The Royal College of Ophthalmologists' response to the GMC Consultation on a new 'credentials' framework

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The GMC are currently consulting on their proposal to introduce a new framework of 'credentials', which has implications for the way sub-specialty training is developed, regulated and recognised in future. Their aim is to have a structure which provides for more flexible training, better meeting evolving workforce needs and allowing flexibility in how and when sub-specialty training occurs, in line with the principles advocated in the Shape of Training Report.

https://www.gmc-uk.org/education/standards-guidance-and-curricula/projects/credentialing

What is a credential?

Credentials are optional components of training, treated by the regulator in the same way as other postgraduate curricula. They will describe the expected outcomes and capabilities that doctors must demonstrate as they become experts in the field. The GMC will approve and quality assure these key areas if there is a demonstrable need, based on patient safety, for consistent standards, training, experiences and assessments. They intend to recognise attainment of the credential on the List of Registered Medical Practitioners (LRMP).

Purpose and rationale

1. Page 2 of the draft framework identifies two problems it is intended that credentialing will address. Do you agree that change is needed in order to solve these problems?

Yes the introduction of credentialing should help ensure a standard level of practice in unregulated areas currently outside training programmes. There is a need for this where there are significant safety issues or risks present and there is no current training programme or assessment such as around cosmetic surgery and interventions.

However Royal Colleges must set the curriculum, oversee the delivery of training and assessment for the credential. They should therefore receive some funding and support to enable this. There are huge implications for Colleges depending on the number of credentials to be developed. There will need to be clarity of ownership where credentials are across more than one College or Faculty.

There are hidden costs such as developing a suitable e-portfolio or adapting current ones, more staff required in College departments. This could be expensive if the credential is for an area of practice that is not widely required but important, as there may be few candidates and so there should be consideration as to who bears the cost for this. Overall this needs to be properly resourced within the NHS.

We also need to be very careful that credentialing does not restrict appropriate practice. Appraisal and revalidation are already tools to ensure a doctors practice is reasonable and safe. Not all skills within a credential will need to be undertaken by someone with the credential and so not having a credential should not prevent them being undertaken by a practitioner working within their limits and safely. Care should be taken that this does not stifle innovation and the development and adoption of new techniques.

The aims as described in this consultation seem clear yet are at complete variance with the Curriculum Oversight Group suggestion of how our College should develop them. There it has been suggested that we should develop

credentials for all specialist areas of interest in Ophthalmology. This does not fit with the model proposed here and is a significant concern to us as that suggests we have multiple credentials covering all areas of normal practice. This could devalue the CCT and reduce flexibility considerably for new consultants compared to the proposed way we wish to deliver specialty training and assessment. We perceive that credentials should be kept quite separate from the normal training programme.

2. Do you think the proposed use of credentials will enable greater flexibility and/or opportunities for doctors?

Credentials may be successful in improving flexibility if they are able to help with under-filled posts and specialty areas. This would mean that doctors could take this to begin practice in a specialist area post CCT where there is need, or be helpful if the population needs change or disease profile changes due to other medical developments so the doctor can move to a new specialty area i.e. supporting re-training.

There could be a significant difference between the level that a post CCT doctor and an SAS doctor working in that specialty. It would need to be clarified whether the SAS doctor with the credential was then working autonomously or not. For example in ophthalmology it could be helpful to have SAS doctors who are able to perform the majority of the patient care required for a specialist area without undertaking the surgery and are credentialed to demonstrate they have met the required standard. The credential for a post CCT doctor would be expected to include the surgical management as well. So there could be a case for a different grades or stages of a credential.

If the credential is not adequately resourced it will not help provide more opportunities for doctors.

Defining and identifying credentials

3. Is the description of a credential (pp4-6) clear and coherent?

The description of a credential is clear. The Curriculum Oversight Group have asked the Royal College of Ophthalmologists to consider developing credentials for all special interest areas of practice. This is completely at variance with the rationale for credentialing described here.
We believe it will be helpful for patients where there are areas of significant risk and no current formal training e.g. in cosmetic work.

4. Is the use of the word credential appropriate to describe the modules of training described in the 'Defining Credentials' section? Would another word be more appropriate?

