



Postgraduate Medical Education and Training Board

## **PMETB Fees Consultation: December 2005**

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## PMETB Fees Consultation: December 2005

### EXECUTIVE SUMMARY

This consultation document provides the rationale for the proposed changes to the fees charged by PMETB from 1<sup>st</sup> April 2006 to 31<sup>st</sup> March 2007. It complements the proposed fees rules.

In the document we set out the legal context, a summary of our work to date and the ambitions, and costs, of the five year strategy we have published for our future work. Our strategy reflects the role we see PMETB occupying as a leader *in* and a champion *of* postgraduate medical education in keeping with our statutory obligation to *develop and promote* postgraduate medical education. It also sets out why we believe the proper fulfillment of our statutory role is particularly crucial at the current time. The income we receive from fees and elsewhere will enable us to realise this strategy to the benefit of trainees, patients and the NHS.

The year 2006/07 will be our first full working year, and the real cost of our work evident for the first time. Our current fee level is only possible because of the considerable financial support provided by government. The Departments of Health have said that, whilst they will continue to fund our work, as an independent authority they expect us to be financially self-supporting. Their grants will therefore be on a reducing scale. It is our policy too that we should be financially independent. Fees are the only way in which we can meet that difference.

The fee proposals which we make are based on a set of important principles:

1. PMETB must achieve financial independence to be an independent standard setter for postgraduate medical education.
2. Income must enable PMETB properly to fulfill 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.

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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 General Practice 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.

Applying these principles the proposed fee rates are:

	Proposed Fees from 1 <sup>st</sup> April 2006 to 31 <sup>st</sup> March 2007	Current Fees from 30 <sup>th</sup> September 2005 To 31 <sup>st</sup> March 2006
CCT Application	£750	£250
Article 11/14 Application	£1,250	£700
Appeal – written	£1,400	£1,000
Appeal – oral	£2,100	£1,500

The fee proposals are based on the best forecasts we can make at the current time with only two months operational experience. As such we are committed to reviewing our assumptions in the light of experience and the principles we propose above. Our hope is that we will not require further substantial changes in the next two to three years but we will consult again should this be necessary.

The consultation seeks comments from a wide range of bodies and individuals by 13<sup>th</sup> January 2006 on:

1. The principles which have underpinned our proposals.
2. The fees proposals.
3. The proposed future approach to revising the fee structure.

Finally the paper includes additional sections on the other financial options which we considered in making these proposals and answers to some of the questions the consultation might raise. Annexes are attached which include further detail on our five year strategy, on specific fees and a glossary of terms.

## 1. Introduction

1.1. PMETB assumed its statutory responsibilities on the 30<sup>th</sup> September 2005. In this consultation we:

- **Set out the legislative context.**
- **Outline some of our work to date.**
- **Outline our five year strategy (2006-2010) to meet our statutory obligations** laid out in the General and Special Medical Practice (Education and Qualifications) Order 2003\* (“the Order”) The strategy was published on the 11<sup>th</sup> October 2005. We have already begun work on aspects of it but it will be fully implemented from 1<sup>st</sup> April 2006.
- **Establish the costs** of realising that strategy and the **income streams** which we are able to consider.
- **Outline the principles** which we propose to apply in meeting these costs.
- Based on these we set out our **proposed fee scales**, including a summary of the financial options we have considered.
- Finally we address some of the questions which we think this consultation may raise.

## 2. Legislative context.

2.1. Under the Order (Article 3(2)), the principal functions of the Board are:

*“(a) to establish standards of, and requirements relating to, postgraduate medical education and training;*

*(b) to secure the maintenance of the standards and requirements established under sub-paragraph (a); and*

*(c) to develop and promote postgraduate medical education and training in the United Kingdom.”*

2.2. The Order also sets out (in Article 3(4)) what the main objectives of the Board shall be in carrying out its functions:

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\* Statutory Instrument 2003 No 1250

*“(a) to safeguard the health and well-being of persons using or needing the services of general practitioners or specialists;*

*(b) to ensure that the needs of persons undertaking postgraduate medical education and training in each of the countries of the United Kingdom are met by the standards it establishes ....*

*(c) to ensure that the needs of employers and those engaging the services of general practitioners and specialists within the National Health Service<sup>1</sup> are met by the standards it establishes ....”*

2.3. In addition to these statutory functions PMETB is the competent authority for approving the specialist training of doctors and certifying that doctors have achieved the standards and requirements which enable them to be included in the Specialist Register and the future Register of General Practitioners maintained by the General Medical Council (GMC). PMETB took over these functions from the Specialist Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP) on 30 September 2005.

2.4. Article 24 of the Order reads:

**“Fees**

*(1) The Board....may ....charge reasonable fees to cover the cost of providing services in the course of the performance of any of its functions under or by virtue of this Order.*

*(2) The Board ....may ....set those fees at levels such that the fees also cover the cost of such of its overheads as are reasonably attributable to the performance of its functions under or by virtue of this Order, but the fees must not include any element of profit.*

*(3) The fee charged by the Board ..... for any particular service must not include more than a reasonable proportion of the total cost of its overheads referred to in paragraph (2).*

*(4) .....*

*(5) If the Board .....charges any fee in accordance with paragraph (1), it shall specify the amount of the fee in rules.”*

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<sup>1</sup> In the context of this document we have taken ‘NHS’ to include provision which is currently met by the private and independent sector.

### 3. Realising the benefits of PMETB: early work.

#### 3.1. PMETB will seek to bring the following benefits:

- Better trained GPs and specialists
- Strategic leadership to the direction, development and delivery of postgraduate medical education, seeking to make it more responsive to the needs of an evolving NHS
- Improved standards in the quality, monitoring and delivery of postgraduate medical education
- Closer involvement of patients and the public in the development of the skills and training required by doctors in modern health care.

3.2. The benefits of PMETB are clearly spelled out in the Order and can already be seen practically in the work we have undertaken on setting standards for curricula, standards for assessment, criteria for entry to the Specialist Register and the generic standards which we will work to achieve consistency across all specialties including general practice. Medical Royal Colleges are currently working to achieve the standards for curricula and assessment by the end of 2006, for example, the RCGP and College of Psychiatrists have already developed new curricula. Our early work on principles and standards for assessment has been followed up with detailed work on postgraduate examinations and workplace based assessment, including the publication of a practical paper on the implementation of workplace based assessment which we expect to have a significant impact on future training and the RITA process. The value of our early standard setting work is already being recognized: for example, one forthcoming College journal article notes: *'PMETB Standards and Principles are educationally sound, sensible and achievable, and meeting them will undoubtedly lead to substantial improvements in curricula and examinations'*.

3.3. Currently we are developing entry standards for postgraduate medical education which will apply to training following the Foundation Programme. These will be finalised in 2006 and will affect all trainees. In the future we will develop new standards for all educational supervisors and for postgraduate deanery procedures for the quality control of training.

3.4. For the period from the 30<sup>th</sup> September 2005 to the 31<sup>st</sup> March 2006 we have developed a transitional regime for quality assurance that applies, for the first time, across the UK and to all aspects of postgraduate

medical education. Planning for the longer term we recently completed consultation on a very different approach towards the quality assurance of training in the UK, building on the best of the work currently undertaken by Colleges and postgraduate deans but aiming to achieve a more consistent approach across all training programmes.

- 3.5. In particular we will take a risk based approach ensuring that we target inspection work where it is needed the most. It will be complemented by a comprehensive survey of trainees, trainers and education managers.
- 3.6. In time this will enable us, for the first time, to build a national picture of postgraduate medical education, highlighting differences, promoting good practice, but also making it clear where there is scope for improvement. We are, therefore, aiming to minimise the inspection burden on training providers, such as hospital trusts and GP practices.
- 3.7. PMETB brings general practice and specialist medicine together for the first time enabling a more consistent approach and better linkage between the two. The processes which have already been put in place will enable GPs to be entered on to the General Practitioners Register, to mirror the Specialist Register, when it is put into place in April 2006. PMETB will determine the eligibility for entry to both registers through determining the requirements for CCT and Article 11 & 14 certificates. The registers are maintained by the GMC.
- 3.8. Our strategy for 2006-2010 outlined below will enable us to take this work forward.

