Postgraduate Medical Education and Training

The Medical Education Standards Board

A Paper for Consultation
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Dear Colleague

I am pleased to send you a copy of our Consultation Paper about future arrangements for postgraduate medical education in the UK. The paper sets out proposals for doctors only, and does not, for example, affect the arrangements for dentists or nurses. We expect, however, that other health professions will have an interest in our proposals.

The UK’s doctors do a brilliant job for patients. Our country has some of the best doctors in the world. Our system of medical education is rightly admired throughout the world. But change is needed, because health care is changing.

When we announced in the NHS Plan\(^1\) that we would modernise the arrangements for postgraduate medical education, we needed to be sure that the NHS of the future would have doctors capable of delivering quality services in ways that patients want. Medical education needs to be flexible and adaptable, capable of responding quickly to changes in the NHS.

Doctors of the future will work in an NHS which is designed to deliver quality care within an educative, questioning, learning culture. The NHS will value its staff and demonstrate effective leadership in partnership with patients. The education and training of doctors must reflect these principles as well as providing doctors with the clinical and communication skills called for in a modern health service.

The proposals in this paper set out the principles that we believe must underpin postgraduate medical education in the future. In particular, quality assurance, clinical governance, and patient focus must be built in at the centre. We give our analysis of the current arrangements, and test them against our guiding principles. Finally, we set out our proposals for the future, and invite your comments.

We know that some of our proposals will be seen as radical. For the first time, we want to give the NHS, as the major employer of doctors in the UK, a say in how those doctors are trained. We want to ensure that patients have more than token representation at the highest decision-making levels. We are

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\(^1\) Secretary of State for Health “The NHS Plan” London: Stationery Office 2000 (CM 4818-I)
challenging traditional boundaries between doctors and patients, between health professions, and between doctors and health service managers. Finally, we are installing quality assurance and accountability arrangements to provide effective feedback as the basis for continual improvement.

I look forward to receiving your comments. Details of where to respond are at the end of the consultation paper.

Alan Milburn
Secretary of State for Health
Executive Summary
Medical Education Standards Board

• The programme of modernisation in the NHS is introducing a comprehensive framework for quality including mechanisms to set standards and to assess and inspect performance. NHS organisations must assure and improve the quality of services they provide to patients through clinical governance. Specific policies and programmes will protect patients by improving safety and recognising and dealing effectively with poor practitioner performance.

• The quality of care delivered to patients depends crucially on the calibre of staff working in the NHS. To ensure that we continue to have the best NHS staff possible, we must identify the needs of the service now and for the future, set clear standards, create high quality training placements, ensure that education and training programmes meet our standards, and make continual improvements as a result of feedback from trainees, trainers, patients and NHS providers.

• The system for supervising and approving postgraduate medical education (PGME) will therefore have to be reformed to ensure that the training of growing numbers of medical staff supports the NHS Plan’s ambitions for higher quality standards and improved services. 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. Decisions on PGME are not informed by an NHS based quality assurance and accountability framework.

• As the NHS Plan indicated we intend to create a single body – the Medical Education Standards Board – to bring together responsibility for all PGME. Its primary duty will be to supervise PGME. New legislation will underpin responsibilities and will give the Board, as the “competent authority”, oversight of all PGME activity in the UK. The Board will play a role in the proposed NHS University, as its supervisory and standard-setting role covers all doctors in post-registration training and employed in the NHS.

• To assure the quality of training, the Board will be responsible for monitoring training in the NHS and elsewhere. Medical education and training will be aligned with the needs of the future NHS and other employers. It will produce doctors who are equipped to meet the

2 The NHS Plan HMSO July 2000
challenges of the patient-centred, modern NHS set out in the NHS Plan. The Board will ensure a single unifying framework for PGME, supporting the drive to improve standards and assure the quality of NHS services.

- Through its committees, the Board will draw on the medical Royal Colleges for their knowledge, experience and expertise in setting standards. It will look to the medical Royal Colleges to provide professional members of its visiting panels. The Board will apply consistency in approach to visiting and inspecting. Visiting will be carried out taking full account of the importance of ensuring high quality and locally accessible services. Under our proposals, the Royal Colleges would support the Board by working within a framework and to standards set by the Board. The Board will ensure that the standards it sets are consistently applied across both hospital specialties and general practice.

- The Board will:
  - issue certificates to those doctors meeting the standards it sets for the successful completion of training;
  - require doctors to produce evidence of having met its standards; and
  - be responsible for ensuring that assessments and examinations undertaken as part of training are reliable, valid, and fair.

- Certification will entitle a doctor to be registered on either the recreated Specialist Register or a newly created General Practitioner Register, as appropriate. Registration will be a necessary requirement for working as a consultant or as a general practitioner. Transitional provisions will ensure that all doctors currently eligible to practise will be registered.

- The Board will also assess the postgraduate training of doctors coming to this country with both part and full training undertaken elsewhere and who do not satisfy EEA requirements for mutual recognition of qualifications. It will be able to permit these doctors to be registered, if their training meets UK standards, or, if not, to require them to undertake additional training and assessment either in the UK or elsewhere.

