ROYAL COLLEGE of PHYSICIANS of EDINBURGH

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

28th November 2018

Joint letter from the three Physicianly Trainee Committees regarding the GMC consultation on the framework for credentials

Executive Summary

Credentials have the potential to answer an unmet need and bring potential benefit. However the proposed framework does not provide sufficient depth or detail to be considered a complete framework

Salient points:

- The use of credentialing in the pre-CCT space needs extensive consideration
- There is a true risk of developing a sub-consultant grade, devaluing CCT, loss of smaller specialities and loss of existing specialist skills through a process of 'mission creep'
- The definition of credentialing is currently insufficient and requires revision
- Clarity over the actual process from recognition that a credential is needed by the curriculum oversight group (COG) and the delivery of it. The process requires standardisation and increased granularity within the framework in terms of commissioning, key stakeholders, development leads and ring-fenced resourcing
- Flexibility will only be increased if implementation plans are given appropriate forethought and formalisation within the framework
- Placing credentials on the LRMP will only be effective if a credential is the only recognised process to achieve the identified skills/experience or if there is a list of approved routes to include a credential in the subject
- Consideration has to be given to how consultants and speciality doctors already practicing an area which become credentialed validate their skills and become recognised on the List of Registered Medical Practitioners (LRMP)
- The place of credentials with allied healthcare professionals and their regulatory bodies needs consideration
- A phased approach to implementation is entirely appropriate. However given the number of unanswered questions and areas for development a commencement date of April 2019 appears unrealistic

Introduction

Credentialing has been on the transformation agenda within the GMC since the Shape of Training report in 2013. It is increasingly accepted that credentialing in some form will become part of postgraduate medical practice. It is clear that credentials can be beneficial in certain circumstances. However what constitutes a credential and the processes involved in developing and delivering a credential have yet to be confirmed. Whilst the framework document goes some way to answering these questions it by no means provides sufficient depth or detail to be considered a complete framework. The document also gives rise to a number of further questions outlined below.

Clarity needed regarding the timing of credentialing

Up until the publication of the framework, discussion regarding credentials had always placed them in the post-CCT space. If there is to be an option of undertaking credentials prior to CCT during higher specialty training (HST) the logistics, funding and time allocation to do so need to be answered either in a separate document or at least in more depth here. There are a significant number of unanswered questions which require attention if credentials are to be feasible in the pre-CCT period. Undertaking credentialing during HST or the removal of certain skills/procedural competencies which are currently covered in existing curricular and moved into the credentialing space are particular concerns. It could be argued that these skills/attributes are already taught, regulated and covered in HST and thus do not fit the remit of credentials in the first instance.

Concern about the potential of a Sub-Consultant grade

There is significant and ongoing concern that rebranding of certain skills as credentials has the potential to create a 'sub consultant' grade with a workforce that is not prepared for post CCT work in the same way their consultant colleagues currently are. This document fails to reassure trainees that there isn't a risk of credentialing being a mechanism by which training will ultimately be shortened and result in clinicians being relatively less skilled, thus devaluing CCT.

Pre-CCT credentialing issues- how would this work in practice?

There are numerous questions which need consideration prior to pre-CCT credentials being a possibility: as HEE/NES/HEIW fund training will they also fund the credentials? Would the trainee need to take a period of OOPE to undertake a credential? Could a trainee go out of area to undertake a credential? How would the criteria for approval for a trainee to undertake a credential be developed? Additionally there needs to be greater clarity regarding the status of a trainee who holds a credential; what would the boundaries of practice be including their interaction and practice under the educational/clinical supervision of a consultant who does not hold the credential. Significant clarification and development is required before credentials can be instituted.

Please find further comments on the framework below, laid out in the requested sections.

In response to 'Why are credentials needed?'

Trainees are aware that, in certain circumstances, credentials have the potential to bring a positive change to the status quo both in terms of standardisation of care in certain areas and improving equity of access to training in certain skills/ areas irrespective of the individual's parent speciality. Credentials could act as a vehicle for service development and robust clinical pathways. If novel credentials are created in the face of new diagnoses/techniques/treatment they would provide an effective way to deliver new learning in the post-CCT setting, and could be an excellent way of demonstrating CPD. However, there are also a number of related concerns.