#### **4. Taking this forward: our five year strategy.**

- 4.1. Our five year strategy sets out what we aim to achieve and therefore what we will need to fund. (See Annex 1 for a summary).
- 4.2. In this we reflect the role we see PMETB occupying as a broker, bringing together, for the first time, the key players who will ensure the quality of training. It also sets out why we believe the proper fulfillment of our statutory role is particularly crucial at the current time. In the strategy we highlight changes which will affect training, including demographics and changes in society (in both patients and the characteristics of the medical workforce); external factors (e.g. the UK Working Time Regulations); politically driven developments (changes to the structure and funding of service provision) and changes to the delivery of health service provision (e.g. pharmacology rather than intervention, multi-professionalism, competence based training, and patient focused outcomes becoming increasingly important).

- 4.3. Over the coming years we believe that the collective impact of these will be profound. They will demand a fundamental review both of what we are training our doctors to do and how we train them to do it, if we are to ensure we maintain both quality and the continued relevance of the content of training to a changing world.
- 4.4. In responding to these pressures we need to ensure that the direction of postgraduate medical education is intimately linked to those who will rely on our future doctors as patients and as service providers. We will only do this by working to embed a culture of education and training in the NHS at every level and across all four nations of the UK. We will achieve this by ensuring we address our statutory objectives to meet the needs of employers, alongside patients and trainees.
- 4.5. To that end, PMETB will seek to be both a leader *in* PME and a champion *of* PME in keeping with our statutory duties to *develop and promote* postgraduate medical education.
- 4.6. Our strategy over the next three to five years has four broadly overlapping phases.
- Phase 1: 2005-2007: Consolidating the work we inherit, particularly on certification, and supporting implementation of the standards we have established prior to our go live date of 30<sup>th</sup> September 2005.
  - Phase 2: 2006-2007: Implementing a QA methodology for the future.
  - Phase 3: 2006-2008: Developing our leadership role in PME; consulting on key questions which will shape our future work.
  - Phase 4: 2008/9: Implementing new standards and requirements, following consultation on the key questions and reviewing the Order based on our experience of implementation.
- 4.7. In addition to our statutory work on standard setting and maintenance of quality, over the next five years we will undertake a number of specific pieces of work as part of our responsibility to *develop and promote* postgraduate medical education. These include:
- A major consultation on the content and outcomes of training to be achieved in all training programmes. This will include consideration of a core and options approach and the possibility of a generic curriculum, common to all specialties commencing 2006/07 to be completed during 2007/08. As part of this we will seek to ensure the importance of academic medicine, medical education and medical management is fully recognised.

- The possibility of work with the RCGP and other medical Royal colleges in defining curriculum outcomes for GPs with a special interest and their relationship with other specialists.
- A major consultation on the question of the content and scope of a CCT, combining this with a consultation on standard setting for sub-specialties and the relationship between specialty and sub-specialty training. In doing this we will consider the relevance of models used elsewhere in Europe.
- Work closely with the GMC in its review of the Specialist Register seeking to ensure that the needs of trainees, patients and the NHS are properly considered as part of this.

4.8. Through this work we aim to realise the benefits envisaged in the Order, working closely with Colleges, providers, the GMC and other stakeholders to ensure that the needs of tomorrow's trainees, patients and NHS are properly addressed.

4.9. This consultation paper is set in the context of delivering our strategic plan and invites views on draft rules which set the fees PMETB will need to charge from 1<sup>st</sup> April 2006 to fulfill our statutory duties. Further details of the strategy can be found at [www.pmetb.org.uk](http://www.pmetb.org.uk).

## **5. Stakeholder input to the plan.**

5.1. Our primary purpose in setting out our five year plan has been to meet the statutory objectives required of PMETB. However, prior to considering the plan, the Board considered the views of stakeholders on the priorities PMETB should set.

5.2. The main themes which emerged from these discussions were:

- The wish to see PMETB as ambitious.
- The need for PMETB to be seen as independent of government, the medical Royal Colleges, postgraduate deaneries and providers.
- The potential for PMETB to play a role as a broker/leader in postgraduate medical education.
- The importance of PMETB as a champion of standards but also, potentially, in shaping, or at least strongly influencing, the delivery mechanisms for postgraduate education.
- The importance of PMETB in developing and promoting PME, including potentially a role as an advocate for PME.

- The importance of PMETB to be seen as a promoter of equal opportunity.
- The possibility of PMETB engaging in, or supporting the development of, R&D in PME.
- The need to engage with others, particularly patients and trainees, but also the NHS, and trainers.
- The question of whether PMETB should engage in the wider debates on the future of medicine.

5.3. In our launch press release the CMO (England) commented: *“I have no doubt that it [PMETB] will become a central and authoritative voice in medical education and training, with a strategic vision to build closer partnership between the regulation of undergraduate and postgraduate medical education.”*

5.4. The issues which were raised support the strategy proposed for our first five years.

## 6. The cost of delivering our work.

6.1. **Fees to 31<sup>st</sup> March 2006.** In setting fees for the period to 31<sup>st</sup> March 2006 the Board took the view that it would not initially seek full cost recovery through fees, not least because during this period, it would be laying the foundations for future work and establishing our basic certification processes. This decision was made possible because of the high level of grant provided by the four Departments of Health. As a result the fees which will be charged to March 2006 represent only a small proportion of total costs required to meet our statutory objectives. PMETB did however move to equalise the treatment of general practice and specialist medicine for the purpose of fees. No fees were charged for general practice in the past as these costs were fully met by a grant from the Departments of Health. For specialist medicine, the Board inherited a fee regime which had seen no increase in Certificate of Completion of Specialist Training fees since 1996.

6.2. **Costs for 2006/07.** We now need to establish costs, and therefore fees, for 2006/07 with only 2 months of operating experience. With this limited operational experience we cannot accurately forecast key variables which will affect both our income and our expenditure, in particular demand for Article 11/14 applications and appeals. The figures we have used are based on estimates from what we know now and from past experience, although there is no previous precedent for Article 11/14

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applications. The figures which follow must be viewed with these important caveats.

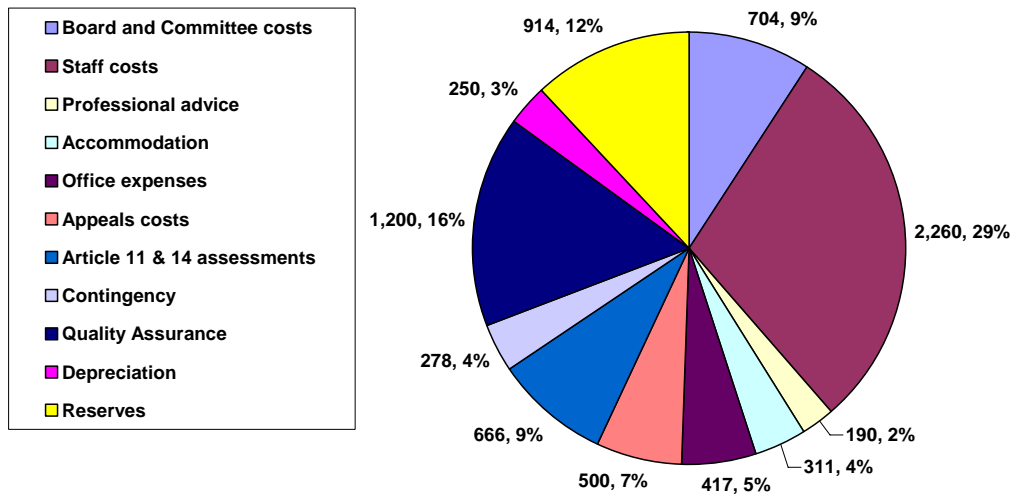
6.3. We currently expect our expenditure in 2005/06 to be somewhere in the region of £5.5m to £6m dependent on the volume of Article 14 applications. Of this we expect fees to contribute around one third of income with the balance met by the Departments of Health.

6.4. The financial year April 2006 to March 2007 will be the first full year of PMETB's work and hence will be the first year in which the real cost of operating is evident.

