



Response to the

Modernising Medical Careers (MMC)

Inquiry

July 2007

Introduction

The Postgraduate Medical Education and Training Board is pleased to be given the opportunity to provide written evidence to the MMC Inquiry. This submission focuses on explaining our role in postgraduate medical education and training. PMETB has already made available to the Inquiry documentation relating to our interaction with Modernising Medical Careers and the Medical Training Application Service.

About PMETB

The Postgraduate Medical Education and Training Board (PMETB) was established by the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 (the Order) to develop a single, unifying framework for postgraduate medical education and training. It began operations on 30 September 2005, subsuming the responsibilities of the Specialist Training Authority of the Medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP). The Board reports to Parliament through the Secretary of State for Health and acts independently of the Government as the UK competent authority.

The Board's statutory remit is to oversee the content and standards of postgraduate medical education and training (PMET) across the UK. The Order sets out the legal framework for its operation.

PMETB's statutory responsibilities

The principal functions of the Board and illustrations of its activities are as follows:

- To establish standards of, and requirements relating to, postgraduate medical education and training
- To secure the maintenance of the standards and requirements established
- To develop and promote postgraduate medical education and training in the United Kingdom.

The main statutory objectives of the Board in exercising its functions are to:

- safeguard service users
- ensure that the needs of those undertaking education and training are met
- ensure that the needs of the employers are met.

PMETB's remit does not extend to:

- undergraduate education
- recruitment and selection in postgraduate medical education training (including the application process and scoring system) other than determining the standards to be reached by doctors to enter specialist training
- workforce planning
- determining or setting the number of training posts.

The development of an independent postgraduate medical education and training regulator

The move to establish an independent regulator for PMET has a long history. Recurring themes in reports and debates that examine postgraduate medical education and training include the need for clear standards, and to ensure input from patients and the health service into PMET.

In 1975, the *Merrison Report*¹ concluded that PMET was in need of a regulatory framework. The Committee found that neither the Royal Colleges or the then Postgraduate Councils nor the NHS, had control of overall standards. The Report recommended that the General Medical Council (GMC) undertake this role in addition to its existing responsibilities for undergraduate and pre-registration training, and should hold a register of specialists and GPs. This recommendation was not put into effect.

The *Calman Report* of 1993² recommended that legislation should be enacted introducing the UK Certificate of Completion of Specialist Training (CCST) - awarded by the GMC to trained specialists on the advice from the appropriate Medical Royal College - thus ensuring consistency with EC law. Holders of CCSTs or EU equivalents could then have this reflected on the Medical Register. The report also recommended that medical Royal Colleges and Faculties should set standards in medical education, but that greater cooperation between bodies was required. It argued that the NHS management and Postgraduate Deans had a legitimate interest in training.

The April 1995 consultation paper³, which followed the Calman report, proposed that the statutory arrangements in relation to training requirements should be adjusted to reflect practice at the time – the medical Royal Colleges and Faculties having responsibility for the content and standards of training in their specialties. It was, therefore, suggested that all functions listed in the Medical Directive relating to specialist medical training be assigned to a new body comprising representatives of all the UK Medical Royal Colleges, called the “Council of Medical Royal Colleges” or the “new College Council” (later to become the STA), which would be the UK competent authority. The GMC would still be issuing CCSTs on receipt of appropriate information from the new College Council.

*The European Specialist Medical Qualifications Order (1995)*⁴ created the Specialist Training Authority of the medical Royal Colleges (and the Specialist Register held by the GMC). The legislation gave the Authority

¹HM Stationery Office *Report of the Committee of Inquiry into the Regulation of the Medical Profession* (1975)

² Department of Health *Hospital Doctors: Training for the Future. The Report of the Working Group on Specialist Medical Training* (1993)

³ Department of Health *Hospital Doctors: Training for the Future. Proposals for Implementing Legislation “The Specialist Medical Order”* (1995)

⁴ *The European Specialist Medical Qualifications Order Statutory Instrument No. 3208* (1995)

the statutory responsibility for specialist training, and defined a predominantly profession-based membership. General Practice training was overseen by the Joint Committee on Postgraduate Training for General Practice.

