Association of Anaesthetists response to the GMC consultation on credentialing.

GMC credentialing consultation

The General Medical Council (GMC) are planning to introduce a process of credentialing in 2019 which they will recognise expertise and provide training opportunities in areas of practice where:

- there may be significant patient safety issues, or
- training opportunities are insufficient or do not provide adequate flexibility to support effective service delivery.

The draft framework sets out the GMC's proposals for credentialing, including how credentials would be identified and implemented

Consultation questions

Why credentials are needed
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.**

Association response:
The Association of Anaesthetists represents the medical and political views of over 11,000 anaesthetists in the UK, Ireland and internationally. The Association has a broad constitution to promote and advance education, safety and research in anaesthesia.

Patient safety is the Association of Anaesthetists' highest priority. By introducing what appears to be a "2 tier" system of qualification some clinicians may have added credentials that others do not despite both delivering the same service. Doctors in grades other than consultant (Staff Grade, Associate Specialist and Specialty Doctors (SAS) and other Trust grades have a credential that allows them to work independently of a consultant. This may cause confusion for patients.

Credentials could enable more flexibility in working, once achieved, increasing the clinical and professional development opportunities for SAS, Trust and other grades especially. However, it would need to be clear to the patient who is responsible for their care.

Given the pressure of workforce numbers on service delivery, keeping older doctors at work should be a priority for all specialties. Credentialing may offer opportunity to develop new skills better suited to an ageing doctor and helping to retain them at work.

Remote and rural areas have difficulty in recruiting and retaining. Developing supported and broader scopes of practice may offer a life-line to some at risk services.

Availability and cost of credential provision could be a barrier to uptake, becoming a potential cause of decreased flexibility in the workplace. It would need to be clear where the funding for the credentialing process will come from and who will be providing the training for achieving them.

It is important to keep a check and balance of how the process develops to ensure that credentialing does not become postgraduate training done of the cheap.

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Defining a credential
This is for comments on 'Defining credentials' in the framework. We're interested in your views on:

- **whether we have described credentials clearly**
- **if an alternative word should replace 'credentials'- and ideas welcome**
- **any other thoughts on this section.**

Association response:
The initial description of credentialing is clear. However, the word "credential" means many things to many people. How credentialing would be made obvious needs to be clear before any definitive process is put in place. The proposal that placement on the List of Registered Medical Practitioners seems reasonable but is it the only way that the credentials will be noted?

More thought needs to be devoted to what else we might call these, for example General Practice has "Special Interests". We believe the word credential may be too vague. Another possibility might be Additional Clinical Practice Modules (ACPM).

Criteria and threshold for credentials
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**

Association response:
The criteria proposed are not unreasonable. More importantly, though, is the need for transparency throughout the process. Issues may arise if doctors believe the process to be guarded or secretive. There needs to be a clear and logical threshold for the introduction of credentials in each area of medicine. Some clarity or definition about what makes a patient safety issue worthy of developing a credential and who is responsible for deciding which services are suitable for redesign and use of credentials would be useful in this respect. Will these activities be led locally, regionally or nationally?

Professional development should be encouraged with recognition of existing expertise. Some doctors may already have developed expertise in certain skills areas and are providing care already. Will there be a type of grandfathering clause introduced allowing current experience and service delivery to be registered on the LRMP?

Mental health, breast and cosmetic surgery are already highlighted as potential areas for credential development. It is important that credentialing is not used as a soft way to deliver regulation where regulation would be the better option but is currently not considered achievable.

Review of curricula should involve a wider scope of stakeholders than simply the Royal Colleges. Many membership societies, like the Association of Anaesthetists, are responsible for delivering much of the postgraduate education opportunities.

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The regulatory process
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.**

Association response:
Credentials should be subject to a rigorous and detailed sign off process similar to medical post-graduate training modules. Many postgraduate training schemes, anaesthesia included, already include optional units. The concern is that these 'extras' may become an additional expectation of trainees and increase the sense of an already over-burdened training programme thus adding to burnout. Strong checks and balances will be required if credentialing is not to develop into a box ticking exercise in the race to be competitive at job interview. Trainees should not be required / encouraged to seek credentialing.

Local service should be determining the needs for the service and championing local doctors to gain the necessary credentials. It would be a travesty if credentialing became a postgraduate pastime /hobby; and even more so if credentialing became a right-of-passage to more local discretionary points or clinical excellence awards.

Appraisal and revalidation should be sufficient for yearly review of credentials. Quality assurance processes will need to be transparent and logical. Pay progression should not be dependent on credentialling. Over-regulation may become a barrier to the uptake of this process.

Placing credentials on the register could be seen as a doubled-edged sword. On one side, until there is good, robust evidence that the system improves patient safety, it may not be appropriate to list on the specialist register but the information should be maintained centrally for requests if required. On the other side, if the training is completed and the criteria are met then the qualification should be published. It may be better if the GMC were to sign-up to evaluating the process after say 5 years and publishing the results ahead of a review of the process. Continuation of credentialing should be dependent upon results.

A phased approach to implementation
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.**

Association response:
Too much regulation will have damaging effects on recruitment and retention. It would be useful to know whether these credentials will be implemented as pilot projects in individual areas or a national roll-out.

Change management is important. Innovators and early adopters will not create the critical mass for adoption. Addressing the points raised in the consultation will provide the best opportunity for implementation. Emphasis on openness, transparency and shared decision- making will be important.

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Supporting flexibility in training in other ways. 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.**

Association response:

There are specialties, such as anaesthesia, where optional modules are already included in the curriculum. It would seem unnecessary, at present, to convert these to credentials. There is a risk of providing credentials for progressively smaller areas of practice, thereby increasing the administrative burden but not necessarily improving patient safety.

There is potential to endorse particular training modules, outside of the parent specialty, as post-graduate credentials to allow more flexibility among the workforce. Developing the wider use of multidisciplinary team approach to patient care may support credentialing. When a MDT makes a decision on treatment, the patient should be informed about the decision making process and be made aware of who will deliver that care.