6.5. For the year 2006/07 currently we expect the cost to be around £6.5m (see Chart 1).

### Chart 1: Estimated 2006/07 Expenditure.

CURRENT EXPENDITURE ESTIMATES 2006/07 (BASED ON EXPENDITURE OF £6,525,000 AND RESERVES BUILD OF £914,000)



6.6. Having factored out the differential arising from budgeted Article 11/14 demand in the two years most of the difference represents full year QA costs for the new system; full year staff costs, including some small additions, almost entirely in QA and Policy to meet our statutory duties; unavoidable depreciation charges and beginning to build a small reserve. See principles below.

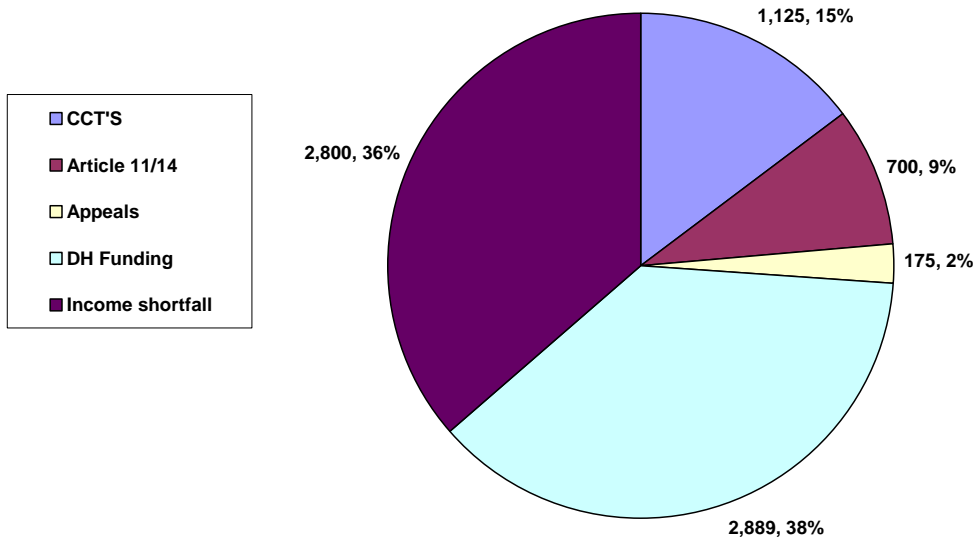
6.7. Against these increases we have offset savings in a number of areas, but particularly Board and sub committee costs by implementing a less

onerous sub-committee structure. The Board have also indicated their wish to consider further reductions in Board costs.

6.8. Overall our operating costs in 2006/07 are not significantly higher than we would have expected for a full year operating year in 2005/06.

6.9. However, unlike 2005/06, we cannot in 2006/07 rely on the same level of grant from the Departments of Health. Chart 2 indicates the expected level of grant in aid from the Departments of Health and the amount of funding we would generate from fees if we did not increase them from the 2005/06 levels.

**Chart 2: Projected Income needed in 2006/07 and shortfall with no increase in fees** (Total income = £7,689,000, shortfall would = £2,800,000).



*NB: Income required includes actual expenditure, plus depreciation and reserves contribution figures.*

6.10. As can be seen, with no increase in fees, given anticipated funding from the Departments of Health, our income shortfall would be £2.8m or some 36% of budget. The Departments of Health would be meeting 38% of our total costs but have also indicated that this level of funding will be progressively reduced in 2007/08 and 2008/09, with no guarantee of any funding in 2009/2010.

## **7. Meeting our costs.**

PMETB has four possible sources of revenue to finance its services:

- 7.1. Fees paid by doctors who apply for a Certificate of Completion of Training (CCT) or a statement that they are eligible for the GMC's Specialist Register or future General Practitioners Register, or other forms of certification.
- 7.2. Fees paid by doctors who appeal against a decision on their application for certification or by institutions which appeal against a decision made by PMETB to withdraw an approval or make approval subject to conditions.
- 7.3. Income from fees which we may be able to charge for other activities under Article 24 of the Order. During the course of the five year plan PMETB will consider options for further income streams, in particular through charges for quality assurance as we proceed with implementation. As proposals are developed, they may be the subject of further consultation, depending on their nature
- 7.4. Grant from central government. As noted above it is currently proposed that government grant to PMETB will be reduced progressively over the next three financial years. Although this specifically relates to England, under the formula governing contributions from Scotland, Wales and Northern Ireland any reduction in grant from England, also reduces grant from each nation.

## **8. Proposed principles to inform our approach to setting fees.**

The principles which have informed our approach to fee setting are and our application of them are discussed in more detail below.

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

The proposals will enable this to be achieved by 2009/2010 based on what we can currently estimate about our cost structure and income profile. As noted above however one of the problems in having to agree fees at this stage is that we have only two months of operating experience. As such it is difficult for us accurately to predict our eventual cost base and income levels. We have done the best that we can and factored in what the Departments of Health have told us about future grant in aid.

We have also studied carefully the certification patterns of our predecessor bodies. We will have a better understanding of our costs and income in 12

months time when we come to consider fees from April 1<sup>st</sup> 2007 but in fact we probably need 2-3 years operating experience before we have a clear picture.

**Principle 2: Income must enable PMETB properly to fulfill 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.**

The proposals would enable this to be achieved in a staged way over the next five years as we build capacity and expertise, with some caveats on QA costs where we have further work to do. The proposals do not however include explicit funding for some of the outline objectives included in the five year strategy (see objectives 5-8), nor do they include funding for some of the areas initially envisaged in the consultation which established PMETB (e.g. R&D).

**Principle 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 based 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.**

We see two main beneficiaries from our work: those receiving Article 11/14 equivalence assessments and those receiving CCTs. Our aim, in time, would be to move to an approach which levies fees based on the costs associated with these two workstreams and, as far as practicable, avoids cross subsidy.

However, with less than two months operating experience and great uncertainties remaining as to the number of applications which will be submitted in any year, and the exact costs of processing them, it is simply not possible to establish whether the costs of dealing with the different types of application will vary significantly, save for identifiable direct costs. Any allocation beyond this would almost bound to be inaccurate and unfair to significant numbers of candidates. Given what we know, the only fair way to allocate costs is equally to all applicants. This is also consistent with principle 4 below.

We also believe that it may ultimately prove to be consistent with the beneficiary pays principle as we develop more experience of operating. Broadly speaking CCT applications will be easier to process, are likely to result in fewer appeals, but will benefit more from the work we do to set, maintain and improve standards in UK postgraduate education. In contrast Article 14 applicants will be more complex to process, may result in more appeals, but many will perhaps have benefited less from our standard setting work in the UK. If, in future, Articles 11 and 14 develop into an alternative route to the registers for doctors the differential benefits derived from these applicants and those applying for CCTs may be increasingly hard to distinguish.

The proposals achieve equivalent treatment of specialist medicine and general practice.

**Principle 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 General Practice Registers benefit.**

In applying this all applicants under Articles 8 (CCT), 11 (GP equivalence) and 14 (specialty equivalence) are seen to benefit to a great extent from the totality of the work carried out by PMETB in relation to certification, standards-setting, approvals, quality assurance etc. The rationale for this is that all are measured against the standards and achieve the same benefit from certification in terms of eligibility for entry to the senior level of their profession. While not all Article 11 and 14 applicants will have obtained some or all of their GP or specialist training in the UK, i.e. through PMETB-approved training provision, PMETB's activities in relation to training are still central to the development and maintenance of the standards against which those applicants are measured and to the integrity of the certification which they receive.

As noted above, whilst the Board proposes this as a principle going forward, in practice the Departments of Health will continue to provide some grant in aid to our work for at least the next 3 years. In 2006/07 this subsidy will amount to around one third of our total costs. It is our intention that, during the course of the next three years, we will consider new sources of income which will help to replace this subsidy from the Departments of Health as it reduces to try to avoid further increases on this scale. The most obvious opportunity in this regard is a possible fee associated with quality assurance. As we develop more thinking on this we will consult as appropriate.