We have concern about the term credential. This is already in use for non-medical healthcare professionals and therefore may cause confusion for the patient as to who is looking after them and the qualifications they have. The term approved training component is better though we prefer 'endorsed training modules' or 'endorsed training components'.

5. Nine criteria are identified by which the suitability of any proposed credential will be considered (p8). Are these sufficient and appropriate?

The criteria are overall appropriate however there is no guidance as to what the threshold should be for each of them. It may be difficult to evidence delivery of service as this is likely to depend hugely on geography and population. It could be considered within service needs potentially.

6. What challenges would you anticipate in trying to balance considerations of all of these criteria correctly? Are some likely to conflict, or be more difficult to fully evidence?
There is no outline as to the level or weight of evidence required. This may make it difficult to assess a potential credential, should there be some form of key threshold, particularly for the most important criteria. As number of patients is included this may be hard to consider. Something vital; with high risk, but not applying to many may still be as valid as a credential as an area where it may affect many patients.

7. Is there anything else that should be considered regarding the risk threshold (pp7-8) for credentials?
Should there be a consideration of the numbers of a credential awarded depending on population and service need? Will the risk threshold be used to decide which credentials are developed first?

Regulating and recognising credentials

8. Do you agree that credentials should be approved as part of postgraduate training pathways, alongside the postgraduate curricula to which they are linked?
Yes. Specialty Trainees could undertake credentials or 'endorsed training modules' within postgraduate training programmes. This would allow easier quality assurance of the training. However, the proposed definition is to help regulate areas not within training programmes and allow flexibility for doctors after CCT or SAS and other doctors. So, it appears that this is not routinely for Specialty Trainees so we are not clear how this could be approved as part of a training pathway. The curricula would need to dovetail with the postgraduate curriculum/a of the College. There will be significant Generic Professional Capabilities expected in the credential. These may already have been demonstrated by a doctor who has evidenced such capabilities when achieving CCT. For the credential the evidence required may be of upkeep of these skills. There will be a need for additional Clinical and Educational Supervisors for this additional training and accreditation. This must also be resourced clearly to the NHS.

9. Is the List of Registered Medical Practitioners the most appropriate way to recognise a clinician's successful completion of a credential?
Yes.

Other developments to support flexibility

10. The framework proposes that SPIN modules, which are not currently regulated or recognised by the GMC, will now become so, as 'endorsed modules'. Is this desirable? If not, what concerns would you have?
There may be a risk of reducing flexibility. It is not clear whether the aim is to have credentials and endorsed modules. How will they be defined? Would it be more appropriate to call them endorsed modules and have different stages or levels as proposed earlier for SAS doctors for example.

11. The GMC proposed to bring more areas of practice related to training, which don't meet the proposed threshold for a credential (e.g. post-CCT fellowships), under the GMC quality assurance system, requiring them to meet the requirements in *Excellence by Design* and *Promoting Excellence*. Would you support this? What risks or benefits would this bring?
Accrediting post CCT fellowships would allow a standardisation of training within them and the quality assurance would be of benefit. I is not clear whether these would be expected to lead to an endorsed training module and how these would be different from them. Ophthalmology, currently has post CCT fellowships in all areas of special interest. The proposal for our new curriculum is to include more regulated special interest training within the CCT envelope. The aim is that this will provide the skills to practice that special interest in routine practice. However some doctors will wish to further expand their skills and some posts, such as in tertiary referral centres, may require additional skills. An example of this may be an oculoplastic surgeon who undertakes a post CCT fellowship in order to undertake orbital surgery. The College would support such fellowships being endorsed modules. If fellowships were accredited then other doctors wishing to re-train and credential/be endorsed in a particular area could undertake them with the expectation they would be able to access training that should result in a credential/endorsement. This does increase the level of supervision required and as such Clinical and Educational supervisors will need to be resourced to undertake this. Heads of Schools will have a significantly greater remit under their auspices too and will need more time and support to oversee and deliver on this.

Implementing credentials

12. Do you agree that the proposed plans for implementation of the credential framework (p11 of the framework, and p6 of the annex) are suitable?
Yes a phased approach with frequent review and learning appears appropriate.

13. Do you have any other comments regarding the proposed framework?
There is no mention or acknowledgement of the resources required, financial costs, support for development of staff and training time required for delivery of this training.

Fiona Spencer
Chair – Training Committee