GMC Credentialing Consultation

RCPCH response

From September 2018 – January 2019, the GMC consulted on proposals for the use of credentials to recognise expertise and provide training opportunities in specific areas of practice. The response to the consultation questions from the Royal College of Paediatrics and Child Health was submitted on Thursday 24th January 2019, and is reproduced below.

More information on the consultation and the GMC’s proposals can be found at: https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/credentialing

1. This is for comments about ‘A case for change’ in the framework, and ‘Why we’re introducing credentials’ and ‘Impact and issues’ in the annex. We’re interested in your views on:
   • whether credentials will enable flexibility
   • support necessary change
   • opportunities for doctors
   • any other thoughts on these sections.

RCPCH agrees there would be benefits of credentialing for unregulated areas of medical practice, but not for substantial areas of practice already embedded within the existing training programmes/curricula. Feedback from our stakeholders has been that they could not identify a specific problem within paediatrics which credentialing would solve, and that they may be more necessary to address workforce needs and/or patient safety issues within adult medicine. No specific areas of unregulated clinical practice within paediatrics were identified, although special interest training (SPIN) is not currently regulated or formally recognised. These are currently managed in a similar way to our (sub) specialty training with oversight and sign off by our CSACs. The rationale for introducing credentials mirrors the purpose of our SPIN portfolio, so we could see relevancy in replacing the SPIN modules with credentials in time.

A stated purpose of credentialing is to meet the need for more generalism, and we fully support this as a specialty which already has a very substantial ‘generalist’ element to our training programmes, but as we have tried to do through our curriculum and training pathway, there must be a balance and generalism should not be over-emphasised at the expense of specialism.

Currently within the paediatrics training programme and curriculum, all trainees undertake generic paediatric training AND specific specialty training in general paediatrics or one of the other paediatric specialties (e.g. neonatology). As far as possible within the limitations of available data, numbers per specialty and region are based on projected workforce need. In addition, SPIN modules are used as optional training modules to supplement the main training programme, increasingly focused on specific areas where a need for clinicians with additional specialty knowledge or another upskilling requirement is identified, available to both trainees and consultants where there is a workforce need and suitable training opportunity available. This ensures all paediatric CCT-holders have the requisite general (‘generic’) and specialty skills and knowledge required to provide a safe and comprehensive service for patients, and combined with the influence regional workforce has on rotas and job descriptions, this ensures that in paediatrics, there is already significant flexibility and the ability to be responsive to population/service needs. A recent survey of the RCPCH Curriculum Speciality Advisory Committees (CSACs) indicated that in regions/settings where there is a service need for specialists to give support to the general paediatric rota or clinics (e.g. very rural areas) this is happening routinely, but it is not commonplace for (sub)specialist paediatric consultants to be asked
to do so. It is however very established for paediatric (sub)specialty consultants to regularly undertake hands-on out of hours cover within their own specialty area, and this model best ensures safe care for patients.

We noted that the supplementary document (page 8) states that credentials are designed to complement training not replace or alter it, a position we fully support, but this is not in line with the COG’s previously expressed wish for paediatric specialty training to move to credentialing. We do not see any benefit in introducing credentials to replace the main specialty training pathways (e.g. general paediatrics, neonatology, paediatric respiratory medicine etc) as had originally been suggested by the COG, but we would welcome the opportunity for credentials to provide a more formally recognised and regulated structure for our optional training modules, which are currently offered in paediatrics as SPINs. In line with the consultation document, the use of credentials would focus on ensuring the paediatric workforce is suitably flexible that clinicians can be upskilled or add in additional skills/knowledge throughout their careers, to meet the evolving needs in their region or specialty. We are currently reviewing our SPIN portfolio to ensure all modules offered have a clear purpose and meet a specific workforce need, reflecting the requirements for regulated curricula in the GMC's ‘Excellence by Design’. For example, the High Dependency Care SPIN has been developed in response to the report ‘High Dependency Care for Children - Time to move on (2014), giving general paediatricians the additional skills, knowledge and experience they need in order to develop or lead a Paediatric Critical Care Unit. In line with the declared purpose of credentials, we hope our SPINs provide ‘flexible training in substantial practice areas to address service gaps’, and would therefore welcome the opportunity for these to be standardised and successful completion more formally recognised through a credentialing framework.

