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GMC-regulated credentials for doctors FAQs

This document sets out questions and answers that have arisen during discussions and engagement with a wide cross section of interest groups and those who may be affected by the introduction of GMC-regulated credentials. It explains our current position, but we will update both the questions and answers as appropriate. Please see the [framework for GMC-regulated credentials](#).

This document has been developed in partnership with the UK Medical Education Reference Group.

What is a GMC regulated credential?

We are introducing a new process to formally recognise a doctor's expertise in a specific area of practice – a GMC-regulated credential. Our aim for credentials is to approve them in areas of practice where they will help reduce risks to patients and support the service to provide better patient care. They will provide approved approaches to develop doctors in an assured and educationally supervised environment.

Credentials will be developed and delivered by other bodies, but approved, quality assured, and recognised by the GMC. GMC-regulated credentials will be recognised on the doctor's entry on the List of Registered Medical Practitioners (LRMP), which the public and employers will be able to see.

We have identified four types of areas where credentials might be required – focusing on specialised or discrete areas of practice. The examples in each category are to illustrate them, there is no suggestion they will or should be credentials:

- Areas of practice, currently components of training, where there is a patient need for increased provision eg interventional neuroradiology (acute stroke), liaison psychiatry.
- Areas of medicine with limited regulation where there is increased patient risk eg cosmetic surgery.
- Emerging areas of practice that are not currently part of an approved training programme and where there is sufficient patient risk eg rural and remote medicine.
- Extending and enhancing skills for specialists and/or GPs that are not covered in training sufficiently and where there is a patient need eg transplant medicine.

Medicine is rapidly evolving with new technologies and treatments. Credentialing will help the profession to adapt to the future needs of patients and maintain consistent standards across the UK, as well as building on existing skills, experiences and qualifications.

Credentialing offers an opportunity for doctors to continue to develop new skills, and will complement postgraduate training programmes, not undermine them. We will introduce the process for approving and assuring credentials gradually, so we can make sure this works for patients, doctors, and employers. Our aim is to support organisations that are developing credentials in a small number of prioritised areas to start going through the approval process by 2020.

Why are GMC-regulated credentials being introduced?

GMC-regulated credentials will help the profession to adapt to the future needs of patients and maintain consistent standards across the UK. Any credential will have to show it will address significant patient safety issues, and/or offer opportunities to develop doctors flexibly to help support more effective service delivery.

Areas of practice, currently components of training, where there is a patient need for increased provision

These types of credentials provide some doctors with the opportunity and flexibility to extend their scope of practice, in relevant or related areas that are not, or were not, covered by their training. This would provide one way for the service to meet certain needs of patients and the healthcare service much more quickly. For example, a pilot credential in liaison psychiatry was developed by the Royal College of Psychiatrists in response to the priority of improving mental health services. This has received positive feedback from both the doctors who've completed it, and from employers.

Areas of medicine with limited regulation where there is increased patient risk

Some doctors develop expertise in areas of medicine not covered during their specialty training. For example, a doctor who trained as a general surgeon might go on to work in cosmetic surgery. And where these areas carry evidenced known risks to patient safety, it's important that patients and employers can assure themselves about doctors working in this area. Credentialing will give patients the opportunity to have access to a consistent and reliable way to check their practitioner is working to a specified standard within that particular area.

We do recognise that this will not solve all of the patient safety issues, especially in areas where a wide range of regulated and unregulated professionals work, such as cosmetic interventions. The GMC only regulates doctors, but we are aiming to have a positive impact with credentials being part of that assurance. We are also working with other agencies to identify ways we can help improve patient safety overall within the cosmetic industry.

Emerging areas of practice that are not currently part of an approved training programme and where there is sufficient patient risk

As medicine changes and evolves, there will be new areas of practice that have not been part of an individual's postgraduate training – for example artificial intelligence – and areas where a new need has been identified, such as rural and remote medicine. Credentials will provide a mechanism for these areas to have UK-wide consistent and recognised clinical and professional standards that will be delivered with appropriate supervision and support.

