

## The Role of the Regulator





# **The Role of the Regulator**

## **Report of the Working Group**

<b>Chairman's Foreword</b>	<b>5</b>
<b>Executive Summary</b>	<b>6</b>
<b>Introduction and Background</b>	<b>8</b>
<b>Part 1: Regulatory Context</b>	<b>9</b>
1.1 UK regulatory arena - devolution and diversity	
1.2 Coordination or fragmentation?	
1.3 The European and wider international regulatory arena	
1.4 Factors influencing postgraduate medical education and training	
<b>Part 2: PMETB as the Regulator</b>	<b>13</b>
2.1 PMETB's statutory remit	
2.2 Areas outside PMETB's regulatory scope	
<b>Part 3: Roles of the Regulator</b>	<b>15</b>
3.1 Regulator as a guardian and promoter of standards	
3.2 Regulator as an enabler of innovation and improvement	
3.3 Regulator as a broker and a force for collaboration, engagement and partnership	
3.4 Regulator as an influencer and campaigner	
<b>Conclusion</b>	<b>24</b>
<b>Annex</b>	<b>25</b>
Membership of The Role of the Regulator Working Group	
<b>References</b>	<b>26</b>



## Chairman's Foreword

I was delighted to have been asked by PMETB to chair the The Role of the Regulator Working Group. A combination of factors make this a particularly pertinent time at which to take stock and consider regulatory solutions to some of the historical and frequently rehearsed challenges facing postgraduate medical education and training in the UK. This is particularly so with the Government's emphasis on the requirement for proportionate regulation across the health sector and plans for joining all stages of medical education. The Department of Health's (DH) decision to create the post of Director of Medical Education for England, which will cover the continuum of medical training, from initial entry to university to lifelong learning, is a significant and welcome development that should help to strengthen coordination and direction from the centre.

Developments over the last two decades culminating in the creation of PMETB, with its stronger regulatory powers, were undoubtedly a major step forward and have brought consistency to the process of setting standards and cohesion across education and training both for specialists and for general practice. Much has already been achieved by PMETB working with its partners, but there is more that can be done using the regulatory levers that it has at its disposal. However, the concern is not for regulation for regulation's sake, but for ensuring that everything that the regulator does is relevant and practical to those individuals and institutions it has a duty to - specifically patients, trainees and the health service - and that improvement is sustained. So, if we are to have a clear vision of what will be required of future doctors, we must first project the needs of future patients and the wider health service. Patients with co-morbidities, an ageing population, technological advances and pharmaceutical developments all have a direct effect on the way doctors train and work. Government's initiatives, such as the local accreditation of GPs with special interests, and the provision of services through independent-sector treatment centres in England also require an examination of the impact on training. As Lord Darzi made clear in the *NHS Next Stage Review*, 'Workforce planning, education and training needs to change to enable staff to respond more effectively and flexibly to this dynamic environment.'

In this context, this report attempts to define where PMETB and its successors should sit as a regulator, the opportunities that exist for further improvement and how developments can be 'future-proofed' and adaptable to change. We have made reference to some of the helpful and innovative ideas flowing from the reports of the other *Future Doctors* workstreams.

Whatever change takes place in the sector over the next five to ten years - and inevitably there will be change - we must never abandon the principles of professionalism, integrity and honesty that are the bedrock of medicine and the care of patients.

My thanks go to members of the working group who provided their valuable time and expertise to this important work and to the Secretariat for their support.

**Sir Ian Kennedy**  
**Chair, The Role of the Regulator Working Group**

# Executive Summary

## 'The only constant is change.'

Heraclitus (c. 535 BC-c. 475 BC)

Regulation of medicine and medical education and training is constantly evolving, driven by many sociological, environmental, political and legal factors. Across the sector, over the decades, it has developed from a self-regulated 'gate-keeping' role to a more consistent, transparent and inclusive model that aims to assure patients and the public of the uniform high quality standards that meet their needs and expectations, and systems that provide value for money.