In 2000, the *NHS Plan*⁵ called for a joint regulator for both specialist and general practitioner training, called the Medical Education Standards Board (MESB), with membership drawn from the profession, the NHS and the public.

The *Bristol Inquiry*⁶ of 2001 called for more public involvement in all healthcare regulatory functions, and recommended that postgraduate medical education should be regulated by the GMC, as undergraduate medical education had been for many years.

Later in 2001, the Government consulted on the proposed creation of the Medical Education Standards Board⁷ (later to become PMETB). The consultation document set out the argument in favour of an independent overarching regulator of postgraduate medical training, with due public and NHS representation and influence. The document says:

Decisions about PGME have substantial impact on NHS services, but the PGME system currently has little or no input from the NHS or patients. It has grown up piecemeal, and does not have a single authoritative body to ensure consistent standards across the United Kingdom.

It goes on to say:

The Royal College representatives form the dominating majority of members of the STA. Acting in concert as the STA, they therefore approve the standards and examinations they offer individually as Colleges. As a result, individual Colleges and Faculties are effectively free to make decisions about curricula and training approval for their respective specialties. However, the growing awareness of the need to ensure that decisions taken about PGME do not adversely affect the provision of NHS services means that training systems now need to reflect the views of the NHS and patients working alongside the medical profession.

It was suggested that the Board remain separate from the GMC. As a consequence of the consultation, the Board was renamed the Postgraduate Medical Education and Training Board (PMETB) to better describe its remit.

⁵ Department of Health *The NHS Plan. A plan for investment, a plan for reform* (2000)

⁶ The Stationery Office *The Bristol Royal Infirmary Inquiry Final Report* (2001)

⁷ Department of Health, *Postgraduate Medical Education and Training: The Medical Education Standards Board, A Paper for Consultation* (2001)

The 2002 consultation paper *Unfinished Business*⁸ sets out the case for reform of the Senior House Officer training grade. The paper emphasised the importance of a new framework to "...publish programme curricula, ensure a coherent approach to setting standards and managing delivery of training... ensure a consistent and valid approach to assessment, place a strong emphasis on quality assurance of training...". The document concluded that "...a new Postgraduate Medical Education and Training Board will be required to ensure that, throughout training, all assessments and examinations... are appropriate, valid and reliable."

The legislation⁹ creating PMETB was made in 2003 and the Board assumed its statutory responsibilities on 30 September 2005.

The proposals in the Chief Medical Officer for England's Report *Good Doctors, Safer Patients*¹⁰, issued in July 2006 in light of *The Shipman Inquiry: fifth report*¹¹, included transferring the responsibility for undergraduate medical education from the GMC to PMETB for greater consistency across the continuum of medical education. Sir Liam subsequently acknowledged publicly that his key aim was to place responsibility for all medical education and training 'under one roof' whether that be the GMC or PMETB.

The future organisation of medical education and training regulation

This issue of which body was best equipped to regulate medical education and training was debated at length following the publication of the CMO's report, with little support for, and widespread opposition to, moving the regulation of undergraduate medical education from the GMC. In response¹², published in February 2007, the Government rejected any early move to amalgamate the GMC and PMETB. The Government's reasons were:

- First, the proposed wide-ranging reforms to the GMC will be a significant challenge for the regulator to manage while continuing to exercise its core functions.
- Second, PMETB is a relatively new organisation, which, after a difficult start, is beginning to consolidate its performance.

⁸ Department of Health *Unfinished Business, Proposals for reform of the Senior House Officer grade. A report by Sir Liam Donaldson, Chief Medical Officer for England* (2002)

⁹ The General and Specialist Medical Practice (Education, Training and Qualifications) Order (2003)

¹⁰ Department of Health *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients* (2006)

¹¹ HMSO *The Shipman Inquiry: fifth report. Safeguarding patients: lessons from the past – proposals for the future.* (2004)

¹² Department of Health *Trust Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (2007)

- With PMETB engaged in a major programme of work, it is important too that it also has a period of relative stability to enable it to focus on its core tasks.

