Good doctors, safer patients

PMETB Response

November 2006

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Introduction

1. The publication of *Good doctors, safer patients* is a significant and important contribution to the development of better patient safety in the UK. The report's recommendations are far reaching and of interest to all of those who care about improving the safety of patients.
2. As the UK wide competent authority established to promote and develop postgraduate medical education (PME), the Board has spent a significant amount of time considering the report. The Board's response is principally focused on those issues that relate to the development of postgraduate medical education and how this might be regulated to ensure higher standards of patient safety.
3. In doing so, the Board is concerned to develop a model for regulating medical education that will serve both the long term and short term interests of patients.

PMETB and the regulation of postgraduate medical education

4. PMETB has made significant progress in its first year of operation, including:
   - Issuing over 4,000 Certificates of Completion of Training (CCTs) to doctors who have demonstrated that they meet PMETB's standards for inclusion on the Specialist and General Practice (GP) Registers.
   - Introducing a new system to assess the equivalence of doctors' qualifications, training and experience. This system sets consistent standards for the submission and assessment of equivalence applications, regardless of specialty, and permits those who have successfully demonstrated that they meet our standards to join the GP and Specialist Registers.
   - Conducting the first ever national survey of trainee doctors in partnership with the Conference of Postgraduate Medical Deans (COPMeD). Over 25,000 responses have been received and the analysis of data will give a unique insight into trainees' perceptions of their training.
   - Publishing the first ever set of generic training standards in April 2006, which cover all postgraduate specialist programmes beyond Foundation level. These standards will ensure a consistent and robust framework for all UK postgraduate medical training.
   - Developing the first ever generic set of standards which must be met by all Royal College and Faculties' training curricula. PMETB is currently reviewing the curricula across all 58 medical specialties that lead to the award of a CCT.
   - Establishing and initiating a deanery visits procedure. This process is a central component of our quality assurance process and allows us to ensure that standards are met. Seven deaneries have been visited so far, with a further 14 planned by June 2007.
   - Processing over 1,000 approval applications for new posts and programmes.

5. In its first five year strategic plan the Board has laid out an ambitious agenda which includes:
   - bringing patients, trainees and the service to the heart of our work, through the involvement of lay input into all of our decision making processes, undertaking the first ever UK wide survey of all trainee doctors and including service input into all of our work on curricula;
   - the completion of work to ensure curricula are agreed for every specialty which meet our curricula and assessment standards, in time for the commencement of run through training in August 2007;
   - the implementation of a radically different approach towards the quality assurance of postgraduate training moving away from one primarily driven by regular visiting to risk based data driven assessment, supplemented by visits and other sources of information;
   - work with postgraduate deaneries and medical Royal Colleges to ensure local quality management systems, which will enable local problem resolution wherever practicable;
   - the Board's ambition in 2008 to fundamentally re-examine the content and outcomes of all training to ensure fitness for purpose in line with the changing demands of patients, employers and trainers, and taking into account significant shifts in the training environment such as the European Working Time Directive and MMC (Modernising Medical Careers); and
   - steps to achieve financial self sufficiency by 2009/10.

Supporting the doctor as a professional

6. In the development of its strategy and policies the Board has been keen that its work should go beyond simply regulating postgraduate medical education. The Board seeks to make a contribution to the development of a modern understanding of professionalism within medicine. There is a significant and important debate on this subject, for example, the report of the Royal College of Physicians working group on medical professionalism[1], which seeks to define professionalism and PMETB is interested in how professionalism can be reinforced and developed through education. In taking forward *Good doctors, safer patients* the Board wishes that its contribution, and that of others, develops the concept of professionalism.

Capacity and change

7. If implemented in full the recommendations contained within the report would bring significant change to medical education regulation. The Board would need to consider carefully how to meet the issues of capacity that such change would bring.
8. However, the Board believes that issues of capacity are not an impediment to change. Indeed the progress the Board has made since 'going live' and its experience of organisational change could be advantageous. It would take a number of years for the recommendations to be implemented, which would provide time to put in place appropriate plans. Therefore the Board's response is not constrained by PMETB's current structure and function.

