particular doctor.

9 If you think possession of a credential should be a legal requirement, are there particular areas of medicine where you think this should apply?

☐ Yes ☑ No ☐ Don't know

If yes, why?

See above Q.8

What will our processes look like for regulated credentials?

We will decide which credentials are regulated, check the process by which credentials are developed, approved and assessed, award credentials to individual doctors, and record and maintain those credentials on the medical register.

How would credentials be approved?

The graphic on the next page shows our proposed process to approve and regularly check credentials developed by organisations.

It will be open to organisations with expertise in particular disciplines to propose the creation of a GMC-regulated credential. A range of organisations could take on the role of credentialing bodies. Such bodies could include medical royal colleges and faculties, specialty associations, medical schools, universities, or employers. Different organisations may wish to work together to develop a credential.

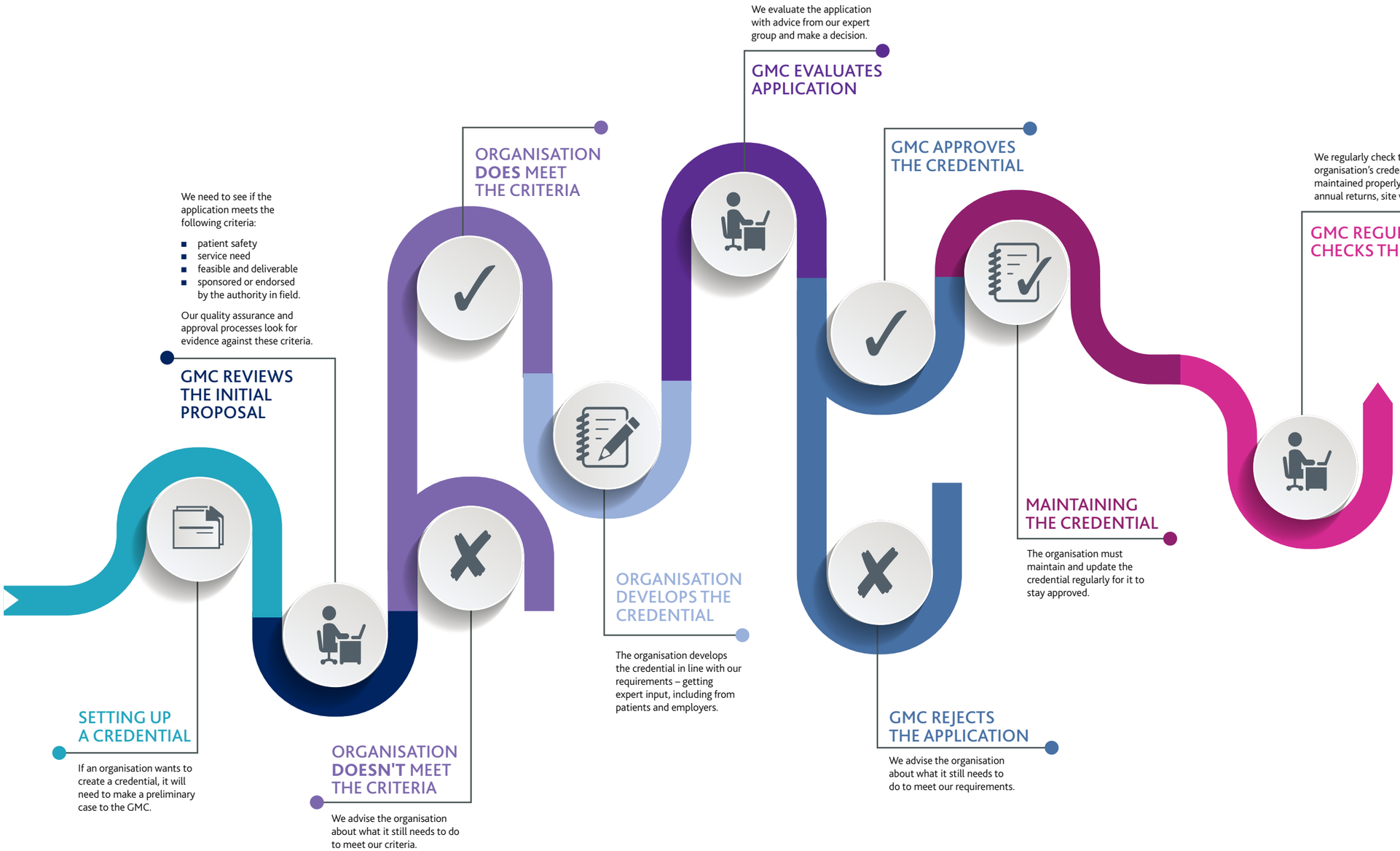
Organisations interested in developing a credential will first have to show that there is a case for having a credential in the proposed field. They will also have to show they are the appropriate body to develop it. They will have to show they have the capability and resources to design, develop and maintain the credential over time, including the educational authority, infrastructure, organisational sustainability and expertise required.