The Government agreed with the proposal, set out by the GMC for a three-board model covering undergraduate education, postgraduate education and continuing professional development . PMETB is to remain a separate legal entity. The Government will review the effectiveness of these arrangements in 2011 to establish whether any further integration of postgraduate medical education would be desirable.

Progress since PMETB took up its statutory responsibilities

PMETB has made significant progress since it assumed its statutory functions in September 2005.

Whilst the transition to an overarching regulator, with new powers and responsibilities, has caused tensions - particularly with some of the medical Royal Colleges and Faculties - the Board has a considerable record of achievement.

Key achievements

In less than two years PMETB has achieved much:

Publishing the first-ever generic standards for postgraduate training across all medical specialties: bringing consistency and greater transparency to the postgraduate training of doctors. The standards include a patient safety domain.

Approving curricula for all 57 specialties, plus 30 subspecialties, against new standards for curricula drawn up by PMETB. When the Board assumed its statutory powers in 2005, fewer than half of the specialties in the UK had a defined curriculum.

Ensuring that, across all our work, there has been input from lay and service representatives. For example, seeking input from the service through NHS Employers and National Education for Scotland on the curricula as part of our approval process.

Working to ensure assessments are fit for their educational purpose by undertaking a rigorous process of testing against PMETB's principles.

Ensuring clear career pathways for those wishing to pursue a career in academic medicine. PMETB has encouraged and approved curricula that have generic academic competencies.

Undertaking the first-ever national survey of postgraduate medical trainees. The first survey, in 2006, organised with the support of COPMED, attracted nearly 25,000 usable responses – a 64 per cent response rate.

Issuing over 7,500 CCTs in all specialties (including General Practice) since we went live in September 2005.

Developing and introducing new equivalence routes to specialist registration. Prior to the Board's establishment there were limited pathways for doctors who had not followed a traditional training programme to join the specialist or GP registers. Consequently, their career development opportunities were limited.

Establishing a major project examining the content and outcomes of specialty training.

Curricula

PMETB has worked closely with the medical Royal Colleges and the Speciality Associations to approve the curricula for all 57 medical specialties, plus 30 subspecialties. They are approved against standards for curricula that have been widely accepted. The Board seeks a wide range of opinions on the curricula before approval – including service and deanery representatives. Approved curricula are published on PMETB's website.

The process of approval against published standards is important in ensuring clarity and transparency for trainees, trainers and patients. Prior to PMETB's establishment, the presentation and detail of curricula varied greatly and were clearly defined in less than half the cases.

Assessment systems

In addition to approving curricula, PMETB has put in place a process for approving assessments against PMETB's principles. medical Royal Colleges and Faculties strongly indicated that they would require some time to meet all of these principles. PMETB has therefore required that all principles must be met by 2010, while the following must be met by August 2007:

Principle 1 The assessment system must be fit for a range of purposes.

Principle 2 The content of the assessment will be based on curricula for postgraduate training, which themselves are referenced to all of the areas of the GMC's core guidance, *Good Medical Practice*.

Principle 5 Relevant feedback must be available.

By undertaking this process we are able to provide reassurance to trainees, patients and health service employers that assessments are fit for purpose.

To support this work, PMETB has trained 102 people to join the assessment panels: medical members from Colleges and Faculties, lay members and trainees.

So far, three assessment systems have been approved without conditions, three with conditions, and three have been returned to Colleges for re-submission. This process will be complete by August 2007.

Support in development of academic careers

PMETB as a regulator recognised the important role it can play in supporting academic careers. For example, the Board has worked with the Academic Careers Sub-committee of Modernising Medical Careers and UK Clinical Research Collaboration to contribute to the "Walport" report, designing the Integrated Academic Pathway.