Post-CCT credentials would provide opportunities for consultants (and non-consultants) to retrain and/or upskill, supporting flexibility both for the individual clinician as their interests and career evolve, and also for the service to train clinicians faster in specific area of need. The majority of paediatric (sub)specialties would welcome the opportunity for consultants to be able to take additional training modules in order to move to a related paediatric specialty or upskill in in particular area, based on personal and/or service needs. The flexibility for clinicians to develop expertise in and move to related specialties has the potential to support a more sustainable workforce, if clinicians later on in their career have the opportunity to move to a role in a related but less acute specialty, whereas they may otherwise have switched to LTFT or taken early retirement.

Whether credentials support flexibility will depend heavily on the process for new SPINs to be developed, and whether this is suitably stream-lined to be responsive to needs as they are identified. We have identified two potential barriers to the successful launch and implementation of a new credentialing framework – ensuring funding is available, and ensuring that clinicians have sufficient protected time in order to undertake this additional training, particularly when the credential is undertaken post-CCT. Without a commitment from trusts and HEE to support credentialing, they may not ensure protected time for training that is not part of the main postgraduate specialty training programme (both for the trainee or consultant undertaking the credential, and for their supervisors), and there is a risk that credentials will not be taken up in the areas that would potentially most benefit from them, and that they would be an additional financial burden for any individual doctor undertaking one.

2. This is for comments on ‘Defining credentials’ in the framework. We’re interested in your views on:
   • whether we have described credentials clearly
Feedback we have had from our stakeholders is that broadly the definition is clear to clinicians already familiar with medical education, provided the intention is only, as implied, to use for discrete areas of training. There had previously been suggestions that credentials would also be used to replace larger, broader (sub)specialty training (i.e. our current GRID) and if this were to be the case then this is not reflected in the description within the consultation document. If that were to be added it would then mean the overall definition would not be clear as it would be describing two completely different types of training module with the same term, so we were pleased to see the scope more narrowly defined here. Although paediatric curricula are termed as ‘sub-specialties’, this is purely semantics and the paediatric curricula and training pathway effectively act as specialties. They are of the same depth, breadth and level as adult specialties, and therefore they are not appropriate for credentialing.

Providing the current intention is only to use credentials to regulate optional training modules within a main training pathway, specifically where there is a need for some clinicians to be upskilled in a particular area to meet workforce and/or patient safety needs, then this definition is reasonable. Our stakeholders were generally satisfied with the use of the word ‘credential’ providing it was tightly defined and not also used to describe elements of the main postgraduate training programmes/curricula. They felt that the word was becoming recognised and established and so changing it at this stage may create confusion.

If the GMC are keen to identify a new word which is not tainted by any past confusion as to what form a credential would eventually take, then we would suggest reflecting academic qualification language e.g. award, certificate, or diploma. This would also allow the potential for differentiation of the size of the credential (e.g. those with fewest hours are an award, and the longest a diploma), giving greater flexibility for using credentialing to formalise the very short as well as longer and/or more in-depth training modules. This terminology would also be more widely accepted and understood by the general public, aligning with other academic and vocational sectors.

3. This is for comments on ‘Identifying credentials’ in the framework. We’re interested in your views on:
• whether we’ve got the criteria right
• anything we might need to be aware of in trying to balance the criteria correctly
• anything we should consider regarding the risk threshold
• any other thoughts on this section.

The suggested criteria seem to be clear and appropriate. The most challenging is workforce planning, as this is always tricky to project accurately, and even more so in paediatrics due to the very high number of LTFT trainees and maternity/paternity leave. An ever increasing number of paediatricians are now retiring early, in their late 50s, particularly those on the 1995 pension scheme. Therefore accurately predicting need several years in advance and balancing the numbers undertaking the credential according to workforce needs will naturally be a ‘best judgement’ rather than a certain forecast. Assessment of need must also take note that there are some niche areas where it is crucial that a very small number of clinicians nationally are trained in that subject, e.g. genomics, in able to provide adequate treatment for rare diseases and conditions. In these cases need must be assessed based on national numbers required and suitable geographical spread rather than each specific region, and numbers should not necessarily be the driving factor as it may still require that handful of clinicians to be trained in order to deliver safe clinical care to children and young people with those rare conditions.
We agree that a risk-based approach to determining suitability of credentials is essential. It would be a judgement for COG to make based on the evidence for each proposed credential whether a sufficient number of criteria have been met, to the appropriate degree. We anticipate that the weighting or importance of each of the nine criteria will and should vary depending on the nature of the proposed credential, e.g. ‘complexity’ will be a key reason for some credentials being proposed, but not relevant for others which have merit for other reasons.