- The Board will work closely with other bodies with an interest in medical education. In particular, the Board will have close links with the General Medical Council, in recognition of the Council's role in undergraduate medical education. We will look to the Board and the GMC to work together in developing a seamless approach to medical education and training. The Board's work will be quality assured.

- The Board will have a membership of no more than 25. This will include medical; lay; and NHS members. The chair may be either lay or medically qualified. The Board will have effective administrative support, and will be able to raise its own revenue through, for example, charges for certification. It will be accountable to the Secretary of State, on behalf of UK health ministers.
Introduction

1. The NHS is modernising. Changes are creating a health care system which meets the needs of patients in the new century. For the first time, mechanisms are being embedded which ensure that the focus is firmly on the quality of service. As well as setting standards for quality, these will also ensure that, throughout the NHS, performance and delivery are inspected, assessed, and reviewed. This clinical governance framework ensures that

“NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

2. Services are only as good as the staff who deliver them. Local NHS employers need to know that they can rely on staff, whether clinical or non-clinical, to have received appropriate training. Staff need also to have effective continuing professional development opportunities to ensure that they remain “quality assured”. This process must be informed by the views of patients, carers and the public but must involve professional interests as well.

3. All training of doctors must be firmly integrated into this framework. Medical training needs to incorporate the same lessons and take in the views both of the NHS, as the major employer of doctors in the UK, other employers (for example, in the private sector) and of patients. This process cannot be confined solely to the undergraduate medical schools, and is even more relevant to doctors who have begun postgraduate careers in the NHS. Here, medical education follows an apprenticeship-based model. Training may be structured and planned but it is service-based; it is delivered “on-the-job” with competence acquired through supervised and graduated experience working directly with NHS patients.

4. Postgraduate medical education is a key part of the NHS quality framework and must be capable of adaptation to suit the changing needs of the service. In the remainder of this paper, Part One identifies particular drivers for change, while Part Two sets out our proposals for the future.

**Postgraduate Medical Education**

5. Postgraduate Medical Education (PGME) is the training a doctor receives after his or her primary medical qualification has been obtained and before the doctor enters a “service grade” post – for example, as a staff grade, a consultant or a general practitioner. Doctors in Senior House Officer (SHO), Specialist Registrar (SpR), or GP Registrar (GPR) posts make up the majority of doctors in PGME.

6. Of 110,000 doctors currently practising in the United Kingdom there are about 39,000 doctors in the training grades: some 5,000 pre-registration house officers (PRHO); 18,000 SHOs, 14,000 SpRs; and 2,000 GPRs. Together they represent the largest single part of the medical workforce.

7. For almost all trainee doctors, unlike many other professionals, there are no higher or further education institutions providing a managed academic framework in which to learn and attesting to their success. In contrast, training is managed and delivered by the NHS through postgraduate deaneries supported by educational and clinical supervisors. Standards are set and monitored by independent bodies, which also attest to the competence of individual doctors. This is a tested approach widely applied in medical education throughout the world. The system has its challenges – in particular, the tension between service and training may test the aim of delivering a sound and coherent training programme.

8. In Scotland, the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE) has overall responsibility for organising and managing PGME as part of devolved arrangements. Proposals have, however, been announced by the Scottish Executive to refine arrangements in Scotland. Similarly, in Northern Ireland, the Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE) has comparable functions to SCPMDE. This is different from the supervision of PGME in the UK, which remains a UK competent authority function reserved to Westminster. References to regulatory aspects in this document apply across the UK, while references to the organisation and management of PGME generally refer to England only.
9. Specialist training and general practice vocational training generally commence at the end of the PRHO year. At this point the doctor will have acquired Full Registration with the General Medical Council (GMC) (it is possible for hospital-based training to be undertaken with Limited Registration in certain circumstances). Training ends when the doctor has completed his or her course or programme with the award of a Certificate of Completion of Specialist Training (a CCST) or a general practice Vocational Training Certificate of Prescribed Experience (a VT Certificate). During training, trainees provide significant service in both hospital and general practice and, on completion of their training, are eligible through application for advertised posts in the NHS to become consultants and general practitioners.

10. Doctors train not only in large urban teaching hospitals but also in smaller hospitals across the UK, and much more widely in primary and community services. Doctors typically spend 2-4 years as an SHO, moving on to 5-7 years as an SpR, or a year or more as a GPR. The cost of postgraduate training to the NHS in England is funded by a central budget, reflecting trainees’ contribution to service and the training they receive while delivering that service. This was £701 million for England in 2000/2001, a rise of £178 million over the 1996/7 figure. Decisions about medical training can have, therefore, considerable and immediate impact on resources and on service provision.

11. From 2002, the Government intends to centrally fund all SpR posts in England. In Scotland 100% of the basic salaries of all doctors in training are already funded centrally.

12. Training must produce doctors who are fit-for-purpose, and the Government has set out its policy in respect of postgraduate education in England in two major policy documents: “The new NHS: modern and dependable”⁴ and “The NHS Plan”⁵. We will ensure that the principles in these documents, endorsed by all UK Health Departments, are embedded in the system of postgraduate medical education and training:

"the Government will continue to look to individual health professionals to be responsible for the quality of their own clinical practice. Professional self-regulation must remain an essential element in the delivery of quality patient services. It is crucial that the professional standards developed nationally continue to

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⁵ Secretary of State for Health “The NHS Plan” London: Stationery Office 2000 (CM 4818-I)
be responsive to changing service needs and to legitimate public expectations. The Government will continue to work with the professions, the regulatory bodies, the NHS and patient representative groups to strengthen the existing systems of professional self-regulation by ensuring that they are open, responsive and publicly accountable.”