It is clear that areas not currently part of a formalised training pathway such as cosmetic surgery would benefit from a standardised training pathway. However it is unclear whether the current

route of multiple certifications would continue to be a valid, and the credential simply added as an additional option. In this instance, regulation would be incomplete. The alternative is that the GMC will enforce credentialing as the only option by which to practice, suggesting all people will have to credential in areas that a credential exists in. This could lead to issues such as a backlog of accreditation, a waiting list to undergo appropriate assessment and a challenge to identify appropriate assessors – is there a strategy to deal with this? This is not covered by the current proposed framework. Additionally, the entry for credentials in this setting will have to be clear or it is conceivable that the credentialed clinician could undertake a particular action but be ill-equipped to manage any potential complications.

The consideration of other specialities being able to credential in a skill/ procedure that would not normally sit within their speciality is an attractive one. However, it is unclear if those working in the parent speciality would also have to credential. For example, will interventional radiologists have to credential in mechanical thrombectomy? Or would it only be required for other specialists such as Stroke physicians or Neurologists? At present this is unclear within the framework and requires careful consideration.

Smaller specialities such as Clinical Pharmacology, Allergy and Audiovestibular medicine must not be subsumed by credentials. Whilst small there has been a recognised need for specialists in these areas and that cannot simply be replaced by specialist in other areas having a limited level of knowledge that a credential can provide.

Credentials are at risk of creating a climate of deprofessionalisation which may be detrimental to patient care rather than improve it. For example, there is already a call for a palliative care credential – how will such a qualification interact with specialist services? There is a risk that existing skills could be limited by the availability of a credential: clinicians who do not hold a credential in an area may feel reluctant to instigate certain therapies which have previously been considered standard practice (e.g. reluctance to manage the end of life phase, including difficult conversations).

The fact there are different needs across the UK is both an endorsement and a concern for the implementation of credentialing. Whilst the needs of the local population must be met, if credentials are restricted to areas of need this will lead to pockets of training and patchy expertise throughout the country rather than equity. Trusts and Deaneries that can afford to run credentials will do so to attract more clinicians, and whilst this is commendable again leads to potential inequality which will likely worsen over time. National funding to ensure geographical spread of training could resolve this issue, but it is not mentioned in this document.

Credentialing may well enhanced flexibility, however at present there are several unanswered questions regarding this and if unanswered may, in fact, limit flexibility.
For example:

- If a credential is mandatory to run a service then the ability for service cross cover is reduced limiting both the flexibility of the individual to use their skills and the service provision of the trust.

- The number of credentials must be limited Credentials cannot enable a reduction of knowledge and skill currently gained through general experience. If every skill becomes a 'specialist skill', this becomes a lengthy, bureaucratic process which adds little value, limits individual and trust functionality and is unlikely to add anything in terms of patient care and safety.
- The time frame taken to complete a credential must be clearly defined as the time taken out of practice to undertake a credential may impact local service provision.
- A robust, equitable system of allocation must be developed otherwise an individual's current roles and responsibilities impact on their application success thus limiting flexibility.
- Individuals may have less flexibility to select areas of interest if these are not required locally, and may be forced to consider training elsewhere.
- If credentialing is required to practice in a specific area, it may be that limited places for training and limited funding will restrict flexibility rather than promote it.

In response to 'Defining a credential'

Currently the definition of a credential is over-complicated and yet remains non-specific. The current definition tries to be all things to all meanings, however there appear to be3 distinct areas which require precise definition of workforce need and patient risk:

1. An area of practice not currently regulated
2. An area of practice with significant workforce need not sufficiently covered by HST
3. An area of practice with significant workforce need with multiple potential special entry points

Alongside these definitions there needs to be a clarity of the process for commissioning/decommissioning of credentials. In reality the definition of a credential has not been fully answered in this document and is likely to actually be more than one definition with associated qualifications, regulations, ownerships and standard operating procedures.

There are varied views of the term 'credentialing', with some happy with the name and others suggesting a change. However, it is likely that if the definition(s) is/are improved the actual term used is likely to cause less of a division of opinion.

In response to 'Criteria and threshold for credentials'

The current credential criteria are very broad and provide no strategy to prevent 'mission creep' where they will take over all parts of specialist practice and encompass everything beyond perceived 'core 'competencies'. A clearer criterion with aims and indications for each credential is necessary to be sure that a credential and its associated work are truly required. In the absence of this credentialing may simply add additional tick boxes to training and hoops to jump through without reflective gain over and above the current situation.