Regulation of medical education

9. The report recommends that undergraduate and postgraduate education should be brought together under one body. The role of the General Medical Council to set the content of the medical undergraduate curriculum and to inspect and approve medical schools would be transferred to a renamed (Postgraduate) Medical Education and Training Board. This recommendation has provoked considerable discussion which gets to the heart of effective regulation of medical education. The Board's response is focused on the function of medical education regulation rather than where the function is located.

The function of the medical education regulator

10. Regulating medical education is one of four regulatory functions, the others being: registration; standards setting; and ensuring fitness to practise. Each of these functions requires a different approach. There are different organisational and legal frameworks for these different functions.
11. Therefore the Board welcomes the report's acknowledgement that the functions of the education and training regulator are distinct from the other regulatory functions.
12. The role of the education regulator should be supportive and developmental. The regulator should take a long term view to ensure the right framework is in place to deliver competent doctors and aid their continued professional development. The education regulator should seek to ensure doctors are able to operationalise standards of medical practice.
13. To achieve this, medical education regulation should:
    - focus on the needs of patients, the service and trainees, and seek to command their respect;
    - be independent, accountable to Parliament;
    - be coherent and integrated across undergraduate education, postgraduate education and continuing professional development;
    - apply clear, transparent standards and principles to ensure public, employer and professional confidence;
    - pay due attention to the necessary curriculum content, processes and experience that are required to develop a trained doctor capable of independent practice;
    - ensure support for academic and research medicine which leads to potential future benefits;
    - provide leadership and promote education and training;
    - observe good regulatory practice;

[1] Royal College of Physicians *Doctors in society. Medical professionalism in a changing world* RCP 2005.

- be governed through structures which include a mix of medical and lay members which fairly represent stakeholders.

The establishment of a single regulator for education (Recommendation 19)

14. There are arguments to support a move to a single regulator that would integrate all levels of medical education, including continuing professional development, and would deliver the functions of the medical regulator.
15. These arguments include the benefits of a common set of standards and integrated regulatory and inspection systems across the whole of medical education and training; ensuring consistency through the entire continuum of training from medical school through to CPD; the ability to act in the long term and strategically across the spectrum of medical education; a single point of accountability to Parliament; and the ability to focus solely on education and training.
16. However, there are real and significant costs to bringing the existing bodies together, not least the potential loss of focus by both the GMC Education Committee and PMETB on their strategic aims during the process of establishing a single body. Furthermore there are strong working relationships between PMETB and the GMC with no significant boundary issues with the exception of the Foundation Programme and there would be a considerable financial cost to bringing the two bodies together.
17. Given the proposal to end the GMC's role in undergraduate education, the Board noted that there is no criticism of the GMC Education Committee in *Good doctors, safer patients* or suggestion that the Education Committee is not delivering effective regulation.
18. The Board notes that in the public debate following the publication of *Good doctors, safer patients*, there has been considerable discussion about the fragmentation of medical education regulation and greater cohesion under a single body.
19. This is an important debate and a significant factor in any discussion of the costs and benefits of bringing medical education regulation under one organisation. There may well be benefits to stronger coordination between regulators, particularly given the widespread view that further work should be undertaken on CPD.
20. A single education regulator will mean, in effect, a new body rather than an extension of PMETB as is suggested.
21. In deciding to go forward with Recommendation 19 all those concerned with medical education need to consider if the costs of change outweigh the benefits.

Financing a joint body

The Board acknowledges the discussion about the financing of any extension of the Board's role including the development of a joint medical education regulation body. However, financing issues need not be a significant restraint on change. There are a number of models for financing a joint body which would not be an additional overall burden on the taxpayer or doctors, one of which is suggested in the provisional costs note which accompanies the report. The Board acknowledges that this would need further consultation and debate. There is further consideration of funding issues towards the end of this document.