Once the need for the credential, and the suitability of the credentialing organisation, have been agreed, the second step is for the organisation to develop the detail of the credential. This will mean setting the standards and content of the credential, and the methods for assessing whether doctors who wish to obtain the credential in future have the necessary competences and capabilities.

We will only approve a credential that has been developed by an organisation if it meets the standards that we have set. We will check that those standards are being maintained over time. We are reviewing the standards that we use to approve postgraduate curricula and assessment systems and will consult on them in late 2015 or early 2016. We intend to apply the same standards to both postgraduate training and credentialing.

We will work with governments, employers, commissioners and providers to make sure credentials in different fields are developed to take account of health and population priorities in the four UK countries.

How organisations **get a credential** approved by the GMC



10 Do you agree with our proposed process for organisations to establish GMC-approved credentials?

☐ Yes ☐ No ☑ Don't know

Do you have any comments?

If credentials are to be developed; this process seems to be sensible. Going through the process will of course involve considerable extra time & effort both for organisations & the GMC.
The GMC approval process has to be extremely robust and probably subject to scrutiny from external bodies.

What will doctors have to do to gain a credential?

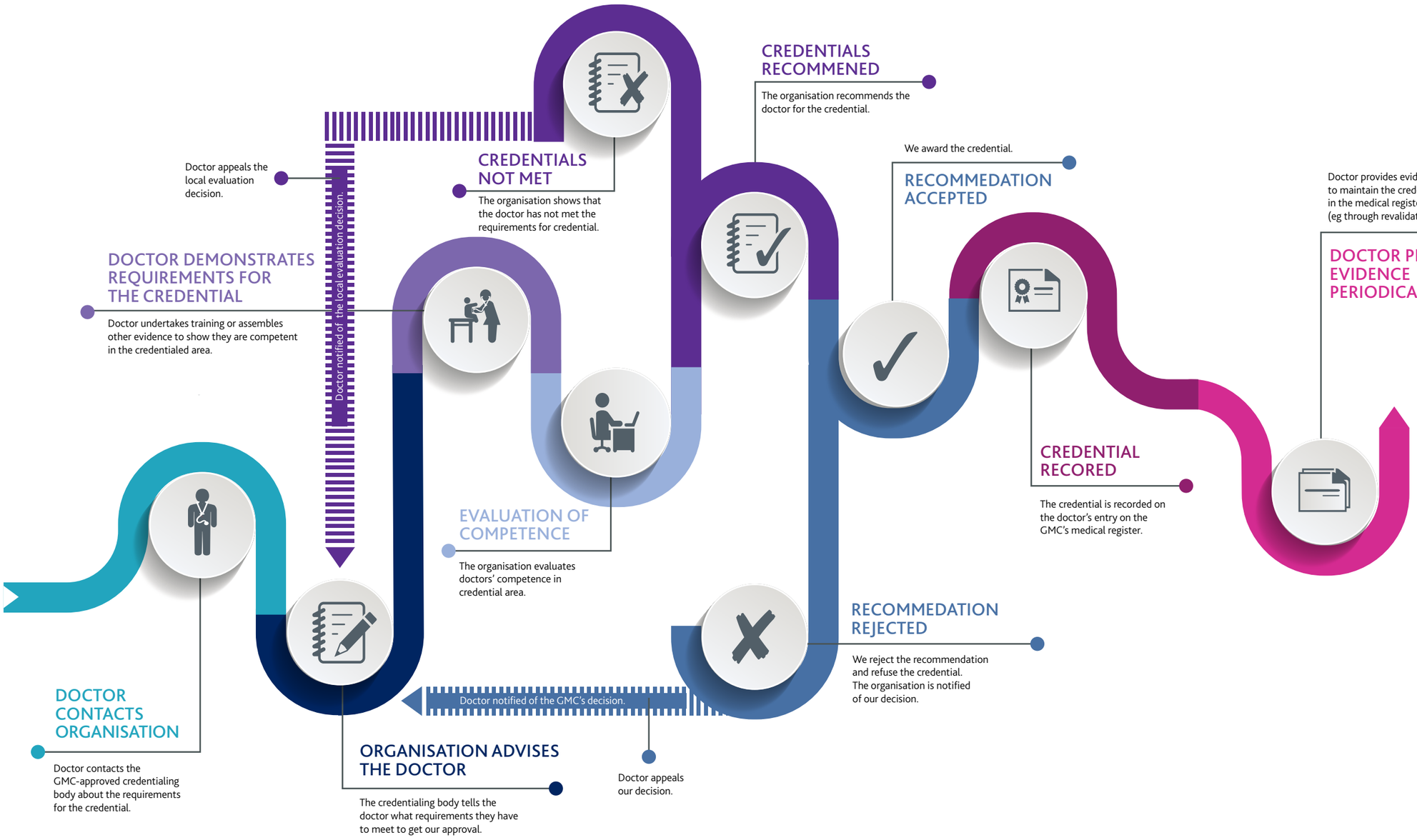
The graphic on the next page shows our proposed process for how doctors will be recognised on the medical register with a credential.