It may be clearer to split the criteria into two groups – mandatory and additional criteria? Mandatory criteria must be demonstrated for ALL proposed credentials (e.g. demonstrating the workforce need for clinicians to have the specified skills/expertise, confirming how the credential can be delivered) in order to secure approval. The remaining ‘additional’ criteria would each be relevant in some but not all cases, and to varying degrees e.g. ‘complexity’, ‘outside NHS’ etc. Only those additional criteria which are relevant to the particular credential would need to be evidenced, and some to a greater or lesser degree than others depending on the specific credential’s purpose.

4. This is for comments on ‘Regulating credentials’ in the framework, and ‘How we propose to regulate credentials’ in the annex. We’re interested in your views on:

- if approving credentials as part of the postgraduate training pathway is right
- if credentials should be recognised on the List of Registered Medical Practitioners
- any other thoughts on these sections.

Regulating training modules as credentials is a positive move, and we would welcome any change which ensures training is delivered and attainment assessed in a structured, consistent manner. However, the phrase ‘as part of the postgraduate training pathway’ causes concern, as this again opens the door to specialty training being downgraded to credentials. It would be clearer, and better reflect the expectation that credentials will be opened to those other than just clinicians undertaking postgraduate specialty (i.e. pre-CCT) training, to describe credentials as being regulated on a par with the postgraduate training programmes, subject to the same regulations and approval processes.

One further concern expressed by our stakeholders is that regulation always has the potential to hamper flexibility and stifle innovation. If credentials, which in some cases are designed to be pushed out to meet service needs as they are identified, are to be submitted to same COG/CAG process as the main curricula, there would need regular opportunities to submit and guaranteed responses within agreed appropriate timescales. Lengthy delays in being able to secure approval for new credential curricula would seriously impact on the potential for credentials to be developed and deployed responsively.

Provided that credentials are only to be used for additional training blocks rather than as a replacement for the existing, substantial, (sub)specialty training pathways currently undertaken by all paediatric trainees, we would be satisfied with this being reflected on the LRMP. If there was any move to use a form of credentials to replace larger aspects of the current specialty training, then the LRMP would not be appropriate and designation should remain by means of the speciality register. Failure to maintain specialty register designation for the existing, substantial, (sub)specialty training pathways would certainly cause confusion for patients, with mis-conceptions as to the level of expertise of the clinician in the specialty or sub-specialty area. Furthermore, any move which appears to downgrade the recognition of postgraduate specialty training for some specialties, such as paediatrics, would have a detrimental impact on our ability to recruit sufficient numbers into the specialty.
Most important is that whatever the decision is regarding the extent to which credentials are used and whether this replaces what is currently part of (sub)specialty training, it must be applied consistently across ALL specialties. Failure to ensure training of a similar depth and breadth is recognised equally would have the unintended consequence of devaluing some specialties compared to others, raising anxieties in patients and parents about a potential lesser level of expertise and training of their consultant paediatrician, compared to clinicians in adult specialties. Paediatrics has shared training pathways with adult specialties in some cases, and in most paediatric (sub)specialties consultants work alongside their adult specialist counterparts to manage adolescent patients and transition from paediatrics to adult services, and therefore must be recognised and regulated in the same way as adult specialties.

The consultation document does not give any indication of the anticipated life span of a credential. The final guidance should indicate whether the review schedule is fixed or determined by the credential owner. The GMC have expressed a desire to ensure the number of credentials offered is not excessive, and so regular curation of the entire range available and re-checking need (and reviewing impact?) will be necessary.

5. This is for comments on ‘Implementing credentials’ in the framework, and ‘Plans for implementation’ in the annex. We’re interested in your views on:
   • any issues we need to consider in our plans for implementing credentials
   • any other thoughts on these sections.