“The new NHS, modern and dependable” para 7.15.

“We will rationalise the complex arrangements for medical education. As a first step we will establish a new body – the Medical Education Standards Board – to provide a coherent, robust and accountable approach to postgraduate medical education, replacing the separate bodies for general practice (the Joint Committee for Postgraduate Training in General Practice) and hospital specialties (the Specialist Training Authority). The Board will ensure that patient interests and the service needs of the NHS are fully aligned with the development of the curriculum and approval of training programmes. Membership of the new body will be drawn from the medical profession, the NHS and the public. It will accredit NHS organisations as training providers.”

“The NHS Plan” para 8.28

The case for change

13. The current arrangements for regulating postgraduate medical education have not always been the result of conscious decisions. Instead, large parts of PGME have grown up piecemeal over many years. For example, within the last decade, the need for the UK to comply with the minimum European requirements set out in Directive 93/16/EEA6 - the “Doctors Directive” – has driven changes to parts of the arrangements for PGME. Recent changes to the Doctors Directive will likewise need to be incorporated with other changes in the new legislation setting up the Medical Education Standards Board.

14. In general practice, while the NHS Act 1977 made vocational training compulsory for GP principals, this requirement was not extended to all GPs until 1995. At the same time, the European Specialist Medical Qualifications Order (1995) for the first time set minimum legal requirements for training in hospital specialties7, introduced the Certificate of Completion of Specialist Training (CCST) and instituted a Specialist Medical Education Standards Board to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.


7 In this context includes public health medicine.
Register for those doctors eligible to be appointed as consultants. In 1997, it became a legal requirement for doctors to be on the Specialist Register before taking up a substantive consultant appointment.

15. It is a requirement of the Directive that a competent body or authority supervises PGME. For general practice, this is currently the Joint Committee on Postgraduate Training for General Practice (JCPTGP); for hospital specialties, the Specialist Training Authority of the Medical Royal Colleges (STA). The General Medical Council (GMC) is the UK competent authority for basic medical education.

**The competent authorities in the UK**

**JCPTGP**

16. There are 33 members of the JCPTGP comprising principally representatives of the Royal College of General Practitioners (RCGP) and the General Practitioners Committee (GPC) of the British Medical Association (BMA). There are also representatives of others involved in GP education, particularly Directors of Postgraduate General Practice Education (DPGPE), and two lay representatives nominated by the GMC. Each UK Health Department sends an observer to JCPTGP meetings. The Committee, which has no statutory existence although it carries out statutory functions, is entirely funded by Government for its activities. It operates internally according to its own rules and procedure over which neither patients, the NHS nor the Health Departments have influence. It therefore chooses its own chairmen and determines its own membership.

**STA**

17. The 25 members of the STA include representatives of all the UK medical Royal Colleges, the Faculties of Public Health Medicine and Occupational Medicine and two representatives from the GMC. In addition, the Secretary of State for Health appoints four members. Two must be postgraduate deans, while the other two must be non-medically qualified. The STA is a company limited by guarantee and is registered as a charity, raising its own funding (eg) from charging doctors for certification. Again, the NHS as the principal employer of doctors has no direct influence on the standards and training for key members of its workforce.

18. The UK competent authorities set standards for training, monitor its effectiveness and attest to the satisfactory completion of training by individual doctors. The UK government is responsible for constituting
bodies as competent authorities, and ensuring that domestic legislation
sets the minimum standards which competent authorities must apply.
The competent authorities typically apply considerably higher standards
than the minima specified by law.

19. The JCPTGP and STA also approve the curricula for training and judge
whether individual doctors have reached the standard set by them for
“satisfactory completion” of training. They issue certificates (CCSTs or
VT certificates) to successful doctors. Both the STA and the JCPTGP
depend on a network of other bodies to carry out tasks on their behalf,
although a competent authority cannot legally devolve or delegate its
responsibilities to another body.

20. The JCPTGP, supported by the Royal College of General Practitioners,
works primarily through the deaneries, in particular the Directors of
Postgraduate General Practice Education, in assessing the standards of
training provided in general practice. The STA relies almost entirely on
the medical Royal Colleges and their Faculties (who make up the
majority of the STA membership).

21. While both the JCPTGP and STA have some lay representation, they are
predominantly medical organisations. The STA’s membership is defined
in controlling legislation, but (as described earlier) the JCPTGP is not a
legally constituted body and works to its own internal rules.

22. As a result of the diverse arrangements in both UK competent authorities
and in their controlling legislation, there is little congruity in the
arrangements for postgraduate training for general practice and
postgraduate training for hospital specialties. Both the legal and practical
processes differ. This might not matter were it not that these factors can
make it difficult for doctors to alter career choices or to change career
paths. High quality candidates may be unable to move quickly through
training and into posts. Both the service and trainees suffer as a result,
with decisions made at the beginning of the long training period leading
to an inbuilt lack of flexibility.