Doctors who want to get a credential will contact the body responsible for that credential (the credentialing body) to find out what they need to do. Our pilots showed that different approaches will be needed for different credentials. Some credentials will involve specific elements of training, while others may allow doctors to draw on a portfolio of evidence from their current and previous practice and training to show that they have met the standards needed for the credential.

If the credentialing body is satisfied that the doctor has met the standards for the credential it will send us a recommendation that the credential should be awarded. Unless there are exceptional circumstances, we will accept the recommendation. We will award the credential and will record details on the doctor's online register entry.

The sort of circumstances in which we might not immediately accept a recommendation are where we are aware of relevant matters relating to the doctor's fitness to practise or if there were concerns about the evaluation process used by the credentialing body in making its recommendation to us. However, checking the processes used by credentialing bodies will form part of our ongoing quality assurance, so concerns about individual recommendations should be rare.

The doctor's journey to **get a credential**



11 Do you agree with our proposed process for doctors getting a GMC-approved credential recorded on the medical register?

☐ Yes ☐ No ☑ Don't know

Do you have any comments?

If credentials are to be introduced, this process seems sensible, but again there should be proper scrutiny of the review of the quality of practice for the credential at appraisal & revalidation. If you wish the review of credentialed practice to be done via appraisal you may wish to consider some form of guide for appraisers to assess the ongoing validity of credentials. eg number of cases/proportion of time spent doing credentialed work/ outcomes data etc.

How will doctors maintain their **credentials?**

Building on an existing framework

Doctors already have to bring information about their practice to their annual appraisal to show that they are up to date and fit to practise in the work that they are doing. This results in their responsible officer sending us a recommendation on whether they can be revalidated. However, the medical register doesn't currently show doctors' fields of practice.

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

By using revalidation to do this in the long term, we would be able to build on an existing framework of regulation already familiar to doctors, employers and patients rather than having to invent new processes and structures. We believe this would reduce the costs and impact of implementing credentials, while at the same time giving an opportunity to enhance revalidation.

What changes would be needed to the revalidation process to take account of credentialing?

We recognise that the revalidation process isn't yet ready for us to do this. Further work, and also legislation, would be needed. For example, appraisers and responsible officers would need very clear guidance about what information a credentialed doctor should bring to appraisal for their area of practice. Nevertheless, we would like feedback about whether we are right in principle to aim in the longer term to use revalidation as the means of showing on the register a doctor's field of credentialed practice.

Using credentialing bodies to help doctors maintain their credentials

Even if it is agreed that revalidation is the right vehicle for helping doctors to maintain their credentials we could not do this without further legislation. So, in the short to medium term, a different solution is needed. An alternative model would be for a credentialed doctor to go back to the body that first recommended the award of their credential for confirmation that they remain up to date in the credentialed field. The credentialing body would then tell us its conclusions. But doctors using such a process would still need to be revalidated as a separate process.