Complexity does not necessarily reflect a need for more staff and/or training but often a need for more equipment/ support. For example, primary PCI requires on site availability of facilities and

support staff as well as a trained clinician. The UK does not suffer from a lack of Interventional Cardiologists but instead a lack of catheter laboratories / facilities. Credentials will not solve geographical variation in resources or patient safety issues, as the majority of these are not due to inappropriately or insufficiently trained clinicians.

The process for credentialing agreement is not sufficiently robust in its current form. It is outlined that the driving committee for credentialing is the curriculum oversight group (COG). It is unclear if there would be other stakeholders involved (such as Royal Colleges, patient groups, clinician associations). It is imperative that there is agreement between the pivotal stakeholders that a credential is needed, not simply a unilateral decision.

In relation to this, it is currently unclear who will be tasked with the development of the credential framework for each credential. It is clear that neither the GMC nor HEE can deliver the curriculum and assessment framework for credentials in isolation. Will this fall to the Royal Colleges as the other curricular do? Will it be devised locally- and if so, how will equity of training provision be maintained?

It seems vital that senior experienced clinicians in the relevant field are at the core of developing and delivering a credential through the Royal colleges and the appropriate SACs. However has the additional resource that will inevitably be required to deliver credentials been considered and appropriately ring fenced? Additionally, from a regulatory perspective, will the GMC commit resources to the development, assessment and ongoing regulation of the credentialing course itself, not simply the trained clinicians? If not, who will ensure credentials remain current and valid?

The practice of Medicine will always carry a degree of risk. Credentialing as evidence of expertise in certain areas / skills should aim to reduce the associated risks, and provide reassurance to patients. However, within the current framework it is perceivable that the requirement for credentials could progress so that eventually they are required for all procedures which would devalue existing knowledge and skills and be detrimental to doctors, patients and trusts alike. A risk-assessment framework to clearer distinguish between skills with currently acceptable regulated standards and those without needs to be developed.

Clarity is required around what is meant by ‘level of specialty expertise’, as all CCT holders are recognised to have speciality expertise in their respective areas. Specialist skills are often ubiquitous to all in a particular field (e.g. endoscopy for gastroenterologists). Some require additional training (e.g. ERCP).

In response to the ‘The regulatory process’

It is accepted that the GMC already have oversight of all actions of clinicians with the UK and credentials are no exception. When considering revalidation, will the panel have the specialist knowledge to confirm whether an individual’s experience is sufficient? Will guidelines for credential review within revalidation be produced? If the GMC will be involved, credentialing should be centrally coordinated to allow standardisation and evaluation of delivery. Whilst it seems reasonable

to list people on the list of registered medical practitioners (LRMP), is it feasible and realistic for it to remain up to date if the process is monitored using a revalidation model? If not then it runs the risk of reducing patient confidence rather than improving it.

Given that a large number of the techniques and processes that are likely fall under the heading of credentialing in the moderate future what plans are there regarding people already with the particular skill – are they going to be asked to formally illustrate it and they become listed on the LRMP? Will all clinicians have to illustrate competence in areas they have been working e.g. SAS doctors? Will other qualifications of competence in a particular area be listed on the LRMP as well as the standard credential? If options are not considered then having credentials lists on the LRMP may lead to confusion and erosion of public/patient confidence.

The pursuit of credentials also raises multiple financial questions: will clinicians receive a financial incentive for undertaking and completing credential? Will there be pay enhancements associated with the position of credentials? If not, what drives the assumptions that doctors will want to undertake further qualifications to meet local requirements? If there are financial incentives, will this also be the case if credentials are completed as a trainee? Are these changes likely to be considered and reflected in the consultant contract? Furthermore, if the area a clinician works in does not run a credential or will not endorse it as there is no local need, will there be central funding that can be applied for? Will payment for a credential be covered under the study leave budget if undertaken pre-CCT? Without comprehensive planning for funding, uptake is likely to be limited.

In response to 'A phased approach to implementation'

Whilst a phased approach to introduction is absolutely essential, the paucity of information within the framework is insufficient. Some questions that have arisen include: how many credentials is phase one going to contain; how long will they run for before assessment; how will success of the programme be monitored and assessed; who will give the go-ahead for phase 2; and what criteria will be used for this?