For the next three years the Departments of Health have, in principle, given us assurances that funding received from them will be paid at a level which we expect will at least cover our direct costs of quality assurance work.

**Principle 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.**

Most appeals are expensive and the fees set by PMETB are unlikely to meet the actual costs as we understand them at present. However, as appeals are directly related to certification work we believe it is appropriate that certification work should be regarded as a whole, of which appeals form one part. As we gain more experience of appeals we will wish to aim towards the attribution of relevant

appeals costs to the two certification workstreams (CCT and equivalence). To offset the cost for successful appellants we will normally offer a refund of the appeals fees.

Within the period of the current five year plan we are also committed to re-examining our appeals procedures should appeals costs have a significant impact on overall operating costs which we would have no choice but to reflect in fees.

Notwithstanding this we believe we need to seek to cap liabilities for costs arising out of appeals and we have opened up discussions with the Departments of Health on their meeting these costs beyond a certain level. The Departments have indicated that, in principle, they would look favourably on such an approach.

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

The financial plans which underpin these proposals allow us gradually to build up a reasonable reserve commensurate with our continued viability as an independent body and good risk management practice. This will cover:

- a prudent in year cash flow reserve to cover reasonable fluctuations in demand driven income and avoid the need for substantial variations year on year;
- by the end of 4 years a year on year strategic reserve to enable PMETB to be perceived as an ongoing entity with sound risk management;
- reasonable fluctuations in the processing costs associated with increases in the number of appeals, until such time as we have some sense of the likely steady state position (unlikely until April 2007 at earliest).

We regard the minimum level for such reserves as 3 months operating expenditure, an ideal might be 6 months expenditure for an independent body with fluctuating income streams. Clearly, if we built up excessive reserves based on the fees charged we would have to consider reductions in future years but it would be imprudent to assume this is likely based on what we know at present.

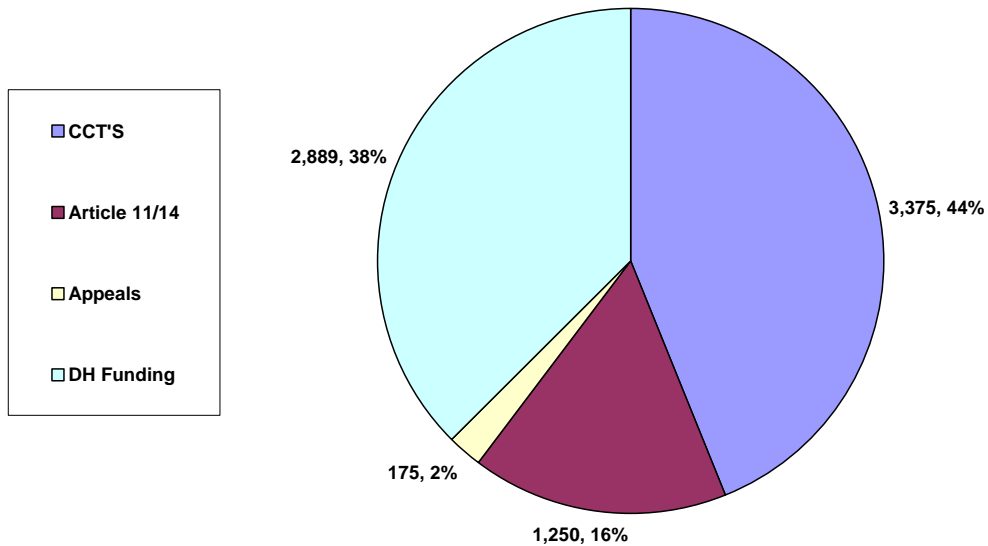
**9. Proposed fees.**

After applying the principles above, the proposed fee structure for the major categories of fees are:

	Proposed Fees from 1 <sup>st</sup> April 2006 to 31 <sup>st</sup> March 2007	Current Fees from 30 <sup>th</sup> September 2005 To 31 <sup>st</sup> March 2006
CCT Application	£750	£250
Article 11/14 Application	£1,250	£700
Appeal – written	£1,400	£1,000
Appeal – oral	£2,100	£1,500

Chart 5 below indicates the impact of the proposed fees on meeting our anticipated 2006/07 costs.

**Chart 5: Proposed sources of income 2006/07 (£7,689,000).**



*NB: Includes depreciation and reserves figures.  
As can be seen the contribution from the Departments of Health remains 38% of total costs, but fee income covers the remainder.*

**10. How we have applied the principles in arriving at the proposed fees for the period 1<sup>st</sup> April 2006 to 31<sup>st</sup> March 2007.**

Given the principles above our approach in arriving at the proposed fee levels for 2006/07 has been to:

- (1) Identify total 2006/07 costs.
- (2) Subtract from (1) income which will be received from sources other than fees, which for 2006/07 consists entirely of funding provided by the four Departments of Health;
- (3) From the figure in (2) subtract our estimate of the specific costs which will be incurred in dealing with applications for certification under articles 11 and 14 of the Order which are not incurred in dealing with applications for CCTs. (This estimate is based on assumptions as to the numbers of such applications which will be received in 2006/07 and may be subject to error).

These are the costs of the substantive assessment of qualifications, training and experience which must be carried out in order to determine these applications and which are not necessary for applications for CCTs.

These costs are clearly identifiable because this further assessment is currently carried out by third parties on behalf of PMETB, under contractual arrangements which currently provide for payment of £500 per application. The manner in which we process these applications in future may change but the additional costs are likely to remain due to the complexity of the work involved.

(4) The figure produced under (3) represents the remaining costs and overheads which it is proposed should be met by fees charged under Article 24 for our certification services.

(5) The fees for the less administratively complex certification and competent authority functions, i.e. functions other than those calculated under Articles 8, 11 and 14, are calculated on the basis of best estimates as to the costs to PMETB of performing those services and a reasonable relationship between the extent of the service provided and the level of the fee. The total number of applications under these articles is expected to be small and will therefore not have a significant impact on costs, or income.

(6) The remaining amount of the total overheads is then allocated to fees for services provided under articles 8 (CCTs), 11 (GP equivalence) and 14 (specialty equivalence). This allocation is carried out so that, using assumptions as to the volume of applications to each service, each applicant under each of these articles will bear the same level of operational costs, which is £750. This is the fee proposed for applicants for CCTs.

(7) The additional direct costs of dealing with applications under articles 11 and 14, as described in (3) above, are then added to the figure of £750 to produce the proposed fees of £1250 for these applicants.

(8) The proposals for appeals fees are fixed at a level which recovers as much of the actual cost as possible while remaining consistent with principle 5. This is based on legal advice regarding the need to maintain access to the appeals system in order to comply with the Human Rights Act.

### **11. Revising Fees in Future.**

Given the changes to fees which we are proposing we believe it is right that we should seek views on these proposals.

We are committed to reviewing our estimates/assumptions and approach for future years in the light of experience over the remainder of this financial year and the year which will be covered by the new fees Rules.

We would aim to reduce certification fee levels if it were to become clear that we were receiving more income than required to cover costs or decided that it was more appropriate to meet certain costs from income streams other than certification services.

It is our hope that we will not need to seek changes on this scale in the next 2-3 years. We would therefore propose not to consult on changes which lead to a change to any individual or to overall fees of less than an appropriate inflationary measure (e.g. RPA) plus or minus 2%, unless there were also major changes to the way in which any fees were calculated.

### **12. Your views.**

This consultation details the background and rationale to the fees proposals and sets out the principles which underlie the proposals. Within the annexes it includes a summary response to some of the questions which we think the consultation may raise, including a summary of some of the financial options we have considered before arriving at the proposals we make in this consultation.