What will this mean for the medical register?

Whichever model we use for doctors' to maintain their credentials, we want the information on our registers about the credentials that doctors hold to provide an up-to-date statement about their current practice, rather than just an historical record of a qualification they once obtained.

If a doctor does not provide information to show that they remain up to date in their credentialed field, their medical register entry would show their credential as lapsed and no longer current. It is important to note that just because a credential is no longer current, it would not prevent a doctor from revalidating. It might be, for example, that the doctor is no longer working in their credentialed field but is nevertheless able to fulfil the revalidation requirements for their new area of practice.

On the next page is a mock-up of how it may look on the medical register.*

* This is only an illustrative example of what the medical register may look like with credentials.

General Medical Council

Working with doctors Working for patients

Search Again?

Refine Search

Results

Doctor Details

Doctor History

You are here: **Online medical register**

Dr Fred Bloggs

Doctor details

GMC reference number	2124353
First names/given names	Fred
Surname	Bloggs
Status	Registered with a licence to practise. This doctor is on the Specialist Register.
Specialty	This doctor has been trained as a plastic surgeon.
Credentials	This doctor has additional credentials in the following areas: • Cosmetic surgery (breast) 2017 • Cosmetic surgery (facial) 2020 He provides these specialist services in the following areas: • Liverpool • Doncaster See expired credentials.

Further information

Primary medical degree	MB BS University of London
Provisional registration date	15 July 1985
Full registration date	11 Aug 1986
Specialist Register entry date	21 Aug 1996
Information for employers	View information for employers

12 Which model do you think would be the best way of doctors maintaining their credentials?

- [x] Through revalidation
- [ ] Through a separate recommendation from their credentialing body

Please explain why.

Revalidation & Appraisal both assess the Entire Current Practice of a doctor.
It would be inefficient in terms of effort, time & paperwork/documents to establish a separate process for assessing the currency of credentials. Revalidation is a complex process in terms of gathering information, and it would be off putting to have to collect other information in a similar fashion for another body.
The organisation involved in establishing the credential could issue guidance to appraisers & Responsible Officers to help assess the quality of performance in the credentialed area. (See above; Q 11).

Who pays for **credentials?**

The way that the development of individual credentials is funded is not for us to determine. Similarly, the funding of the management and delivery of training opportunities associated with credentialing is a matter for others. However, this section sets out where we think the costs of credentialing should fall in relation to our regulatory role.

The organisation (or combination of bodies) that establishes the credential would bear the cost of its development and ongoing maintenance. We would also expect it to cover the cost of our approval and quality assurance of the credential and for our handling of credentialing recommendations on individual doctors.

Doctors who want to apply for a credential would pay a fee direct to the credentialing body, but not to us. In putting forward a proposal for a credential, an organisation will therefore need to be clear that the demand exists to sustain the credential over time. Where the case for the credential aligns with government priorities, it may be appropriate for the work of the credentialing body to receive governmental or other backing.

How will the credentials of individual doctors be funded?

The way that individual doctors are funded to obtain credentials is likely to vary. Employers or commissioners of services may choose to support their employees in obtaining credentials where that meets local needs. Some doctors will be self-funded. If in future, as recommended by the Shape of Training review, credentialing becomes part of the architecture for postgraduate sub-specialty training the funding of that training will be a matter for those implementing the Shape of Training agenda to decide.

We feel that the approach described here has two main advantages. First, it means that the principle costs of credentialing are borne by those interested in developing and obtaining credentials. Second, by integrating credentialing as far as possible into our existing processes for approving education and training, we can minimise the cost we take on and the regulatory burden on others.

13 Do you have any comments about how the regulatory aspects of credentialing should be funded?

☑ Yes ☐ No ☐ Don't know

Do you have any comments?

There is no comment in this document about the considerable extra costs that would be incurred by the GMC if credentialing were to be introduced in the way suggested. The GMC costs would have to be met by the licensed doctors on the GMC register.

What are the implications for credentials

of the changes to postgraduate training proposed by the Shape of Training review?

The Shape of Training review by Professor David Greenaway proposed that postgraduate training should be broadened out. Doctors should be trained in the generality of their specialties. Highly focused areas, such as sub-specialties, should be delivered through credentials outside of postgraduate training.