Shared standards setting (Recommendation 16)

22. PMETB supports, has adopted and is committed to Good Medical Practice (GMP) and recommends that these standards should be enforced and fully implemented as standards for generic medical practice.
23. The Board understands the argument for proposing a joint standards setting function between the education and training regulator and the standards regulator. However, in practice the current arrangements, which include a statutory duty on PMETB to work with the GMC, are effective providing the Board continues to be given full opportunity to comment.
24. It is not clear whether there is a significant benefit from joint standards setting – particularly given the model suggested in the report which sees the education regulator jointly developing standards with the GMC but for the GMC to adopt them. The education regulator, however constituted, should focus on ensuring the standards are reflected and reinforced through education and training.
25. Indeed PMETB believes that *Good doctors, safer patients* fails to give due recognition to the importance of GMP. The standards have been revised and, in the Board's view, improved. They have widespread support throughout medical practice and beyond.
26. Therefore fitness to practise and education standards should continue to have a common stem in the GMP with relevant standards derived from these to fit the specific context.
27. The work of PMETB to date demonstrates how this can be achieved. PMETB's standards for assessment of equivalence for application to the GP and Specialist Registers draw directly from GMP. So do our generic standards for training, which provide the basis for much of our quality management, including our curriculum approval process.

Specialty specific standards and revalidation (Recommendations 17 and 31)

28. PMETB sets standards for entry onto the Specialist register, both in specialties and sub specialties. These standards are distinct from standards for fitness to practice which might be applied to re-licensure or re-certification in a specialty context. However, PMETB's experience of setting specialty specific standards for education is relevant.

29. PMETB standards ensure doctors have completed a UK programme of specialist training or have proved equivalence. The standards suggested here should help employers to ensure doctors are fit for the role in which they are employed.

30. PMETB has established a close working relationship with the medical Royal Colleges and specialty associations to establish and then implement generic and specialist standards. Good examples of this joint work would be:

    - the development of specialty specific guidance in relation to equivalence work - specifically, the Articles 11 and 14 equivalence routes to the GP and Specialist Registers;
    - the application of generic standards for curricula and assessment to the new run through curricula for each specialty; and
    - more recently, through work to extend our generic training standards for all training to include specialty and specific standards.

31. This approach enables consistency across specialties and will help to maintain both patient safety and the confidence of the public, employers and the profession in the standards.

32. PMETB is of the view that the development of specialty specific standards should be undertaken against a common framework and common standards, overseen by the appropriate regulatory body.

33. The Board notes that Recommendation 17 does not make specific reference to emerging thinking on credentialing that includes training in areas of specialty and general practice medicine, which might be seen to constitute more than ongoing CPD but less than the acquisition of a new sub specialty or specialty.

34. Regulatory oversight should also apply to the development of credentialing, if such credentials are to take their place alongside existing formal qualification on a more informative medical register.

Revalidation (Recommendations 26 and 31)

35. PMETB supports a process of revalidation on a five yearly basis and welcomes the recommendation that this requires positive affirmation of a doctor's fitness to practise.

36. Given the debate above, PMETB would wish to assert the importance of the relevant regulator having oversight of both re-certification and re-licensure.

37. The method of re-certification must be as appropriate for those gaining entry on to the GP or Specialist Registers through the equivalence routes (PMETB Articles 11 and 14) as it is for those following the traditional training routes. It is important that the standards for newly accredited specialists and those for re-certification are clearly linked, of a similar level, and that the relationship between them is understandable to doctors, the public and employers.

38. The process which will typically rely upon membership of, or association with, the relevant Royal College must also be open to other specialist bodies.

39. The tools for assessing doctors against the standards may be different from those used in training to reflect the different clinical settings and the doctor's experience.

Local system for fitness to practise regulation and student registration (Recommendation 2-6; 23)

40. PMETB welcomes the concept of a local system for maintaining fitness to practise which should include the ability for trainees to raise concerns with senior members of staff and for staff to raise concerns about a trainee.