We would welcome views on the following:

**Q1: Do you agree with the principles which have underpinned our proposals? (Paragraph 8)**

**Please indicate which you agree with and which you disagree with?  
If you disagree do you have alternate suggestions?**

**Q2: Do you think the proposals are consistent with the principles?**

**Q3: Do you have comments on the fees proposals themselves?  
(Paragraphs 9 and 10).**

**Q4: Do you have comments on our proposed future approach to revising  
the fee structure (paragraph 11).**

### **13. Consultation process**

This consultation will be sent to:

#### **Government bodies**

Department of Health (England)  
National Assembly for Wales  
Northern Ireland Department of Health Social Services and Public  
Safety  
Scottish Executive Health Department

#### **Regulatory and other public bodies**

General Medical Council  
Commission for Patient and Public Involvement in Health  
Council for Healthcare Regulatory Excellence  
Educational Commission for Foreign Medical Graduates  
Healthcare Commission  
International Association of Medical Regulatory Authorities  
NHS Education for Scotland  
NI Medical and Dental Training Agency  
Health Protection Agency

#### **Royal Colleges and their Faculties**

Academy of Medical Royal Colleges and its members  
Junior Academy of Medical Royal Colleges  
Royal College of Anaesthetists  
Royal College of General Practitioners  
Royal College of Obstetricians and Gynaecologists  
Royal College of Ophthalmologists  
Royal College of Paediatrics and Child Health Care  
Royal College of Pathologists  
Royal College of Physicians  
Royal College of Physicians and Surgeons of Glasgow  
Royal College of Physicians of Edinburgh  
Royal College of Physicians of Ireland  
Royal College of Psychiatrists

Royal College of Radiologists  
Royal College of Surgeons of Edinburgh  
Royal College of Surgeons of England  
Royal College of Surgeons in Ireland  
College of Anaesthetists, (RCS Ireland)  
Faculty of Accident & Emergency medicine (RCS Eng)  
Faculty of Dental Practitioners [UK]  
Faculty of Dental Surgery (RCS Eng)  
Faculty of Occupational Medicine (RCP Lond)  
Faculty of Pharmaceutical Medicine of the Royal College of Physicians UK  
Faculty of Public Health (RCP Lond)  
Royal College of Midwives  
Royal College of Nursing  
Royal College of Veterinary Surgeons

18 Postgraduate Deans

**Professional associations, medical defence organisations and other bodies representing medical or NHS personnel**

British International Doctors Association Ltd  
British Medical Association  
Junior Doctors Committee of the BMA  
Medical Defence Union Services Ltd  
Medical and Dental Defence Union of Scotland  
Medical Protection Society  
NHS Confederation  
Medical Womens' Federation  
Locum Doctors' Association  
Gay & Lesbian Association of Doctors and Dentists (GLADD)  
National Association of Clinic Tutors  
British Association of Physicians of Indian origin  
Association of Surgeons in Training

**Bodies representing patients and the lay public**

Action Against Medical Accidents  
Age Concern  
National Consumer Council  
Long Term Medical Conditions Association  
Patient/Public Involvement Group of the Academy of Royal Colleges  
Patients' Association

**Other**

Several doctors who have recently being awarded CCTs.

COPMeD

COGPED

Health Foundation

National Governors Council

Nuffield Trust

King's Fund

Further copies are available on our website: [www.pmetb.org.uk](http://www.pmetb.org.uk). They are also available on request from PMETB, 7<sup>th</sup> Floor, Hercules House, Hercules Road, London SE1 7DU.

**14. How to submit comments**

Comments are invited on the draft Fees Rules and this consultation document. If you require further information, please contact us at the address below.

Written comments should be sent **by Friday 13 January 2006** (by letter or e-mail) to:

**Jan Quirke**  
**Board Secretary**  
**PMETB**  
**7<sup>th</sup> Floor**  
**Hercules House**  
**Hercules Road**  
**London SE1 7DU**

**[Jan.quirke@pmetb.org.uk](mailto:Jan.quirke@pmetb.org.uk)**

**Additional Information: Other financial options considered.**

***On-going grant in aid.***

Even if the Board did not wish to be financially independent, the Department of Health in England has indicated that it will not currently consider further grant in aid from 2009/10 and that it will reduce grant in aid in stages to that point. The consequence of the formula which secures support from Scotland, Wales and Northern Ireland means that reductions in England would have a commensurate impact on their grant. If we did not increase fees or receive additional funding from another source we would fail to meet our statutory obligations.

***Make payments for CCTs annually during the course of a training programme.***

This would have been consistent with our wish to see the award of a CCT as a package from the beginning to the end of training and would have spread costs, but it would have significantly increased collection costs because we would have no means of ensuring payment annually. These collection costs would have to have been reflected in the total costs charged and would have served to increase these. Any bad debt would have to be met by those who did pay. It would also have been impossible to apply this to Article 11 and 14 applications.

***Charge an annual levy to those on the register.***

Our legal advice has indicated that this would not be possible under the Order. Moreover to do this the GMC would have to collect these funds and distribute them back to PMETB. It would also have meant that those who have completed their training previously were meeting the costs of work which would benefit current trainees.

***Staged increases?***

The pace at which we have to increase our fees is dictated by the reduction in grant in aid from the Departments of Health. The only way in which we could stage these increases would be if the departments were to agree to increase their interim funding to make up the shortfall until the fee level to cover our costs was reached.

Ultimately however, even if the Departments were to agree to this, we would still need to move to the levels proposed to achieve financial independence. The only advantage of a staged approach would therefore be to benefit those who complete their training during the brief period where the Departments decreased their grant – and therefore provide more notice of the increase. From a PMETB perspective this would also enable us to establish fees when we have a much better idea of our actual costs and income but, from our current estimates, it seems unlikely this would mean less than the scale of fees proposed.

**Reductions in costs?**

Only a small part of the increase arises from an anticipated increase in our costs and this is entirely driven by the fact that in 2006/07 we will be operating for our first full financial year and have to meet our full statutory obligations.

The proposals we have put forward already include some elements of cost reduction, for example Board and Committee costs, office costs and legal costs, although these are counter balanced by the funding we will need to become fully operational over a full year.

With less than 3 months post go live operational experience we must be cautious in making promises to reduce our cost base and it would be foolish to commit to a target until we know what our baseline cost is. However we are committed to examining four significant cost drivers which may help to reduce costs, and therefore the scale of future fee increases:

- The method we use to arrive at Article 11 and 14 decisions.
- Our appeals costs – especially if the new equivalence routes generate a higher volume of appeals than we might otherwise have expected.
- Quality Assurance costs.

The Board have also indicated that they wish to re-examine Board costs as we move to less frequent meetings.

In order to monitor this we have established a new Resources Committee reporting to the Board. This will scrutinise our budgets and ensure we achieve cost efficiencies wherever possible.

**Generate other income?**

The Order permits us to charge fees for our work but we would also like to consider the opportunity to raise money from other activities associated with our core work. Two examples might be conferences and publications. However, in the short term the scope for this is limited and it is important that we focus on getting the basics right. Within the next 3 years we are committed to considering alternative sources of income. The most obvious one is QA charges.

**Fees reductions in future years?**

We really need a much better understanding of our costs and fee income before we could consider this. At present it looks unlikely because, even at the fees proposed, we are unlikely to have excessive income over and above that which we believe we need to be a viable entity achieving our statutory objectives.

## Questions and answers.

### Why haven't you left longer to consult?

We have not been able to complete this work until we were clear about the level of funding we could expect from the Departments of Health in 2006/07. The notification of this arrived on October 7<sup>th</sup>. The Resources Committee and Board considered these proposals at the first meetings after this. We also needed at least some experience of post go live operating.

We need to complete the consultation in mid January to allow enough time for a Statutory Instrument to be laid which will allow the new fee regime to be in place on the 1<sup>st</sup> April 2006.

### What benefits will trainees receive?

- 1. An investment in training from beginning to end.** Given our statutory obligations the fees which trainees pay for our work represent an investment not just in the end point of training, but in the whole system which ensures that that end point is reached, including the standard setting, maintenance and quality and development and promotion of postgraduate medical education. Given the changes occurring in medicine and the environment in which it operates, equally importantly the fee represents an investment in ensuring that training continues to be relevant and flexible within the workplace in which they find themselves. This is reflected in the development programme within our strategy.
- 2. The development of dual routes to certification and equivalence.** Whilst initially most current trainees on standard training programmes will use the standard CCT route, over time Articles 11 and 14 will offer an alternative route for those who wish to build up a portfolio of experience, qualifications and training in the UK, rather than follow the traditional route towards a CCT. With the current Modernising Medical Career (MMC) proposals on run through training this could be an important route for trainees who cannot follow the traditional CCT route. It will also be valuable to those who wish to take career breaks and take a more flexible approach towards their training. To facilitate this we have already published specialty specific guidance and advice to applicants in most specialties but we will improve and develop this work as we learn from our earlier experience. We will also continue to refine the process. The aim being to make sure it is as clear and as fair as possible.
- 3. Entry to Specialist and, for the first time, General Practitioners Registers.** Although these will be maintained by the GMC, PMETB will, in effect, determine who is eligible to gain entry to them.