Additionally, the Board encouraged the medical Royal Colleges and Faculties to ensure that generic academic competencies, including research awareness and education, are built into all PME curricula. PMETB's Training Committee has demonstrated a supportive approach to the approval of new posts and programmes for academic pathways. We have approved 104 posts – 74 academic clinical fellowships and 30 clinical lectureship posts, with 10 more in progress.

PMETB recognises the value that can be obtained by a period of training or research overseas, and the Order specifically empowers the Board to approve such training, provided it can be shown that it forms part of the doctor's overall clinical and/or research training.

Competence and excellence

All doctors must be competent, that is, properly qualified, to do what they purport to do. The public, employers and, above all, the profession itself, would be incredulous if a medical professional were to claim otherwise.

However, the requirement to be competent should not in any way undermine the pursuit of excellence which has been a feature of the culture of medicine for centuries. PMETB requires that curricula make clear the knowledge, skills, behaviours and attitudes that must be demonstrated before a CCT can be awarded. The Board would fail in its duty to the public and to trainees if it did not do so. This is no different to the undergraduate medical curriculum where the GMC has, for many years, required that everyone receiving a primary medical qualification has a basic minimum level of knowledge and skills. Yet that requirement has not diminished the pursuit of excellence by medical schools and their students; nor should it in postgraduate medical education and training.

PMETB and the quality assurance of postgraduate medical education and training

The quality assurance system that preceded the Board's inception was based around hospital inspection visits. Some 800 such visits took place each year. In the lead-up to assuming its statutory powers, PMETB reviewed the previous arrangements for quality assurance through a working group under the chairmanship of Professor Dame Carol Black. The working group considered the pre-existing arrangements in the context both of the approaches taken in other, similar countries and current best practice. It recommended a rigorous and robust quality assurance process that is guided by the *Principles of Good Regulation* and the concept of risk, and takes into account all those with a major interest. The working group also recommended that Postgraduate Deans should be held accountable for the quality management of postgraduate medical training and education in their area. Visits are still central to PMETB's approach, but are not the only source of information and public reassurance.

Trainee surveys

To ensure that PMETB can see the full picture of postgraduate medical education and training in the UK, the Board has initiated national surveys of doctors in training. Surveys measure trainees' perceptions of their training provider's compliance with our generic standards for training.

The surveys are used as screening tools to identify areas where trainees perceive weaknesses in their training. In turn, deaneries use the data to draw up action plans. The first survey, in 2006, organised with the support of COPMED, attracted nearly 25,000 usable responses – a 64 per cent response rate. Subsequent surveys will take into account the views of both trainees and trainers.

Deanery-wide visits

PMETB ensures that its standards for training are being met by deaneries across the UK, through a programme of deanery-wide cross-specialty visits. Those visits evaluate training programmes in a range of specialties for that deanery. Each visit has a similar pattern and lasts four days, but with additional time for preparatory and follow up work. This cycle of visits started in April 2006 and was completed in July 2007.

This approach has provided a useful benchmark for assessing quality management at both local and national level, and has enabled more recent visits to focus on areas of concern.

There have been many examples of good practice within each deanery and/or the specialty programmes that could be emulated elsewhere. Visit reports are published to give reassurance to the public and help disseminate good practice.

Overall, the cycle has identified that there are improvements that can be made to the provision of quality assurance and deanery quality management systems.

Triggered visits

To supplement the regular visits process, PMETB has also developed a triggered visits process. This enables PMETB to respond to concerns that there may be serious educational failure needing prompt investigation, and action, particularly concerns which have not been addressed locally, either adequately or at all. Examples are serious and persistent lack of supervision; trainees persistently being required to take on tasks for which they are not competent; and lack of opportunity for trainees to learn new skills.

Triggered visits are arranged by PMETB in partnership with a deanery, medical Royal College, or others with training expertise. PMETB has had 13 requests for triggered visits. Nine of those were resolved once we expressed our concern, without the need for a visit to take place, and three were resolved very rapidly following our visit. One is currently ongoing.