Summary

23. It is vital that service pressures do not compromise the training of
doctors. Equally, the training of doctors must be driven by the needs of
the service in which they are employed. There is a pressing need for a
better balance between training requirements and service needs. We need
to change the arrangements for the competent authorities because:

• they are differently constituted and operate in different ways;
• there has been no clear vision for continuous improvement in postgraduate medical education and training with policy developments being ‘bolted on’ as they occurred over the years;

• NHS interests are poorly represented;

• the efficacy of accountability arrangements is not generally evident;

• there is little or no public, patient or non-professional input;

• where training is not fit-for-purpose, making changes to improve its relevance to the health service is difficult to achieve;

• educational decisions in setting standards or in judging whether individual training locations, training programmes and individual doctors have met those standards have profound effects on the viability of hospitals and therefore on other local health services - if an Accident and Emergency Unit loses training approval, the hospital is unable to employ any “training grade” doctors in that Unit and may not be able to deliver important services to a local community.

24. As well as the JCPTGP and STA, other bodies and groups, particularly the medical Royal Colleges and the Postgraduate Deaneries, play important roles in PGME in the UK. They possess expertise and experience, and will need to contribute to the new arrangements. The next section looks at how these bodies might be incorporated in future arrangements we propose for PGME.

The medical Royal Colleges

25. The medical Royal Colleges are independent organisations constituted by Royal Charter. Although they have long taken responsibility for setting standards and supervision of PGME there has never been a statutory basis for this responsibility. Colleges assumed these responsibilities under their charters. They have carried out their role in PGME to high standards, but there have not always been strong partnerships with those using local and national health services. Their decisions critically affect both use of NHS resources and the provision of NHS services.

26. Since the early 1970s the Colleges have received an annual direct grant-in-aid from Government (currently £1.4m) for their work in standard setting. Independently, they also set examinations, which have been accepted by the STA as part of the evidence of progress through
specialist training. 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.

The postgraduate deaneries

27. Deaneries in England are responsible for managing the delivery of PGME at a local level, working to standards set by the UK competent authorities. They are resourced and supported by Government, accountable to Government and reflect local partnerships between service and universities. They secure and manage contracts for training, locally manage the funding which pays a proportion (50-100%) of the basic salary costs of doctors in training and oversee the appointment of doctors to many training posts and programmes. Finally, they supervise and monitor the progress of doctors through the training grades for both general practice and hospital specialties.

28. With the introduction of new workforce planning arrangements, deaneries in England are being reformed. They will work in tandem with workforce development confederations to ensure integrated and multi-professional workforce planning and development underpinned by new funding provisions. In Scotland, SCPMDE has overall responsibility for managing the delivery of PGME and provides 100% of the funding for the basic salaries of all doctors in training. Through the Scottish Postgraduate Deans, SCPMDE ensures the delivery of PGME at a local level. The NICPMDE subsumes all the functions of the Postgraduate Deans in Northern Ireland.

Strengths of the present system

29. The advantages of the present system of postgraduate medical education and training are:

- the state has not had to assure standards of medical education directly nor administer the system of training approval – we intend that this will continue to be the case in the future;
• the medical profession collectively has had authority to decide about standards of professional education, and this has extended to doctors in specialties;

• doctors derive educational autonomy, self respect and professional status from their independence;

• the medical profession has generally trained doctors to acceptable standards of clinical practice; and

• stability and continuity, essential to provide coherent education and training for the profession and for individual doctors.

Weaknesses of the present system

30. There are a number of inherent weaknesses in the existing system. These are:

• existing arrangements do not necessarily reflect, nor take account of, the changing needs of the modern health service and are too far determined by detailed requirements set out in legislation. Adaptability and flexibility is therefore dependent on amending legislation - including primary legislation - which is rarely easy and this contributes to inertia in the system;

• policy development has lacked consistency and focus;

• the decision making process is not always transparent, nor clear;

• the system is not always sensitive to service need and is slow to respond to change;

• integration of training needs and service requirements has not been achieved either at a managerial or at a practical level;

• accountability, both professional and public, within the regulatory framework for decision making and use of resources is unclear and ill-defined; and

• without proper accountability mechanisms it is largely impossible to judge the effectiveness of the existing arrangements.
Reforming the regulation of postgraduate medical education

31. The present arrangements for regulating postgraduate medical education are based on requirements first instituted in Victorian times. They are not best placed to deal with the very different demands of today’s health service, modern medical practice, the movement of doctors between countries and patient empowerment.

32. The first Medical Act dealt only with the educational standards necessary for a doctor to become registered. Just as the registration system has grown more complex and unwieldy over the years, with additional categories being added, so also the scope and complexity of medical education has increased, and now includes legally mandatory training for a range of specialties and for general practice.

33. The requirements of European law have also now to be observed. Furthermore, many doctors from outside the UK come to this country to pursue education and training and to gain employment. Some of these are from the EEA but many “overseas doctors” also come from other countries. Together they form a significant part of the medical workforce - their needs and their contribution to UK healthcare must not be forgotten.

34. In reforming the system it will be important not to replicate existing difficulties, for example:

- the lack of involvement of the NHS in decisions affecting the service;
- the artificial separation of arrangements for training for general practice from training for hospital practice; and
- the absence of effective patient or public representatives.