- 4. Standard setting and quality assurance in PME.** As noted above. Our aim is that our approach towards core and developmental standards can be a force not just in spreading best practice but in driving improvement. A tangible example would be the standards for assessment which have already begun to ensure that any exams trainee sits are consistently fair, transparent, have feedback and will be less likely to allow discrimination on unfair grounds.
- 5. The development and promotion PME.** Our third statutory responsibility is to develop and promote PME. In our five year strategy we have indicated our wish to be a leader, and a champion of, PME. Developing our own ability to be an effective champion will not happen overnight but we are determined that we will play a major role in ensuring that training is embedded within an NHS. All trainees will benefit from this.
- 6. Improvements to service levels.** As we develop our operational capacity and invest in IT over the period to March 2006 we aim gradually to be able to offer a number of service benefits to trainees, these include improved web and on line facilities and better tracking of applications. We have already extended our enquiry line to offer a full five day service for all applicants including General Practitioners. Previously this had only been offered to specialties other than General Practice.
- 7. Improvements to the consistency in which applications are dealt with** arising from our greater statutory powers to ensure a greater degree of standardisation across Colleges. This has already been reflected in the approach which we have adopted towards the development of specialty specific guidance for each of the specialties – this had never existed in one place before. As we make more decisions on the award of CCTs and equivalence we will be able to ensure a greater degree of consistency in the way in which these decisions are applied across specialties, encouraging good practice and working to improve practice. Our own quality assurance work in particular will aim to ensure consistency and good practice across all the colleges.

**Your track record initially on service to trainees has been mixed. How can we be sure these promised improvements will be achieved?**

The certification work which we undertake is complex and inevitably there have been teething troubles, particularly with GP certification. We have largely ironed these out now but we know that we need to get the basics right first. For that reason we have proposed in our strategy that the period to March 2006 should be about just that: consolidating our basic certification work, and developing the detail around our QA work.

The new standard setting and development work which we envisage in our strategy will not begin until April 2006 as we develop confidence in our basic processes and we will not begin this until we are sure that our core certification processes are functioning.

**Isn't this all about jam tomorrow? Why pay for it today?**

It's true that many of the benefits we outline above will accrue in the future because we are only just beginning our work. However we would hope there is already enough evidence to show we are making a difference and will do so in the future. Added to this many of the benefits to trainees outlined above are immediate. However, we recognize the sensitivity of this and for that reason we believe it is right that we should seek to achieve financial independence over a number of years, rather than seek to achieve it in 2006/07 as had been proposed last year. The financial strategy which underpins these proposals assumes ongoing grant in aid in line with the proposals from the Departments of Health. In practice this means therefore that the increase in charges will not be as large as it might have been and that the Departments of Health are cross subsidising our early work, albeit on a reducing basis as we move forward.

**If trainees and applicants have to meet the costs, will they have a say in your work?**

Trainees are one of three groups whose needs we are required to consider as part of the Order. The others are patients and employers. The strategy which we have published and which we wish to implement from April 1<sup>st</sup> 2006 commits us to placing trainees at the heart of our work, including all of that outlined above.

The Order does not enable PMETB to determine representation on the Board but it does enable us to do this for statutory committees. To this end we have recently advertised for trainees and NCCG doctors to join our statutory committees.

Rather than set up standing reference groups with no specific purpose the Board has decided to make trainees (patients and employers) central to each of the specific pieces of work we undertake as we implement our strategy. We will be engaging with representative groups, particularly the Junior Academy of Medical Royal Colleges and the Junior Doctors Committee at the BMA to consider how this can best be achieved.

As a tangible example of our commitment to involving trainees we have already decided that a national trainee (and trainer) survey will be a core part of the QA system which PMETB will begin to implement in 2006/07. This will enable every trainee to take part.

Our hope is that this will become an invaluable tool in pinpointing problems in training (locally, nationally and by specialty) and identifying both good and bad practice. For the first time ever it will give us a national picture of training across all four nations.

We have also ensured that the development of key pieces of work to date, for example the generic standards for all training programmes, has involved significant trainee representation.

Similarly our work on Articles 11 and 14 have involved significant contributions from NCCG doctors as part of the Article 11/14 sub committee which, prior to go live, advised on the processes and procedures we would apply.

**Have you considered the other fees which trainees pay to Colleges prior to receiving a CCT?**

We have identified these costs but if we are to be financially independent and achieve our statutory objectives we need to set fees on the basis of what it costs to deliver our work, not what trainees pay to others. For specialist medicine the cost of training currently ranges from £1,660 to £4,060 over the course of a training programme, with the bulk of these fees paid to medical Royal Colleges. For general practice they are currently £350. Some of these fees contribute towards the ongoing standard setting, educational and quality control work which Colleges will continue to undertake, both locally working with postgraduate Deaneries, and nationally, on behalf of PMETB. These activities are funded directly by Colleges from their own resources under their different charters. The Colleges already make a charge for this work within their fees. As such they are an integral part of the provision and assurance of medical education. The work of PMETB will introduce a greater degree of accountability for such work, within an overall approach to standard setting and QA. However, PMETB's work will have a significant impact on Colleges. They are likely not to have to incur such heavy QA costs through visits and they will benefit from some of the administrative improvements and standardisation which PMETB will introduce over time.

Equally, trainees themselves will benefit financially if, for example, the standards for assessment which we introduce lead to more work place based assessment in place of College exams as we move towards more competency based assessment. As noted above, PMETB also opens up an equivalence route which will enable some doctors to enter the two Registers using alternatives to the traditional route to achieving a CCT which may well reduce their overall training costs.

**Are you concerned that this may deter Doctors entering training?**

We would be surprised if this fee alone deterred doctors from entering or completing their training. However, whilst we cannot take income levels into account in setting fees, entry to the Specialist or General Practice Register is a pre-requisite for selection to a Consultant or General Practitioner post. These positions carry with them considerable earning potential. In the context of the lifetime earning potential of a qualified doctor these one off fees are very unlikely to deter entry to medicine. Moreover, for some doctors, they will offer alternative routes to entry to the registers which may overall be cheaper than the traditional CCT route.

**Will fees be tax deductible?**

We are seeking advice on this, but under current Revenue and Customs guidance our understanding is that is unlikely.

## **Annex 1: Outline Summary of our Strategic Plan: 2006-2010.**

### **Introduction**

The Postgraduate Medical Education and Training Board (PMETB) assumed its statutory responsibilities on 30 September 2005, thus for the first time creating a single body responsible for postgraduate medical education and training (PME) across the UK. As such, PMETB represents a tremendous opportunity. The proposals in the plan are ambitious for a new organisation. We do not apologise for this. The environment in which PMETB finds itself demands no less. The Order which created PMETB gives us the responsibility to ensure that the needs of tomorrow's patients, trainees and NHS are met. We will not shirk that responsibility. Whilst undergraduate and foundation medical education and training has undergone a period of rapid change, postgraduate training has lagged behind. Key questions about the future shape of the medical workforce remain unanswered. Without answers our work takes place in a vacuum. Effective regulation requires that we have a clear view of what the end product of training should be. If the status quo was as good for the future as for today this might be acceptable. But it is not. The changes taking place in the medical workforce, in the needs of patients and in technology alone suggest the need for fundamental change. These are compounded by political and economic drivers. For that reason we believe PMETB must take its third statutory objective: to develop and promote postgraduate medical education and training very seriously indeed. We must be much more than just a standard setter and a maintainer: we will seek to be both a leader and a champion of postgraduate medical education and training. In particular, we feel strongly that a culture of education and training must be embedded at every level in the NHS. It is the bedrock on which the excellence of tomorrow's NHS will be built.