The departments of health are responsible for deciding how the Shape of Training recommendations are taken forward. They have convened a UK Shape of Training Steering Group to consider potential changes to the postgraduate architecture. This group has asked us to make sure our framework for credentials can be adapted easily to fit with any future changes to postgraduate training, including sub-specialty credentials.

Credentialing can work with existing curricula and the medical register

Our proposals allow an approach to approval of credentials that is consistent with the way we already approve postgraduate curricula. We also propose to check regularly that the credentials provide effective training, assessment and evaluation of doctors' ability to deliver safe, high quality care.

Information showing whether doctors hold credentials in a particular field of practice will be publicly accessible through our medical register just as sub-specialty information can currently be found on it. The difference will be that the register will show whether a doctor remains up to date in their credentialed field of practice. This will be unaffected by the Shape of Training recommendations.

What if credentials replace sub-specialties?

If, as a result of the Shape of Training agenda, credentials come to replace existing sub-specialties, it will be important that any transitional arrangements are simple and fair for any doctors who may be affected.

For example, doctors on the Specialist Register who already have a sub-specialty against their name would remain on the Specialist Register, but their sub-specialty would be redesignated as a credential in the same field. Their practising rights would be unchanged. However, such doctors would have to show that they are keeping up to date in the credentialed area if they want to maintain the credential as an active entry on the medical register.

The model of credentialing we have described in this consultation document is not dependent upon the implementation of the Shape of Training recommendations. However, our aim is for it to be is flexible enough to accommodate the Shape of Training recommendations for credentials as and when they are introduced.

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

☐ Yes ☐ No ☑ Don't know

Do you have any comments?

There is some logic in the sub specialties (registered with the GMC already) being transferred to a credential.

Equality and diversity considerations for credentialing

Credentialing is likely to be of interest to different groups of doctors. It will be important that it operates in a way that is accessible, fair and equitable for all those who can show that they have met the required standards.

For example, when deciding whether to approve a credential, we will want to be satisfied that the methods for assessing doctors' capabilities are fair and based on principles of equality.

We have also said that, as a general principle, access to credentials shouldn't depend on doctors possessing a CCT, although they must be able to demonstrate professional capabilities equal to practice at that level in the credentialed field.

15 Are there particular groups who would be helped or disadvantaged by our proposals for credentialing?

☐ Yes ☑ No ☐ Don't know

Do you have any comments?

16 Are there aspects of our proposals that would provide opportunities for or present unfair barriers to such groups?

☐ Yes ☑ No ☐ Don't know

Do you have any comments?

The consultation process

To help us continue to improve the way we consult, please tell us about your experience of taking part in this consultation.

17 Did you find the consultation document (the questionnaire and the instructions if completing it online) clear?

☐ Yes ☐ No ☑ Not sure

There were some technical difficulties I experienced; I was only able to record response by using a the Adobe Acrobat Reader. Normally, Windows 8 can record the responses in PDF format but this document did not allow me to do that.

Thank you for taking the time to give us your comments – we are grateful for your input. There is just one more section to complete.

About you

Finally, we'd appreciate it if you could give some information about yourself to help us analyse the consultation responses.

Your details

Name	Ian Aston
Job title (if responding as an organisation)	Academic Dean
Organisation (if responding as an organisation)	Faculty of Occupational Medicine
Address	3rd Floor New Derwent House 69-73 Theobald's Road, London WC1X 8TA
Email	Ia459@aol.com
Contact telephone (optional)	

Would you like to be contacted about our future consultations?

☑ Yes ☐ No

If you would like to know about our upcoming consultations, please let us know which of the areas of our work interest you:

☑ Education ☐ Standards and ethics ☑ Fitness to practise

☑ Registration ☑ Licensing and revalidation

Data protection

The information you supply will be stored and processed by the GMC in accordance with the *Data Protection Act 1998* and will be used to analyse the consultation responses, check the analysis is fair and accurate, and help us to consult more effectively in the future. Any reports published using this information will not contain any personally identifiable information. We may provide anonymised responses to the consultation to third parties for quality assurance or approved research projects on request.