35. We intend to set up a new system fit for the new century, which meets the needs of patients, the public, and the profession. For example, while there is now a Specialist Register of doctors eligible to be appointed as consultants, there is no similar provision for general practice. We intend therefore to create a new General Practitioner Register.

36. Patients, the public, private sector employers and NHS organisations will benefit from being able to check the status of their general practitioner from a central register – which will include not only GP principals but also all doctors registered in the UK and eligible to work in general practice. This will enable us to move away from a GP system based on
experience to one based much more firmly on current competence and fitness to practise, open to public scrutiny.

37. To meet the demands of the increasing complexity of medical education, the UK, within the last five years, has had to create one new competent authority (the STA) and greatly increase the powers of the JCPTGP. Although these actions dealt with immediate difficulties they did little to address the underlying problems:

- ensuring that the needs of the NHS are properly recognised;
- taking forward new developments in medical education and training;
- supervising effectively the entire continuum of medical education and training - from selection at undergraduate level through to continuing professional development; and,
- placing all medical postgraduate specialities, including general practice, on an even footing.

We intend therefore that the current educational functions of the STA and the JCPTGP should be combined, producing the remit of a new competent authority for the UK. This is not a merger of the JCPTGP and STA. Both bodies are not constituted in legislation, and both could remain in existence after the legislation is changed and their statutory functions have been withdrawn. There will therefore be in the future two UK competent authorities with an interest in medical education: one, the GMC, dealing with registration, conduct, and discipline, as well as basic medical education, the other, the new Medical Education Standards Board, dealing with all aspects of postgraduate medical education and training.

38. In taking forward these proposals to establish the new Medical Education Standards Board we intend to:

- ensure greater participation of the public, the health service and doctors currently in training;
- institute lines of accountability from the new competent authority to Ministers, parliament and the public;
- demonstrate openness wherever practicable and appropriate in the conduct of regulatory matters;
• enable quality assurance - monitoring and reporting on standards of training coupled, where necessary, with effective sanctions;

• deliver, through working with the General Medical Council, coherent arrangements across the continuum of medical education;

• ensure the Royal Colleges continue to play a full part in PGME, within an accountable framework to support the work of the Board; and

• introduce professional registration for both general and specialist practice.

39. Although the Bristol Enquiry Report recommended making the Board part of, and accountable to, the GMC this arrangement would not deliver the objectives outlined above. It would place this broad ranging function within an organisational culture which is quite properly heavily focussed on complaints and fitness to practise and which has no strong relationship with service delivery units in the NHS. There are some benefits in placing arrangements for all medical education under one roof. But we would still have to require accountability direct to Ministers for use of PGME resources, and ensure appropriate NHS, patient and public representation on the Board.

40. Other difficulties also exist. For example, to ensure we meet our European obligations, the Board must be empowered to act independently as the UK’s competent authority (as the GMC currently does for its competent authority functions), responsible to Government, rather than to another body, for its actions.

41. The GMC would, under our proposals, maintain and develop its current administrative role in PGME as the body holding responsibility for registration. This would include entering doctors on the Specialist or General Practitioner Registers after assessment by the new Board. It would also need to work closely with the Board to ensure harmonisation of all medical education, arrangements for quality assurance including revalidation, and a common approach to meeting the needs of the NHS, patients and public.

42. The Royal Colleges would play a key part in the framework supporting the Board. Although the Board would have the task of setting standards and of assuring the quality of training, the Royal Colleges would retain a significant role in postgraduate training. As Royal Colleges exist independently under their Royal Charters, it has previously been difficult to involve them in an accountability framework. They have, as described earlier, attracted significant influence in the NHS through the removal
(or threatened removal) of training approval from hospital posts. Their current role in setting standards, providing training, and assuring the quality of the training in postgraduate medicine is valuable but, in the manner of its discharge, is incompatible with modern public expectations of accountability and transparency and with the needs of the NHS and its patients.

43. We intend therefore that:

- PGME in the UK would be more effectively supervised and co-ordinated across all specialties and throughout the country;
- the needs of the health service would be fully incorporated in decision making; and,
- most importantly, the quality of medical training would be independently assured.

44. In turn the Board would supervise postgraduate medical education other than the pre-registration period which would remain the responsibility of the GMC. The Board would need powers to enable it to harness effectively the contributions of those concerned with PGME, including the Royal Colleges and the deaneries (as well as the SCPMDE in Scotland). It would have specific responsibilities for promoting quality in education and training, ensuring that the needs of the NHS were properly recognised and for keeping the provision of medical education and training under review. It would ensure that improvements in medical education were effected much more rapidly than at present. The Board would therefore make a significant contribution to delivering the quality agenda.

45. The existence of a single body with responsibility for all postgraduate medical education would:

- strengthen and focus the development of medical curricula,
- provide an opportunity for greater patient and public involvement, and
- ensure that the NHS, as the principal employer of doctors, had a central role in determining the training of its own staff.