RCPCH supports the proposal for a phased implementation, although would feel more confident if phase 1 was in the form of a formal pilot, with clear criteria agreed for evaluation and review at a set point prior to launching the framework more widely. In line with the Equality Act 2010 and Public Sector Equality Duty, this phase should also include an Equality Impact Assessment, so that the actual consequences of this new form of training module for all stakeholder groups, including those with protected characteristics, can be more fully understood.

The timescales indicated are incredibly tight, and do not appear to allow sufficient time to gather evidence as to whether the new proposed approach works and meets its intended purpose before rolling out to more areas, particularly with all specialties under pressure to revise all their curricula, including incorporating credentials, by 2020. Without isolated, monitored pilots taking place and being evaluated before refining and opening up the framework to others, potential issues affecting the effectiveness of credentials for the stated purpose may not properly identified and shared and thus will continue to be replicated in the next credentials to be developed. It would also mean the possibility of the guidance evolving substantially over the initial months and years of implementation, creating confusion for those developing and delivering credentials if requirements change mid-development and causing inconsistency between earlier and later developed credentials.

Regarding the phasing, we would also query how some crucial issues regarding credentialing, such as how they will be recognised (e.g. on the LRMP) and confirming QA and governance procedures are currently sat in phase 2, after the first tranche of credentials have already been developed and begun to be used. We believe it is crucial that these operational expectations and processes are defined at the same time as the requirements for credential content/format, in order that organisations can develop the best possible credential which can be delivered effectively and meet the intended purpose, first time around. If requirements and processes are ‘tested and refined’ as described throughout the period that many of the earlier credentials are being developed.
then surely there is a real chance that organisations will be asked to make changes to recently developed credentials or will unexpectedly be asked to meet additional requirements previously not stated, which would incur extra expense, require further clinician time, and cause confusion for clinicians, employers and patients. As a prospective credential developer, we would strongly prefer that the framework and supporting processes and policies are refined in discrete pilots and then launched as a finished article ready for us to use, rather than being tried, tested and repeatedly tweaked over the first few years. Decisions regarding how credentials would be managed and supported (currently our SPIN modules are supported by our Curriculum Specialty Advisory Committees, with the SPIN Lead drawn from those committees), would also be important to clarify prior to the final guidance for credential developers being issued.

6. This is for comments on ‘Other developments to support flexibility’ in the framework. We’re interested in your views on:
- endorsed training modules in postgraduate curricula
- whether QA processes for additional skills areas adds value
- any other thoughts on these sections.

As previously noted, we feel strongly that our SPINs in their current form very much resemble what is described throughout the consultation document as a credential, and therefore we would be seeking to revise our SPIN portfolio in the form of a set of new paediatric credentials, rather than endorsed training modules.

Beyond that, we have no objection in principle to endorsed training modules, but there is some risk that this creates a confusing multi-tiered structure, based on a sliding scale of how important or worthwhile each type of training (postgraduate specialty, credential or endorsed training module) is seen to be. Our suggestion in question 2 of mirroring the academic framework terms of Award/Certificate/Diploma dependent on the size of the module would have benefits here in providing a simple structure for recognising smaller and larger modules in a clear and consistent way. There would need to be far more clarity that in this document as to what constitutes an endorsed module as opposed to a credential, noting that they will need to be important and/or substantial enough areas to warrant sharing standards and QA procedures with the postgraduate curricula and credentials, but also articulate why they do not qualify to be a credential despite this.

In general bringing greater consistency to regulation and recognition of all formal training seems to have some benefits, but we are concerned that if an area is not deemed to meet the criteria for a credential, then the full approval and/or QA processes articulated in ‘Excellence by Design’ would be too heavy-handed, and risk reducing their ability to be developed and deployed effectively and responsively. Getting the balance right in defining whether something is suitably significant to be recognised by the GMC (as an endorsed training module) but NOT sufficient to be a credential, may perhaps be challenging, and more detail on what the value is of a training module being ‘endorsed’ would be beneficial. Cost and funding should also be a consideration – is there a risk that any funding available would end up ringfenced for credentials, and drastically impact on available funding for clinicians to complete endorsed modules, which may be smaller but still have significant value for learners?