41. The Board accepts the need for local resolution wherever practicable but believes that the proposal to appoint GMC affiliates is only one option which should be considered alongside other suggestions. It could, for example, include an extension of the existing clinical governance system. PMETB would, in any case, support stronger links between medical directors and the regulators.

42. The local system of fitness to practise should include public and patient involvement.

43. PMETB draws a link between student registration and a local system for fitness to practise. Taken together, both should help student doctors understand their responsibilities under registration.

44. If adopted, student fitness to practise should not be regarded as an alternative to university systems for maintaining fitness to practise. Expectations of a student will develop as they move through the undergraduate curriculum towards becoming registered doctors.

National exam and English language testing (Recommendations 20, 21 and 22)

45. The report makes a number of recommendations about the oversight and development of a new national exam, English language test and PLAB.

46. PMETB oversees the regulation of postgraduate assessment and has developed principles of assessment. The education and training regulator – whether under the current arrangements or through a new body – should have a role in setting the standards and overseeing the quality of these tests. However, the education and training regulator should not be the provider.

47. In developing these tests, it is important that the assessment burden on students, trainees and those assessing them should be taken into account.

National examination

48. PMETB recognises the work already undertaken by the GMC on a national examination and asks that this be taken into account. However, it is important that those leaving medical schools reach a standard which is consistent across all medical schools. This standard may not necessarily be assessed in a similar manner and the role and content of medical final examinations may need to be re-examined. In response to the GMC consultation in early 2006 the majority of respondents, particularly the medical schools and educationalists, indicated support for some sort of shared database of questions or assessment tools and it should be possible to develop this working alongside medical schools in a manner which does not stifle creativity within curricula.

Language skills

49. There is a significant problem with communications skills in doctors of all grades which is not limited to language skills. Much more careful adherence to the standards inherent in the revised version of GMP would be crucial in tackling the wider problem of poor communications and failure to work in partnership with patients.

Accredited English language test

50. The report proposes that doctors should be checked as having completed an accredited English language test. The Board believes that this proposal should not be limited to those contracting to provide services to NHS patients as is suggested in the report. In principle it should apply across the whole provision of medical services.

An independent organisation for designing and commissioning 360 degree feedback (Recommendation 30)

51. PMETB can see value in the establishment of a national independent organisation which would design and commission appraisal tools. However, there may be other methodologies other than 360 degree assessment that this body might wish to develop.

52. PMETB is mindful of the work already suggested by MMC to develop a national assessment centre. PMETB's Principles of Assessment will help provide a framework for the new organisation. The education and training regulator should have regulatory oversight.

Remediation and rehabilitation (Recommendation 32)

53. The appropriate regulator should have oversight of any action to be taken depending on the reasons for failure. In cases of educational failure the education and training regulator should determine the standards for discontinuation or tailored plans for remediation.

Medical and other registers (Recommendations 38-41)

54. In principle PMETB supports the inclusion of additional information on the registers. PMETB supports the recommendation to have a single registration list. The register should have useful information (for public and service access) with due regard for protecting individual information, for example, ensuring private individual information is protected from Freedom of Information (FOI) requests.

55. The level of education and training should be included for the individual on the register and be relevant for revalidation. For the information to be useful, users of the list will need to understand what standards have been applied. This is particularly important given the discussion above on the development of credentialing.

56. The education and training regulator should have access to the private tier of personal information to assist with its function, such as maintaining the equivalence routes to what is currently the Specialist Register and the checking of personal details on an application for a CCT.

Structure of the GMC

57. In considering the governance of any of the medical regulation functions the Board values a mix of medical members and those representing a wide set of stakeholders and lay members in a manner which avoids dominance by any particular group.

58. The report could be an opportunity to review PMETB's own governance arrangements, which in some respects confuse representation with the requirements of good governance. PMETB's existing governance arrangements are also overly prescriptive on structural matters which should be for the Board to determine in accordance with its statutory functions. PMETB will be interested in the proposed new model for accountability to Parliament which is to be developed for the GMC.