46. Patients, public and the NHS would benefit from a system, which would provide an open and transparent assurance of the standards of education required of doctors, and in which there would be confidence that the training of doctors would continue to be delivered to the highest standards.
We propose to establish the Medical Education Standards Board (MESB or “the Board”), a new body incorporated by statute with a UK-wide remit. It would have the general duty of setting standards for and supervising postgraduate medical education (PGME). It would approve programmes of medical training leading to the award of certificates of completion of training, entitling the holder to be registered either as a fully trained general practitioner or as a fully trained specialist doctor. The Board will play a role in the proposed NHS University, as its supervisory and standard-setting role covers all doctors in post-registration training and employed in the NHS.

Specific registration of all doctors seeking to work in the NHS as an independent specialist (ie a consultant) or as a general practitioner will be required, and the Board will also set the standard required for entry to the Specialist and General Practitioner Registers. The Board would therefore control the post-registration training routes leading to independent practice as a specialist or a general practitioner.

As its primary customer will be the NHS, NHS interests and priorities will be properly reflected in the Board’s activity and outlook. Other employers, for example in the private sector, also have legitimate interests. The new body will be set up in accordance with the “Modern Principles of Professional Self-Regulation” as set out in the Chief Medical Officer’s consultation document “Supporting doctors, protecting patients” (Department of Health, November 1999).

The Government is moving rapidly to provide 100% funding of the basic salaries for the Specialist Registrar grade in England from central budgets as proposed in the NHS Plan. This will take effect from April 2002, and will support the work of the Board by facilitating the establishment of quality training programmes, which will no longer be restrained by the need for part-funding basic salaries from Trusts.

This excludes the period of General Clinical Training (the Pre-registration or intern year) which is part of basic medical education and the responsibility of the General Medical Council.
51. In turn this should ensure that new programmes can be more easily established in specialties such as radiology or pathology – where trainees provide little service in the early training years - and will support improved workforce planning and service delivery. This system has already successfully been in place for some years in Scotland.

**Membership**

52. We propose that the Board will be a small body of no more than 25 (24 members plus a chair) including the medical profession, patients, the public, and the NHS. We will ensure appropriate representation of both lay and medically qualified members, and the chair of the Board may be a lay person. Each of the countries in the United Kingdom would be represented on the Board. The Board would in addition have observers from the UK Health Departments.

*Comments are invited on the size and balance of the Board and the most appropriate means of making appointments and ensuring effective representation.*

53. The Chair will serve for a five-year term. Members will serve for a term of three years. Both chairman and members will have the possibility of extension by reappointment. The initial appointments to the Board may be for longer periods to ensure continuity in the work of the Board in its early days.

**Statutory Committees**

54. There are to be two Statutory Committees – the Training Committee and the Certification Committee - responsible for advising the Board about matters relating to postgraduate medical education and training. The Board would appoint chairs and members of the statutory committees. Chairs of the statutory committees would be required to be medically qualified and would be appointed by the Board from among the medically qualified Board members. The Board would be given extensive rule-making powers to cover the activities and responsibilities of its committee structure.

55. The Board would be able to create other, non-statutory, committees to deal with aspects of its business. These might include, for example, a Finance Committee or an Administration Committee.
56. The Board would be able to set up sub-committees, either of itself, of the Statutory Committees, or of any non-statutory committee. We envisage that the Board will use this power to deal appropriately with the large number of medical specialties, including general practice, and the wide range of posts and programmes of training.

57. The Board will be able to co-opt individuals (both lay and professional) both to the statutory committees, non-statutory committees and to sub-committees. This will be required as the small size of the Board makes it impossible to have sufficient professional expertise to cover general practice and over 50 specialties. It would also be unreasonable to expect the patient representatives on the Board to be truly representative of all NHS patients – including children, the elderly and ethnic minorities, for example. Additional professional and lay people may also be required, for example, to share the task of making up sub-committees and visiting panels.

Role and functions

58. The Board’s functions will include:

- Supervising PGME in the UK, setting standards in PGME, ensuring that training meets UK requirements (which will encompass European minimum training requirements);

- Approving programmes of training;

- Assessing whether individual doctors have completed training in a satisfactory manner;

- Issuing certificates attesting to the satisfactory completion of training;

- Assessing the degree of equivalence of the training of doctors, coming to the UK seeking to practise as specialists or general practitioners, and who do not satisfy EEA requirements for mutual recognition of qualifications; and

- Controlling entry to the Registers of doctors entitled on the basis of their training and qualifications to work as specialists or as general practitioners and thereby guaranteeing the training standards of doctors in the NHS.

Are there other functions that the Board should carry out from its inception?
Supervision and approval of training

59. We intend that the Board will supervise postgraduate medical education and training, set curricula, and issue certificates showing that individual doctors have reached the standard required at the end of training. In doing so the Board will have to be satisfied, amongst other things, that a programme of training is appropriate for its purpose and is appropriately supported by organisations and resources.

60. Where the Board approves training in an NHS organization (eg a hospital or a general practice) as part of an approved programme of training, the organization may be accredited by the Board as a training provider. This may not, however, be taken as an indication that all medical activity at every level in every specialty in that organization is approved for training purposes by the Board.

61. In approving training the Board will work through the existing local postgraduate deanery arrangements in England (where postgraduate medical deans are responsible for managing the delivery of training to the standards set by the Board) and through SCPMDE/NICPMDE in Scotland and Northern Ireland. It will set and publish the criteria underpinning the standards it requires, and ensure that Postgraduate Deans implement these in the deaneries.