PMETB's future Quality Assurance Framework

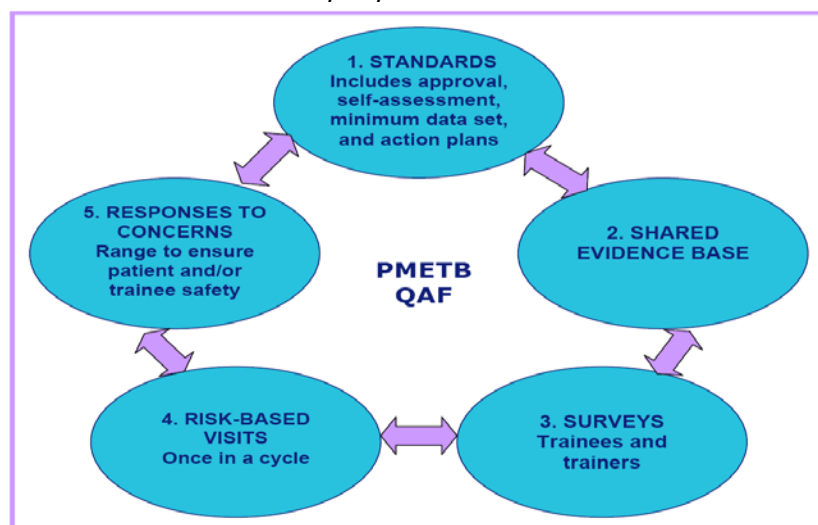
PMETB is currently consulting on the proposed Quality Assurance Framework (QAF), which brings together a range of tools into a new integrated QA framework.

PMETB aims to develop a framework that tests, verifies and improves the local quality management processes and outcomes at postgraduate deanery level. The framework will:

- provide public and professional reassurance about the standards and quality of postgraduate medical education and training in the UK, through a robust, rigorous set of processes;
- reflect fully the principles of better regulation, demonstrate value for money and be fit for purpose;
- enable improvement and enhancement of the quality of postgraduate medical education and training;
- ensure a specialty focus is maintained at local and national level by working with the Academy of Medical Royal Colleges, Colleges/Faculties and postgraduate deaneries.

The QAF consists of five inter-related elements, which will provide a comprehensive, evidence-based system for quality assurance and evaluation.

PMETB's proposed future QAF



Further details of our proposed framework can be found in the document *The PMETB Quality Assurance Framework*.¹³

¹³ <http://www.pmetb.org.uk/qaconsultation>

Certification: Maintaining the standards of applications to the specialist and general practice registers

PMETB operates a number of routes to specialist registration.

Certificate of Completion of Training (CCT)

Those doctors who successfully complete postgraduate training prospectively approved by PMETB are awarded a Certificate of Completion of Training (CCT) enabling their entry to the specialist or GP registers. PMETB has issued 7,658 CCTs across 57 different specialties through this route, a result of collaboration with our partners.

Equivalence routes to specialist registration

The legislation that established PMETB introduced a number of new routes to specialist registration, including the opportunity for doctors who have not followed a traditional training programme, but who may have gained the same level of skills and knowledge as CCT holders through training and experience, to enter the Specialist and General Practice Register. Prior to the Board's establishment, there were only very limited ways for these doctors to join the Specialist Register, with consequent limitations to their career development.

Putting in place a framework for establishing equivalence is complex. There are major implications for patient safety and doctors' careers, which require due rigour. Operating the new equivalence routes has proved to be a significant challenge for PMETB, and for some of the medical Royal Colleges who assess applications and make recommendations to the Board. PMETB has assessed over 1000 CESR applications alone since September 2005.

Postgraduate medical curricula in the future

Having reached a position where all 57 specialties have a defined curriculum, PMETB has now embarked on a wide-ranging consultation on the content and outcomes of specialist training for the future. This is an exciting and important programme of work that is of enormous significance to trainees and the service.

The arrival of an overarching regulator has already facilitated innovation from some specialties – e.g. proposals from vascular surgeons and vascular radiologists for training programmes to provide specialists with both surgical and interventional radiological skills, reflecting the realities of contemporary practice.