Extending and enhancing skills for specialists and/or GPs that are not covered sufficiently in training and where there is a patient need

While postgraduate training sets a baseline of knowledge, skills and capabilities, in some specific areas a doctor may require further training to build on their expertise in a discrete area – for example transplant medicine. The majority of learning and development, outside of formal training, will not need approved standards and outcomes (for example post-CCT fellowships and CPD). But where there may be significant patient safety issues, where training opportunities are insufficient, or where they do not provide adequate flexibility to support effective service delivery, assured, consistent and recognised standards will be required.

Who will be eligible for credentials?

Eligibility requirements for a GMC-regulated credential will describe the required level of training and experience necessary to access the approved learning programme, or have comparable capabilities recognised, in the specific area of practice. Entry requirements will be clearly set out by the organisation proposing the credential during the approvals process and based on patient safety need.

The organisation proposing the credential will identify and describe the entry requirements to a credential, basing them on the necessary expertise and experience that will minimise risk to patients. This may limit many credentials to doctors who are on the specialist and GP register in a relevant area, and we believe that most of the early proposed credentials would be likely to fit in this group.

In some areas of practice, it may be appropriate to allow wider access to doctors who are not on the specialist and GP registers. In order to better understand how this can be done in a way that safeguards patients, we will consider a limited number of early adopter proposals that have wider eligibility, allowing us to explore how SAS doctors may access credentials. We will use this experience to engage again if we think that further GMC-regulated credentials could have more widely accessible entry requirements.

We will only endorse credentials for doctors who have achieved the outcomes necessary to start the credential. The credential will build on, and recognise, capabilities and expertise gained through training and/or experience. We recognise that in some areas, there is an ambition to develop packages of learning for other healthcare professionals or multi-

professional teams. While we are not opposed to these developments, our regulatory remit as a statutory body covers education and training of doctors only.

Will credentials be available to all doctors?

Doctors who have developed their careers outside of formal postgraduate training who are seeking a credential in a discrete area of practice will also need to show that they satisfy the entry criteria for that credential. A key principle of establishing the entry criteria will be how to ensure that patients receive high quality, safe care.

Many credentials may only be available to doctors recognised on the specialist or GP registers in relevant areas because of patient safety requirements. Entry requirements, however, will depend on the credential and be identified by the organisation proposing the credential.

The GMC will consider as part of the early adopters phase how credentials may support entry of SAS doctors into credentialing programmes.

How will doctors with a credential be recognised?

Our intention is that credentials will be noted on a doctor's entry on the List of Registered Medical Practitioners (LRMP) in the same way as recognised trainers are identified on the LRMP. This will remain separate from being on the specialist or GP registers, but will allow employers and patients to see if a doctor has a credential in a particular area.

Will there be retrospective recognition of a doctor's skills?

Credentials will describe the outcomes and standards expected of doctors working in the specific area of practice. Recognition will be gained by either training or an evaluation of evidence that the outcomes have been met.

Where a doctor can evidence they have the skills and experience in an area of practice in which a credential is developed, we would expect them to be able to have this evaluated against the standards to gain recognition. However this will be done on a case by case basis according to the entry requirements and outcomes of the credential.

We will automatically recognise that doctors have met the outcomes of a credential on the LRMP, where a component of their approved postgraduate training is comparable to it. This will allow full transparency for patients and the public.

What about doctors who don't have (or want) the credential?

Credentials will not be mandatory for doctors working in a specific area of practice. The GMC does not have the legal authority to make any postgraduate training mandatory,

including credentials. This is similar to working in a specialty, where it is not a requirement for a doctor to have specialist registration in an area of practice, to work in that area.