62. The Board will monitor by a systematic visitation of each deanery, using “visiting panel” teams of both lay and professional people. This would ensure that deans, in putting together programmes of education and training, do so in a way that takes account of both educational issues and local service pressures including the needs of the NHS and patients. This avoids duplication of visiting and the service loss which ensues, ensures consistency across all disciplines in all parts of the UK, and streamlines the process as far as is practicable. In discharging these functions the Board would involve the relevant Royal Colleges and Faculties. Their expertise will continue to be an essential part of the process.

63. It is crucial that this process works efficiently across all disciplines. The Board will therefore be required to ensure that its operating protocols demonstrate clearly that they are consistent with the needs of patients and of the NHS, and to ensure through its quality assurance visits that these standards apply across the UK. The Board must also take into account and balance immediate needs with the long term needs of the NHS.

Certification and assessment of fitness to practice

64. The Board would issue certificates to doctors on successful completion of training. These would entitle a doctor to be registered on the appropriate Register. The Board will be able to make a charge for issuing the certificate.
65. In addition, the Board will assess the training and qualifications of doctors wishing to practise in the UK, who have not completed a UK programme of training and who do not satisfy EEA requirements for the mutual recognition of qualifications. If it finds that the training and qualifications of such a doctor is such that he has already reached the standard required for registration, the Board will be able to require the GMC to register the doctor on the appropriate register and to award the doctor a certificate attesting to the fact that the doctor has reached the required standard. Where the doctor has not reached the standard required for registration, the Board will be able, in appropriate cases, to recommend a period or periods of training (which may be undertaken in the UK) which, if successfully completed, will allow the doctor an opportunity to reach the standard required for registration.

 Registers

66. A doctor’s successful completion of training, meeting the standard set by the Board, will be publicly demonstrated by entry on either the Specialist Register or a new register of doctors entitled to work in general practice in the UK – the General Practitioner Register. This will sit alongside the Specialist Register. This would be an entirely new provision for general practice.

_We would welcome comments on the proposal to introduce such a Register._

67. Entry to either Register in individual cases would be decided by the Board, and would be conditional (amongst other things) on the doctor being a GMC registered medical practitioner and being of good standing. Requirements for entry to both Registers would be initially as they currently are for entry to general practice as a GP and eligibility for entry to specialist practice as a consultant. We also propose that, with the new General Practitioner Register, entry to general practice in future will be based primarily on evidence of competence – for example, arising from the successful completion of training - rather than the current requirement of “being suitably experienced”.

68. As now, registration on the Specialist Register will be necessary before a doctor may be appointed to a post as a consultant. A similar link for general practice will be created, providing that doctors may not work in general practice unless registered on the General Practitioner Register. This links to the “local list system” being created for Health Authorities, and will provide a central database and point of reference for Health Authorities, Primary Care Trusts and, importantly, for patients.
69. The Specialist Register is presently held by the GMC where the link to the main register, which recognises full registration, enables a unitary approach to registration. We intend to maintain and strengthen this approach. The GMC would therefore enter doctors to the new Specialist Register and General Practitioner Register at the request of the Board. In commissioning the General Practitioner Register transitional provisions will provide that all those who have entitlement to practise under current registration or certification arrangements will not be disadvantaged.

70. We propose that the operation of these registers will:

- show clearly which doctors are eligible to practise as specialists or as general practitioners;
- fit closely with and assist the GMC’s revalidation procedures;
- require the Registers to be published and publicly available; and,
- in certain circumstances, allow the Board to recommend temporary or permanent suspension from the Registers.

**Mode of operation**

71. The Board will rely on the advice of its statutory committees to support its work. Each committee will carry out work on behalf of the Board and will be accountable to it. Their work will, in appropriate cases, cover the administrative responsibilities of the Board as well as issues directly relevant to the supervision of medical education. It is through these statutory committees that the principal work of the Board will be discharged. Each statutory committee, chaired by a Board member, will have its remit, membership, and terms of reference defined by the Board and will report its findings and recommendations to the Board for action. The Board will look to the statutory committees to ensure consistency of approach and to integrate the arrangements for supervising PGME.

72. Sub-committees of the statutory committees would have specific areas of responsibility. For example some would, under the Training Committee, be responsible for the supervision of training in broad areas of clinical practice such as: general medicine; general practice; surgery; psychiatry; child health, etc. Each would look to the relevant Royal Colleges and Faculties to provide advice and much of the membership of the sub-committee.
73. The Royal Colleges and Faculties will need to satisfy the Board about development, review processes and procedures and meet standards set by the Board for such work. This will ensure that they will continue to play a vital role in standard setting, including curricula development, and the assessment of training but within a framework set by the Board. The Board in turn will be responsible for assuring the quality of all functions and for ensuring that these properly reflect the needs of the NHS and its patients.

74. The new PGME system will therefore need the advice and expertise of the Royal Colleges, and we intend that Colleges will continue to play a key role in supporting the Board by working within a framework and to standards set by the Board. The Board, in turn, will provide guidance and advice to the Colleges.

75. The Certification Committee would be required to consider the evidence presented to it about the successful completion of an individual’s training, whether undertaken inside or outside the UK. It would also be required to ensure that all assessments and examinations (with the consequent classification of trainees) throughout training are appropriate, valid and reliable.