The introduction of credentials needs to be a slow process. Results of the first phase must be properly assessed prior to embarking on phase 2. Of upmost importance within this is that the standard of higher speciality training is maintained in the absence of credentials, and that the phase 1 credentials are formally reviewed before acceleration.

The current aim to start introducing credentials in April 2019 is unrealistic: there continue to be unanswered questions and we feel the framework is incomplete as it stands at present.

In response to 'Supporting flexibility in training in other ways'

It is encouraging that the GMC want to consider additional ways to promote flexibility in addition to the proposals for credentialing. In reality this needs to be initiated with a speciality wide information gathering exercise, whereby all courses and certificates to gain skills/knowledge/CPD must be determined. The current provision should then be appraised to determine if they could/should be endorsed by the GMC. This would maximise of the impact of existing courses and modules without

requiring reinvention. The processes outlined in the endorsed modules and additional skills areas would fit within this. However if these elements for flexibility were introduced pre-CCT, funding and time provision would have to be made to ensure trainees could undertake them effectively. All medical (clinical/non-clinical) courses/qualifications require robust quality assurance and as a regulator it seems reasonable the GMC assume this role, but not at the expense of existing and established courses/certificates.

Any Other Comments

Given that the GMC is currently the regulatory body for doctors alone it is assumed that current plans for credentials are limited to doctors. However it would be useful to understand what discussion has been had with other regulatory bodies such as the NMC regarding credentialing. Has it been considered that they may also adopt the credentialing framework to allow further development of advanced nurse practitioners (ANP)? Would this use the same framework?

Similarly is it envisaged that medical associate professionals/physician associates (MAP/PA) will eventually be able to undertake credentials? It is not unrealistic to imagine a situation whereby a MAP/PA is able to stay in one geographical area, within one specialty, within one or more teams and accrue multiple credentials While we appreciate that MAP/PA's currently remain unregulated this still requires prospective consideration, especially if regulation of MAP/PAs is to fall under the GMC's jurisdiction.

Speciality doctors are not mentioned as a group throughout the document. SAS doctors are a much needed group of medical professionals, many of whom will have significant experience in a number of the roles that will subsequently be credentialed, much like consultants. Will speciality doctors have a specific set of criteria to engage with credentials (such as years of experience, placement in specific specialities/clinical areas)? Will they have to undertake credentialing in areas of current practice? Will their activities have to be suspended whilst they complete a credential?

The current intention appears to be that all credentials are clinically based. Is there an intention for non-clinical credentials to evolve as experience with credentials as a whole progress? This area lends itself to development in order to meet the multifaceted role of a senior clinician and may sit well within the credentialing framework.

Conclusion

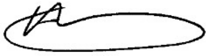
The discussion regarding credentials has been long and complex. Trainees can see the potential benefits of a credentialing system and agree that there are gaps which credentialing could improve. However this framework is not yet in a position to govern such a big change in the qualification and regulation of the next generation of doctors. Furthermore there are significant concerns regarding the potential to devalue CCT, and the possibility of creating a sub-consultant grade, which this document has failed to answer. If credentials are truly to be undertaken in a pre-CCT setting there are numerous issues that need consideration in terms of time, funding and the post-credentialing status of the trainee. Whilst progress is being made on the details of credentialing it seems highly unlikely that credentialing will be ready for mainstream implementation in phase one in April 2019.

ROYAL COLLEGE of PHYSICIANS of EDINBURGH

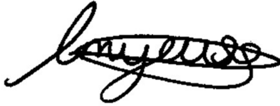
ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

Royal College of Physicians

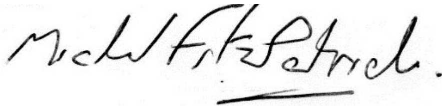
Signed collectively on behalf of the three colleges' trainees' committees:



Dr Anna Olsson-Brown
Chair, RCPE Trainees and Members Committee



Dr Amy Illsley
Deputy Chair, RCPE Trainees and Members Committee



Dr Michael FitzPatrick
Co-Chair, RCP Trainees Committee

Dr Matthey Roycroft
Co-Chair, RCP Trainees Committee

Dr Orod Osanlou
Deputy Chair, RCP Trainees Committee

Ms Mahua Chakrabarti
Chair, RCPSG Trainees' Committee

Dr Jack Fairweather
Vice-Chair, RCPSG Trainees' Committee