In all our work we want to take people with us and our approach to the task will be a collaborative one: working closely with and involving others for whom these matters are of utmost concern. Our approach to the development of our work will be a staged one, starting in early 2006 by building the capacity for the delivery of our forward strategy. We are tremendously appreciative of the work we inherit from our predecessor bodies, but we also know we have a lot to do in consolidating our core certification services and delivering a new quality assurance (QA) system.

But essentially these are processes. If we neglect to consider the content which we play into these processes we neglect our duties. We neglect the unique and historic opportunity which we have. Most important of all, we neglect the needs of future patients, trainees and the health service. We are determined to do what we can to address those needs head on.

## **Outline Strategy: 2006-2010 background**

PMETB is a new UK-wide statutory body with extensive legal powers over the content and standards of PME. This document outlines our strategy for the first five years of PMETB's life from 2006. Further detail can be found on our website: [www.pmetb.org.uk](http://www.pmetb.org.uk).

In setting our strategy the main external developments which we believe PME and therefore PMETB will have to address during this period are:

- Important changes in the gender, ethnic make up and place of training of the medical workforce, including changes which may be driven by the arrival of PMETB itself.
- Increasing tension between service delivery and training.
- Demographic changes coupled with the changing expectations of those who use the NHS.
- Important and rapidly moving developments in the structure of specialist and general practice training.
- Pressure for lighter touch regulation.

In setting our strategy it is clear that external and internal stakeholders wish us to be ambitious, independent and a champion of PME. They also believe that we have considerable potential to play an important role as a broker identifying and addressing the difficult issues with which PME is faced.

The objectives below reflect the role we see PMETB occupying: using the foundation of our statutory levers and powers, coupled with our unique position as the sole body overseeing PME, to provide leadership not just in the current, but also the future direction of PME.

Our approach to this task will be a collaborative one. We will work closely with others for whom these matters are of utmost concern, in particular: the health service, those who deliver training, the medical Royal Colleges and the four Departments of Health. For that reason the strategy envisages that we will consult widely on a number of key issues affecting PME in shaping our work. We will also seek actively to work in partnership with these key stakeholders in developing our future work.

Our proposed objectives for the period 2006-2010 are:

**Objective 1: To establish standards in PME**

- To establish and develop standards for curricula, assessment and training environments, including a major consultation on a possible core and options approach to curricula, on the content and outcomes of training to be achieved in all specialties and the possibility of a generic curriculum, common to all specialties (2006-2008).
- To work with partners to set and implement standards for entry to specialist training based on the principles of equality and fairness (2006).
- To encourage Academic Medicine, Medical Education and Medical Management (2006-2008).
- To consider work to define curricula for GPs with a Special Interest (2007-2008).
- To engage with patients and trainees in undertaking this work.

**Objective 2: To secure and maintain standards in PME**

- To work effectively across all four Nations.
- To implement a new approach to quality assurance of PME (2006-2007).
- To integrate QA for Foundation Programmes with the GMC.
- To consider the development of an exemplar delivery model for PME, subject to consultation (2006-2007).
- To develop indicators which enable targets and benchmarks to be established (2007-2008).
- To ensure appropriate linkage with CME/CPD.
- To monitor our own Standards and Performance.

**Objective 3: To promote and develop PME**

- To make the case for education.
- To assist in the spread of good practice.

## PMETB Fees Consultation: December 2005

- To consider our role in examining incentives to training, subject to consultation (2006-2007).
- To influence future research into Medical Education.
- To influence career development and support to trainees.

### **Objective 4: To establish the outcomes of PME**

- To lead and shape important debates on the end point of PME.
- To undertake a major consultation on the end points of PME, to reconsider the content and scope of a CCT and the relationship between specialties and sub-specialties (2007-2009).
- To consider, with others, the issues surrounding post-CCT specialist training.
- To work with the GMC in its review of the Specialist Register.

### **Objective 5: To consider issues of multi-professionalism where they may have a bearing on our work**

### **Objective 6: To work with others to achieve our objectives**

To establish relations with key groups and organisations, in particular Deaneries, the medical Royal Colleges, trainees and the health service.

### **Objective 7: To establish the international role of PMETB**

### **Objective 8: Funding and supporting our objectives**

### **Objective 9: To fully implement our new governance arrangements (2006)**

### **Objective 10: To review the order which established PMETB (2008-2009)**

## **Annex 2: Details of individual fees**

The draft rules which this consultation documents accompanies include a Schedule listing the proposed fees. Details of each are as follows:

Application for the award of a CCT in a specialty listed in Schedule 3 to the Order, including pursuant to the competent authority functions of the Board. (Articles 8(1), 8(4) and 20(3) (a).)

The award of a CCT marks the end point of a defined specialist training approved by the United Kingdom competent authority. The programme covers the whole period of postgraduate training, including SHO training and successful completion of a higher specialist training programme in the Specialist Registrar Grade.

Application for the award of a CCT in general practice.

The award of a CCT in general practice marks the end of a defined specialist training programme in the United Kingdom. The programme covers three years training which will include time spent as an SHO in hospital specialties and a minimum of 12 months as a GP Registrar in an approved training practice. To be eligible for a CCT, applicants must have completed their training within the seven year period preceding their formal application for a certificate and they must also undertake and pass Summative Assessment.

Application for a determination that training and/or qualifications, or both when considered together, are equivalent to a CCT in general practice, including issuing a statement of eligibility for registration if so requested. (Articles 11(3) and 11(7)).

Article 11(3) refers to doctors who do not qualify for an Article 5 CCT. They have training or qualifications equivalent to a CCT and can be doctors whose experience is in the United Kingdom, Europe or overseas. Article 11 (7) states that doctors who qualify for Article 11(3) and can satisfy the Board that their training and/or qualifications are equivalent to a CCT in general practice will be issued with a 'statement of eligibility for registration'.

Application for a certificate of acquired rights to practise as a general practitioner. (Article 12)

Article 12 applies to doctors who meet the criteria for acquired rights as laid down in the Vocational Training Regulations.

Application for a sub-specialty certificate. (Articles 13(4) and (5))

If it is satisfied, PMETB will issue a sub-specialty certificate confirming that an individual has particular expertise in a field within their specialty. This may be in respect of sub-specialty training as part of a CCT programme in the United Kingdom that is approved by the Board.

Alternatively it may be any other sub-specialty training undertaken outside the United Kingdom which the Board is satisfied is equivalent to sub-specialty training approved by the Board.

Application for a determination that the specialist training and/or specialist qualifications in a specialty listed in Schedule 3 to the Order are equivalent to a CCT in the specialty in question, including issuing a statement of eligibility for registration if so requested. (Articles 14(4) and 14(11)).

Article 14(4) allows doctors to apply to be evaluated for entry to the Specialist Register. This pathway is designed for applicants whose training and/or qualifications are equivalent to a CCT in the specialty in question. The specialty in which the applicant applies must be the same as a specialty listed in Schedule 3 of the Order.

Application for determination that -

(a) specialist training undertaken and/or specialist qualifications awarded outside the United Kingdom in a medical specialty not listed in Schedule 3 to the Order;

or

(b) knowledge of or experience in any medical specialty derived from academic or research work has given a person a level of knowledge and skill consistent with practice as a consultant in the NHS, including issuing a statement of eligibility for registration if so requested. (Articles 14(5) and 14(11)).

Article 14(5) (a) allows doctors to apply to be evaluated for entry to the Specialist Register. This pathway is designed for applicants whose training was undertaken and/or qualifications were awarded outside the United Kingdom in a specialty which is not on the list of standard (CCT) specialties in Schedule 3 of the Order. Applicants must be able to demonstrate that they have attained a level of knowledge and skill consistent with practice as an NHS consultant.

Article 14(5) (b) allows doctors to apply to be evaluated for entry to the Specialist Register. This pathway is specifically designed for doctors whose background is in academic and research work. They will not have followed a conventional training pathway but their skills and expertise will have developed through original research and offer a particular, novel contribution to the care of patients.