76. The Board would appoint the membership of the statutory committees ensuring that each committee has access to the expertise it requires. This will be derived both from the membership and from advice received from other bodies, most notably the Royal Colleges and other expert groups. Subcommittees and visiting panels will always include lay representatives of both the NHS and patients, and may include other health professionals and doctors from different medical disciplines. 

A diagram setting out these arrangements is attached as an Annex.

Appeals

77. Effective rights of appeal will be provided for doctors who feel themselves aggrieved by decisions of the Board. This will cover assessment including progress through training, certification, and entry to the Registers. The appeal process will reflect the requirements of the Human Rights Act. We intend to create both a formal appeals mechanism, which will include the right of appeal to an appropriate Court, and a less formal complaints system, which may be able to resolve many issues without the need for a formal appeal. The right of appeal to a Court is now a requirement placed on the UK by the amended Doctors Directive.
Quality assurance

78. Our proposals require the Board to demonstrate that quality assurance arrangements are in place to ensure that it performs its role appropriately. While the Board will wish to ensure that there are robust systems for internally quality assuring its work there will also be a requirement for external quality assurance from an appropriate independent body or bodies.

We would welcome comments on the most appropriate form for such quality assurance to take, and for the organisation or organisations most suitable to carry this out.

Accountability

79. The Board will be accountable to the Secretary of State on behalf of UK health ministers for its performance against its objectives and priorities. This will need to reflect the contribution of its quality assurance systems, both internal and external. As with the existing UK competent authorities, the Secretary of State will have power to direct the Board in appropriate circumstances and will be able to assume default powers in an emergency.

Relationship with the General Medical Council

80. The Medical Education Standards Board would, under these proposals, be the statutory UK competent authority for postgraduate medical education and would therefore sit alongside the GMC as the statutory UK competent authority for undergraduate medical education and as the holder of the Registers.

81. The relationship between the bodies must recognise that both are UK competent authorities undertaking statutory roles on behalf of the Government. In order to ensure that there are coherent and continuous arrangements for the entire continuum of medical education, the GMC and the Board will need to collaborate closely on the areas for which each has a particular responsibility - the GMC in undergraduate medical education and the Board in postgraduate education. We believe this might be achieved by placing a duty to co-operate on each body, and ensuring that there is cross membership.

82. In the longer term, we would look to the GMC and the Board to work together in developing a seamless approach to the continuum of medical education – from selection for medical school until the day of retirement.
**Funding**

83. The Board will have to be appropriately resourced to carry out its functions properly. We believe that (apart from start-up costs) the Board should be self-financing through, for example, certification charges supplemented by a possible levy on registration charges.

84. The Board will be able to charge for certification including certification for general practice. This would replace the current arrangements under which no charge can be made for general practice certification and where such costs are presently borne centrally.

85. If the experience of the current competent authorities is any indication, the Board will also receive many enquiries and applications that involve considerable time and effort but which do not result in a certificate being issued. Furthermore, some doctors will want to be registered but will not require the Board to issue a certificate (i.e., some overseas doctors and EEA nationals coming to the UK to work). The Board could therefore also undertake substantial work following enquiries and in cases leading to registration (but not certification) and we propose to examine means of enabling the Board to make a charge for this.

86. As it will be required to supervise PGME across the UK, the Board would have to be able to meet its central costs for this function. We propose that existing Government funding, intended to support standard-setting for postgraduate medical training in the NHS (which supports the work of the Royal Colleges), should be reviewed with the aim of channelling this funding via the board.

**Legislative framework**

87. To achieve these policy objectives it will be necessary to revoke the legislation that currently governs postgraduate medical education and training in the UK. This will include:

- the European Specialist Medical Qualifications Order 1995 (UK-wide);
- the NHS (Vocational Training for General Medical Practice) (European Requirement) Regulations 1994 (UK-wide); and
- making amendments to the Northern Ireland, Scotland, and England and Wales versions of the following:
  - the NHS Act 1977 ss 31 and 32;
  - the NHS (Vocational Training for General Medical Practice) Regulations 1997 as amended.
88. These legislative instruments will be replaced by a new Order which will give effect to the above policy objectives. The Board’s controlling legislation will be flexible enough to permit it to adapt and respond to changes in the service, the profession and elsewhere. This might involve taking on new responsibilities if necessary, without the need for cumbersome legislative change.

89. Where possible, detail will be left to schedules or rules. This permits flexibility and ensures that the legislation on which the postgraduate medical education and training system is founded can adapt to the changing needs of the NHS, patients and the profession. There will be formal consultation on a draft legislative Order in due course.

Commissioning

90. We plan to complete the legislation required to establish the MESB in 2002. The transition from the current system to the future system will then begin in earnest, but it will be possible immediately to begin to put in place supporting arrangements. This will be assisted by the creation of a working group which may in time evolve into a “shadow Board” which will bring together the existing UK competent authorities, NHS, patients, and profession, to advise on and ease the transition period.

We would welcome your comments on these policy intentions.

The three-month consultation period will close on 4th March 2002. Please supply any comments you may have by post to:

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Your comments may be made public, but if you would prefer them to remain private, please make this clear when replying.