In addition to ideas of this kind, we wish to encourage a fundamental re-evaluation of the content of all curricula. This will provide an opportunity for Colleges and Specialty Associations to reassess their curricula – e.g. in comparison with international developments; for trainees and recently qualified specialists to express views on the appropriateness of the content of their training; for the service to define its needs – which will be highly varied; and for patients and the public to clarify their expectations.

We are undertaking research to provide the Board with a detailed understanding of the current and likely future issues in postgraduate medical education. We will seek to develop an understanding of trends and challenges facing the medical profession in the future. During the first stage, four work streams, engaging with patient groups, trainees and the service, have been established to analyse and debate the current issues and trends, and to build consensus and recommend the way forward. As part of the review and in order to widen the pool of views, PMETB hosted a conference in May of this year titled *'What does the future hold? Preparing doctors for tomorrow'*.

A number of common themes have already emerged from the initial work. Of greatest interest to the Inquiry will be the widely expressed view that postgraduate training is too inflexible. Trainees have expressed concern about the rigidity of run-through training both in structure and the ability to change specialities. Service representatives have expressed concerns that the current structure of curricula may be over rigid for the future. It is worth noting that many of the new curricula, which PMETB has approved for run through training, have core elements in the early years that are common to a number of specialties, followed by speciality specific elements. This structure may lend itself to some measure of greater flexibility, but this whole issue of flexibility requires further evaluation. It has to be remembered that in the past there has been little flexibility once specialist registrar training has begun. The flexibility has largely been in the ability to experience different specialties before embarking on training at specialist registrar level.

PMETB and MMC

There has been a good deal of confusion about the respective roles of PMETB and MMC, not least because they were established at much the same time. However, PMETB and MMC are quite different. PMETB is the UK competent authority discharging functions required under EC law whilst MMC is a project aimed at making changes to the delivery of medical education and training.

Indeed, even if MMC ceased to exist, PMETB would have a statutory duty to implement standards for postgraduate medical education.

The different nature and responsibilities of PMETB and MMC are shown below:

PMETB	MMC
Statutory	Non-statutory
Accountable to Parliament	Accountable to the four Departments of Health
Determines standards of postgraduate medical education	Determines the career pathways of postgraduate medical education
UK-wide	Four separate programmes

PMETB statutory powers in relation to Medical Training Application Service

The Order establishing PMETB sets out the Board's statutory functions. Under paragraph 4(4)(a), PMETB's function is to establish "the standards required for entry to training". The precise use of words, taken together with context, allows only one reasonable interpretation of this function, which is that PMETB must determine the standards that a doctor must have achieved in order to enter specialist training. Candidates who meet those standards are eligible for consideration for training, and candidates who do not meet the standards cannot enter training at all.

PMETB's statutory remit in matters of selection for specialist training is limited to determining that the selection process can identify those who are eligible to undertake it. PMETB does not have statutory powers over any other aspect of the selection process, including the methods used to select between eligible candidates.

Under its general powers, PMETB can give guidance and set principles across the range of its work. The Board has done so in regard to entry to specialist training but that guidance and those principles do not have statutory force and non compliance, by itself, cannot be a basis for withdrawing training approval.

Conclusion

It is less than two years since PMETB assumed its statutory functions. Any organisation would expect to take time to establish itself, and PMETB is no exception. However, the brief period of PMETB's existence has been marked by considerable challenges and potential for change in both medical education specifically, and medical regulation more generally. PMETB's achievements should be seen in that context.

While PMETB has been establishing itself, the medical Royal Colleges have had challenges of their own, adapting to a new world of external oversight of their activities.

However, PMETB and the medical Royal Colleges have a common goal, which is excellence in postgraduate medical education and training for the benefit of patients and trainees. We must achieve that goal in a social environment that has changed greatly in recent years, not only in the UK but in all comparable countries. It is an environment where doctors still – rightly – command enormous respect and trust. But it is also an environment where there is an expectation that all must be externally accountable for their actions.