We have considered the possibility that doctors without a credential may be limited or disadvantaged, through employer or patient choices. We will monitor this risk as the first credentials are developed and delivered. We will be clear in any communications that doctors with the credential have demonstrated they have met UK approved standards and outcomes in areas prioritised by local patient or service needs, but it is not the only marker of competence. Appraisal and revalidation will continue to reassure patients and employers that all doctors are practising safely, whether they have a credential or not.

We will continue to work with key groups to ensure that patient safety considerations are paramount in developing credentials, or other ways to assure the quality and safety of practice in cosmetic surgery and/or other cosmetic interventions.

How will credentialing affect postgraduate training?

We will ensure credentials will not be used to undermine or devalue the quality of postgraduate training. Our approval process, focusing on patient safety as the primary indicator for a credential, will limit GMC-regulated credentials to where they are a proportionate response. We will ensure the quality of the training or approach to delivering the credential through our quality assurance processes. We will evaluate the impact of the credential, including its impact on relevant postgraduate training, through our data collection and monitoring mechanisms.

The standards and outcomes required for award of a CCT will not change. The content of postgraduate training will be changing as curricula are brought up to date and the generic and general aspects of training are emphasised. This is part of the curriculum review and implementation of the *Excellence by design* standards for curricula, and already occurs independently of credentialing.

Credentials will operate separately from CCTs/CCGPTs and will present specific opportunities for doctors to gain more expertise and experience in areas they didn't cover during their CCT. Clear entry requirements will be required for credentials. We anticipate that in many clinical areas, doctors will access GMC-regulated credentials in areas that build on the knowledge, skills and capabilities gained through their general, specialty or subspecialty training or experience.

In most cases, we do not expect doctors in training to take credentials, since most credentials will be aimed at doctors who are not in training. However, if a doctor in training wanted to gain a credential while they are out of programme, or in an area not provided within their training programme, they would not be excluded from competing for that opportunity provided they met the relevant entry criteria.

If there is an area that is a requirement for all doctors in a specialty, it must be included in the postgraduate training curriculum. We will specifically seek this assurance through our approval process and the curricula review. We will also require organisations proposing credentials to submit an impact assessment of the credential on patients, the service it will be supporting, relevant postgraduate training and the current medical workforce in the area of practice.

Some large optional areas that are part of a training programme may be developed as credentials to support doctors who did not take that optional area as part of their training – but want to or need to develop in the area to meet patient or service needs. Doctors who met the outcomes of the discrete area of practice as part of their postgraduate training would be recognised automatically for the credential.

How will credentials be maintained?

The curriculum content of credentials, like postgraduate curricula, will be reviewed regularly through our curriculum approval processes. New or emerging areas that develop as credentials may influence and inform curricula through the GMC's continuous review of postgraduate curricula.

We envisage that doctors with GMC-regulated credentials will confirm they're continuing to meet the standards and expectations of the credential. The outcome of these evaluations will feed into appraisal and revalidation.

As part of the phased implementation, we will further explore and develop the detail of how this will work in practice over the coming months and use the first small number of early adopter credentials to test our thinking.

When will we know which areas will become credentials?

We will introduce credentials in a phased approach, to make sure we get it right. As part of the process for approving credentials, we will consider the level of risk involved in an area of practice, and therefore whether it needs our full regulatory approach of approval, quality assurance and recognition on LRMP.

We have worked with the UK Medical Education Reference Group (UKMERG) to prioritise a small number of areas that will have the opportunity, in 2019, to enter into the process for approval as credentials. These 'early adopters' include:

- Cosmetic surgery – Royal College of Surgeons
- Liaison psychiatry – Royal College of Psychiatry
- Interventional neuroradiology (acute stroke) – Royal College of Radiologists
- Rural and remote health – NHS Education for Scotland
- Pain medicine – Faculty of Pain Medicine.

As other prioritised areas begin to develop, we will work with organisations to support them through the approvals process.

Who will decide which areas become credentials?