The information you provide in your response may be subject to disclosure under the *Freedom of Information Act 2000* which allows public access to information held by the GMC. This does not necessarily mean that your response will be made available to the public as there are exemptions relating to information provided in confidence and information to which the *Data Protection Act 1998* applies. Please tick if you want us to treat your response as confidential. ☐

Responding as an individual

Are you responding as an individual?

☐ Yes ☐ No

If yes, please complete the following questions. **If not, please complete the 'responding as an organisation' section on page 45.**

Which of the following categories best describes you?

☐ Doctor ☐ Medical educator (teaching, delivering or administering)

☐ Medical student ☐ Member of the public

☐ Other healthcare professional

☐ Other (please give details) _____

Doctors

For the purposes of analysis, it would be helpful for us to know a bit more about the doctors who respond to the consultation. If you are responding as an individual doctor, could you please tick the box below that most closely reflects your role?

☐ General practitioner ☐ Consultant

☐ Other hospital doctor ☐ Doctor in training

☐ Medical director ☐ Other medical manager

☐ Staff and associate specialist (SAS) doctor

☐ Sessional or locum doctor ☐ Medical student

☐ Other (please give details)_____

What is your current practice setting? (Please tick all that apply)

☐ NHS ☐ Independent or voluntary ☐ Other

What is your country of residence?

☐ England ☐ Northern Ireland ☐ Scotland ☐ Wales

☐ Other – European Economic Area

☐ Other – rest of the world (please say where) _____

To help make sure our consultations reflect the views of the diverse UK population, we aim to monitor the types of responses we receive to each consultation and over a series of consultations. Although we will use this information in the analysis of the consultation response, it will not be linked to your response in the reporting process.

What is your age?

- ☐ 0–18
- ☐ 19–24
- ☐ 25–34
- ☐ 35–44
- ☐ 45–54
- ☐ 55–64
- ☐ 65 or over

What is your gender?

- ☐ Female
- ☐ Male

Do you have a disability, long-term illness or health condition?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

The *Equality Act 2010* defines a person as disabled if they have a physical or mental impairment, which has a substantial and long-term (ie has lasted or is expected to last at least 12 months) and adverse effect on the person's ability to carry out normal day-to-day activities.

What is your ethnic group? (Please tick one)

Asian or Asian British

☐ Bangladeshi ☐ Chinese ☐ Indian ☐ Pakistani

☐ Any other Asian background (please specify)_____

Black, African, Caribbean, black British

☐ African ☐ Caribbean

☐ Any other black, African or Caribbean background (please specify)_____

Mixed or multiple ethnic groups

☐ White and Asian ☐ White and black African ☐ White and black Caribbean

☐ Any other mixed or multiple ethnic background (please specify)_____

Other ethnic group

☐ Arab

☐ Any other ethnic group (please specify) _____

White

☐ British, English, Northern Irish, Scottish or Welsh

☐ Irish ☐ Gypsy or Irish traveller

☐ Any other white background (please specify)_____

Responding as an organisation

Are you responding on behalf of an organisation?

- [x] Yes
- [ ] No

If yes, please complete the following questions. **If not, please complete the 'responding as an individual' section on page 42.**

Which of the following categories best describes your organisation?

- [x] Body representing doctors
- [ ] Body representing patients or the public
- [ ] Government department
- [ ] Independent healthcare provider
- [ ] Medical school (undergraduate)
- [ ] Postgraduate medical institution
- [ ] NHS or HSC organisation
- [ ] Regulatory body
- [ ] Other (please give details) _____

In which country is your organisation based?

- [x] UK wide
- [ ] England
- [ ] Northern Ireland
- [ ] Scotland
- [ ] Wales
- [ ] Other – European Economic Area
- [ ] Other – rest of the world (please say where) _____

Email: **gmc@gmc-uk.org**
Website: **www.gmc-uk.org**
Telephone: **0161 923 6602**

General Medical Council, 350 Euston Road, London NW1 3JN.

Textphone: **please dial the prefix 18001** then **0161 923 6602** to use the Text Relay service

Join the conversation

@gmcuk
facebook.com/gmcuk
linkd.in/gmcuk
youtube.com/gmcuktv

To ask for this publication in Welsh, or in another format or language, please call us on **0161 923 6602** or email us at **publications@gmc-uk.org**.

Published June 2015

GMC/IRC/0615

General Medical Council