Application for a duplicate copy of any certificate issued by the STA or JCPTGP or by the Board. (Article 24(1) allows the Board to charge reasonable fees to cover cost of providing services).

PMETB will decide the circumstances in which a duplicate copy of certificates may be issued.

Application for the issuance of a certificate relating to training in the United Kingdom in certain specialties. (Article 20(1)(b))

Previously the STA issued a certificate confirming periods of training in approved posts undertaken by an EEA Member State National in the United Kingdom in accordance with Article 8(2) of the European Directive. The doctor could then ask another EEA Member State how much further training would be required for its own CCT equivalent certificate.

Application for the issuance of a certificate to a person holding specialist qualifications not satisfying the requirements of the Directive awarded following training begun before the relevant date referred to in Article 15(2), by the United Kingdom, or where the person holding that qualification has practised that specialty in the United Kingdom. (Article 20(3)(b))

Article 20(3)(b) relates to Article 9(2) of the Directive. Where a doctor has been undertaking training which meets the minimum standards set out in the European Directive but trained before the Directive was implemented in each Member State, PMETB will be required to issue certificates to enable doctors in these circumstances to obtain recognition in other Member States under their “grandfather” arrangements.

Application for the issuance of a certificate of fulfilment of Directive training requirements in respect of qualifications which do not conform to the designations set out in the Directive. (Article 20(3)(c))

Article 20(3)(c) relates to Article 9(5) of the European Directive. This provision is designed for existing specialists who do not hold a CCT but who hold a UK certificate which is treated in the same way as a CCT – for example, a College certificate of accreditation issued prior to the introduction of CCSTs or a certificate of equivalence previously awarded by the STA. Under the terms of the European Directive automatic recognition must be given to these certificates where the holder is an EEA national with a recognised EEA primary medical qualification. In such cases these certificates are given the same recognition by other EEA countries as a CCT. Doctors eligible for award of a certificate of equivalence can apply to PMETB providing evidence of completion of their specialist training and award of their UK specialist certificate and evidence of nationality.

Application to an Appeal Panel for the determination of an appeal against a decision of the Board. (Article 21(1))

A right of appeal against decisions of PMETB is enshrined in Article 21 of the Order. Individuals and institutions may apply to have their appeal heard by an independent panel which PMETB is required to establish. Appellants may opt to have their appeal heard by the panel on the strength of written submissions alone without the appellant or PMETB being present (written hearing).

Alternatively appeals may be heard with the applicant, PMETB, legal representatives and witnesses present (oral hearing). Hence the two different appeal fees.

Fees will help to defray the various costs associated with holding appeals. Those include payments to the Director of Appeals and panel members, the cost of Appeals Office staff and physical resources and costs of hiring facilities to hear appeals.

Application for a CCST in accordance with Article 6 of the ESMQO 1995 where a person has applied to the STA for a CCST and the application has not been determined before the relevant date. (Schedule 8, paragraph 11(a))

This is a transitional provision which permits PMETB to determine any unresolved CCST applications made to the STA prior to the transfer of statutory powers. In such cases, PMETB will be required to determine an application and issue a CCST to the applicant, if it is satisfied, in accordance with the relevant Articles of the ESMQO 1995. The fees should cover the manpower and other administrative costs associated with the evaluation of the required documentary evidence and the issue of a certificate where PMETB is satisfied.

Application for the determination of an appeal against a refusal by the Board to award a CCST in accordance with Article 13(1) of the ESMQO 1995. (Schedule 8, paragraph 11(b)).

This is a transitional provision which permits an individual to appeal to an independent appeal panel against the refusal of PMETB to award a CCST. This affects those who applied to the STA but did not receive a determination prior to the transfer of statutory powers. Appeals will be heard in accordance with Article 13 of the ESMQO 1995. Appellants may opt to have their appeal heard by the panel on the strength of written submissions alone without the appellant or PMETB being present (written hearing). Alternatively appeals may be heard with the applicant, PMETB, legal representatives and witnesses present (oral hearing). Hence the two different appeal fees.

Application for a determination of eligibility for entry to the Specialist Register in accordance with Article 9(2) or (3) of the ESMQO 1995 where a person has applied to the STA and the application has not been determined before the relevant date. (Schedule 8, paragraph 12(a))

This is a transitional provision which permits PMETB to determine any unresolved applications from overseas qualified specialists for entry to Specialist Register made to the STA prior to the transfer of statutory powers. Any unresolved applications made against the following Articles of the ESMQO 1995 must be determined by PMETB:

- Article 9(2)(b) - Applicant has overseas specialist qualification(s) equivalent to CCST.

- Article 9(3)(a) – Applicant has overseas specialist qualification(s) in a specialty where there is no CCST equivalent specialty. Must have level of knowledge and skill consistent with practice of an NHS consultant in that specialty.
- Article 9(3)(b) – Applicant must have knowledge of or experience in any medical specialty derived from academic or research work.

In all such cases, PMETB will evaluate the application against current requirements, issue a decision with reasons to the applicant and, if satisfied, issue a certificate of equivalence to those approved for entry to the Specialist Register.

Application for the determination of any appeal against a decision of the Board in accordance with Article 13(1) of the ESMQO 1995. (Schedule 8, paragraph 12(b))

This is a transitional provision which permits an individual to appeal to an independent appeal panel against the refusal of STA to approve their entry to the Specialist Register under Article 9(2) or (3) of the ESMQO 1995. This affects those who made an application to appeal to the STA but whose hearing did not take place and the appeal was not determined prior to the transfer of statutory powers to PMETB. Appeals will be heard in accordance with requirements of Article 13 of the ESMQO 1995.

Application for the determination of an appeal against a decision of the STA to be determined in accordance with the relevant Article of the ESMQO 1995. (Schedule 8, paragraph 14).

This is a transitional provision relating to any unresolved appeal applications made against decisions of the STA under the ESMQO 1995 and lodged before the Order establishing PMETB came into force. Appeal applications must be determined in accordance with the requirements of Article 13 of the ESMQO. Fees will help to defray the various costs associated with appeals e.g. Director of Appeals and panel members' fees, the Appeals Office staff and physical resources, costs of hiring facilities to hear appeals.

Application for the performance of a competent authority function of the STA where a person has applied to the STA and the application had not been finally dealt with by the STA before the relevant date. (Schedule 8, paragraph 13 and Articles 20(3)(b) and (c)).

This is a transitional provision which requires PMETB to deal with any unresolved applications made to the STA under Article 3(4)(b) of the ESMQO 1995 e.g. certificates of equivalence, confirmation of UK training posts completed by an EEA Member State National in the United Kingdom. Fees should cover administrative costs for evaluating applications and issuing certificates as appropriate. Fees will not be collected by PMETB if the applicant has already paid the STA.

A new fee has been added to the 2006/07 fee rules:

Application for a statement of the training, qualifications and experience in respect of a certificate by the Board, the STA or the JCPTGP

This will provide official information about the nature and length of training posts and other training elements undertaken by the applicant which were taken into account in the issuance of a certificate to him. The initial trigger for this new category was requests for PMETB to provide to overseas registration bodies details of the training and experience obtained by an applicant which was accepted by PMETB when issuing an article 11 certificate to that applicant. However, in the future that such requests may well come from within the UK and in relation to those holding CCTs and article 14 certificates as well as those holding article 11 certificates, where applicants, employers and prospective employers wish to confirm which experience and training was obtained by the applicants and accepted by PMETB. This service would be provided as an ancillary service to PMETB's certification functions and would essentially involve the issue of an expanded statement or certificate. The issue of such a statement requires PMETB to review the applicant's file in order to confirm what training was considered and accepted.

**Annex 3: Glossary.**

CCST	Certificate of Completion of Specialist Training was awarded by the STA to specialists successfully completing a UK specialist training programme before PMETB took over the STA's functions. The CCST has been replaced by the CCT.
CCT	Certificate of Completion of Training
DH	Department of Health
GMC	General Medical Council – the UK body that holds the register of all qualified doctors eligible to work in the UK
MMC	Modernising Medical Careers
PMETB	Postgraduate Medical Education and Training Board
QA	Quality assurance of postgraduate medical education and training