The UK Medical Education Reference Group (UKMERG) is currently the forum for the discussion and approval of matters relating to medical education and training. It has representation from organisations responsible for UK medical workforce planning and education, such as the four UK Departments of Health, Health Education England, NHS Education for Scotland, Health Education and Improvement Wales, and the Northern Ireland Medical and Dental Training Agency.

In most cases, the UKMERG will prioritise and recommend discrete areas of practice that could be considered as possible credentials in order to help support patients and/or the service. Representatives of the UKMERG, where necessary, may support relevant organisations to scope out, develop and pilot areas before they are proposed to the GMC for approval as a credential.

Our Curriculum Oversight Group (COG) is made up of members of the UKMERG but chaired by the GMC. COG will consider purpose statements (similar to a business case) from organisations that want to develop credentials. The purpose statement will describe the rationale, evidence and feasibility for an area of practice to become a credential. COG will evaluate this information based on patient safety factors.

We'll use the early adopter credentials to refine the process and make sure it works effectively for patients, doctors, and employers.

The GMC will make the final decision to endorse the credential.

Where will the funding for credentials come from?

The four UK governments recognise that the credentialing process will contribute beneficially to developing and supporting a continually evolving service. This flexible approach will support doctors in adapting to the future needs of patients while maintaining consistent standards across the UK. Those who plan services will be able to use credentials to introduce development opportunities for their medical workforce that are responsive to patient needs and help to better address service gaps.

All four nations of the UK are firmly committed to ensuring there are equitable and proportionate funding arrangements underpinning credentials where they have been commissioned or funded to develop and secure NHS services. As such, individual doctors, if successful in securing access to a credential programme can be confident that appropriate funding arrangements have been put in place.

Where the credential is for work outside the NHS, it is anticipated that there will be a different funding model and we are exploring this through our work on cosmetic surgery and interventions.

How have stakeholder views been considered in developing credentialing?

We've spoken to a wide range of relevant interested parties and organisations, including representatives of the four UK governments, medical colleges and faculties, postgraduate deans, SAS doctors, doctors in training, consultants and patient representatives.

We held workshops in England, Northern Ireland, Scotland and Wales with key representatives in each country. These included specific workshops for doctors in training, and we also gave opportunities for individual doctors in training to discuss credentialing with us.

We published the draft framework for credentialing on our website, with a feedback form, so individuals and organisations could share their views from late 2018 to early 2019.

Full details on our engagement and feedback can be found in our [credentialing web pages](#).

When are you introducing credentialing?

We presented our final recommendations for how GMC-regulated credentials would work to our Council on 12 June 2019 and gained approval. These proposals were shaped by the feedback we have received from relevant stakeholder organisations and individuals.

We are running a phased implementation for GMC-regulated credentials, working with a small number of early adopters in 2019. We will continue to learn and refine our processes and once these initial credentials have gone through our approvals process, we will have a review period to identify any issues or changes required.

What is the history of credentialing?

Discussion about the credentialing of medical practice in the UK has been taking place for a number of 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. This was driven by a desire 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.

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. 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.

Professor Sir David Greenaway's 2013 report, *Shape of Training: Securing the future of excellent patient care*, included credentialing as part of the recommended future architecture of specialist and general practice (GP) training. 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.

In 2017, the Shape of Training implementation group, led by Professor Ian Finlay, published a report that made a number of recommendations to implement the principles from the Greenaway report. There was a specific recommendation to introduce credentials that are approved and assured by the GMC. The four health ministers endorsed this report and specifically called for action on introducing credentials.

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. Our policy development work from 2016 has focused on what the regulator's role should be and has included working with a number of organisations on pilots.

Credentialing is also mentioned in our 2017 report, *Adapting for the future: a plan for improving the flexibility of UK postgraduate medical training* under the section on how we will support doctors with specific capabilities or needs. And more recently, credentialing has been included in England's *The NHS Long Term Plan*, and in *Delivering for Today, Investing for Tomorrow: the Government's Programme for Scotland 2018-2019*.

More details can be found on our website about the [background to credentialing](#).