Funding

59. An appendix to *Good doctors, safer patients* includes provisional costings. Any expenditure on medical education regulation will have UK wide implications.

60. The most significant cost would be the financing of a single education and training regulator. The Board would like to understand more about the costs involved in both establishing a single regulator and the ongoing operational costs.

61. However, given adequate scope for adjustment of existing charging and fee structures, PMETB sees no reason why the overall cost of regulation in relation to education and training should be increased by these proposals. Indeed it is likely that, over time, economies of scale would be achieved through shared processes and a reduction in duplication, particularly in respect of the relationship between the Foundation Programme and specialist training.

62. There are a number of models for financing this joint body which would not be an additional overall burden on the taxpayer or doctors, one of which is suggested in the provisional costs note which accompanies the report. However, these proposals would need further consultation and debate.

63. It should be noted that PMETB is currently developing a self funding business model for its current work which will enable it to meet over 50% of its costs directly in 2007/8 and 100% by 2009/10. This model could be equally valid for a single medical education regulator. Details of the principles of this model are set out at Appendix A.

Conclusion

64. The publication of *Good doctors, safer patients* is a significant and important contribution to the development of the UK's system for regulating doctors. The report's recommendations are far reaching and of interest to all of those who care about improving the safety of patients.

65. PMETB has focused its response on those issues which relate to medical education and training; however, this is just one aspect of a comprehensive report. The Board recognises that the proposals in *Good doctors, safer patients* are complex and will take time to implement. Furthermore, as the report acknowledges, there will be significant additional costs associated with many of the recommendations. To ensure the confidence of patients, the public, doctors and employers, the new regulatory framework must demonstrably improve the safety of patients.

Appendix A

Financing the Board: principles

1. PMETB must achieve financial independence to be an independent standard setter for postgraduate medical education.

2. Income must enable PMETB properly to fulfil its statutory duties, in particular it must ensure not only that we set and maintain standards and ensure quality, but develop and promote postgraduate medical education.

3. We should aim to achieve the principle of *beneficiary pays*. The approach and fees charged must be fair to all categories of fee payers based on what we currently know of costs. As such, any differential in fees should be solely on additional costs which can be directly attributed to an activity. As part of this we should aim for equivalent treatment of specialist medicine and general practice.

4. The fees for certification or equivalence include our work in standard setting, maintaining standards and the development and promotion of postgraduate medical education from which all those who gain entry to the Specialist or GP Registers benefit.

5. The right to appeal is an integral part of our certification work and the fee rate for appeals must be set at a level which does not make this too onerous. However, PMETB should seek an arrangement with government to meet the potential cost of liabilities arising from appeals to obviate the need for excessive reserves.

6. Income levels should be sufficient to ensure the financial viability of PMETB as an independent organisation which will require a prudent level of reserves.

PMETB Fees Consultation: 2005

Appendix B

Healthcare Professional Regulation: public consultation on proposals for change

PMETB has principally responded to those issues that relate to medical education. To aid those comparing and analysing responses PMETB's response is mapped to the 11 themes in the consultation questionnaire.

11 common themes

Changes to the governance and accountability of regulators
- Paragraph 13
- Paragraphs 57-58

The importance of defined operationalised standards against which to regulate
- Paragraphs 22-39

The appropriate standard of proof
- PMETB has not commented

Proposals for a 'spectrum of revalidation' across all healthcare professions
- PMETB has not commented

Devolution of some regulatory activity to a local level
- Paragraphs 40-44

The number of regulators for the non-medical professions
- PMETB has not commented

The requirement to record post-registration qualifications
- Paragraphs 32-34

The role of regulation for student healthcare professionals
- Paragraphs 40-44

The need for standardised pre-employment English language testing
- Paragraphs 45-50

Extending the scope of regulation to include healthcare support workers and new roles in healthcare
- PMETB has not commented

The importance, or otherwise, of a lay majority on the governing bodies of the various regulators
- Paragraph 13
- Paragraph 58

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