PMETB emerged among calls for increased public and service involvement in regulation, as well as consistency and transparency between training standards in general practice and other specialties.

Four years in, it has delivered a great body of work, facilitated crucial networks and, with partners, launched many unparalleled initiatives aimed at ensuring consistent standards across postgraduate medical education and training. Having established core operations, the Board could not be complacent. It embarked on a major three-year project in order to future-proof all its functions and the content and outcomes of postgraduate medical education - the *Future Doctors* review. Drawing on the expertise and opinions of stakeholders, part of this work aimed to evaluate the role of the regulator of postgraduate medical education and training and ascertain whether there are opportunities for maximising the benefit it brings to all those whose interests it serves, particularly patients. Announcement of the merger of PMETB with the General Medical Council (GMC) in 2010 if anything raised the importance of 'stocktaking' and forward planning, increased the potential for change and broadened the scope of the review.

The working group leading this workstream considered a wide range of documentary evidence on the regulatory and postgraduate medical education context. The members have identified four platforms that describe the current and potential role of PMETB - and indeed that of its successor - as a regulator. These platforms are already supported by a broad range of systems and activities established by PMETB. However, the regulator's impact on the quality of postgraduate medical education and training could be maximised if existing activities were supplemented by developing the areas such as those suggested by the other workstreams of the *Future Doctors* review:

### 1. Guardian and promoter of standards

- Strengthening PMETB's *Standards for trainers* by introducing accreditation of all specialist, as well as GP, trainers;
- Development of generic outcomes for postgraduate medical education and training;
- Reviewing standards and requirements with a view to facilitating increased patient and public involvement in education, training and assessment.

## 2. Enabler of innovation and improvement

- Increasing the use of guidance to supplement standards;
- Facilitating exchange of notable practice aimed at quality improvement;
- Responding actively to changes in training by promoting and facilitating consistent implementation of the model of graded responsibility, which underpins effective learning at individual pace while providing safe patient care;
- Providing a range of conference, networking and workshop events for the sector to share information and encourage innovation.

## 3. Broker and a force for collaboration, engagement and partnership, actively influencing all matters that serve the interests of patients and the public through maintaining and enhancing the quality of medical education and training.

This can be undertaken on a number of levels, such as:

- Aligned standards and policies;
- Flexible scope of information gathering in order to maximise benefit;
- Shared intelligence and best practice among the regulators of all healthcare professionals.

## 4. Influencer and campaigner, getting involved in wider debate and campaigning in order to influence issues falling outside its direct statutory responsibilities yet impacting on the regulator's responsibilities. Examples of such issues are ensuring due recognition of the value of high quality education and training in the service environment and availability of adequate training resources.

There are unparalleled opportunities for the regulator, be it PMETB or the GMC, to build upon what is already achieved and apply a model of regulation which is both proactive and reactive, and both negative (ensuring a baseline standard) and positive (encouraging improvement).

The challenge will be utilising all these opportunities through a complementary four-dimensional approach set out in this report. With the added benefits presented by the merger, it will ensure that the regulator is not only a standard setter and keeper, but an advocate of medical education and training, a promulgator of good practice and a prominent force in the drive for excellence in medical education.

## Introduction and Background

One of the principal statutory functions of PMETB is to develop and promote postgraduate medical education and training in the United Kingdom. This gives the Board a remit to be a leader and advocate for postgraduate medical education and training.

The *Future Doctors* review was launched in 2007, with the aim of ensuring that training not only best equips doctors with the skills and knowledge required to practice as a specialist or GP now, but that it remains fit for purpose in 10-15 years' time. This report conveys the findings and recommendations of The Role of the Regulator Working Group, which took forward one of the four workstreams.

The working group considered the question 'How should the Postgraduate Medical Education and Training Board use its regulatory powers so as to ensure that, in the years to come, postgraduate training meets the needs of patients, trainees and the service?' This afforded us the opportunity to consider a number of fundamental questions about the extent of PMETB's statutory responsibilities and its wider role as a leader. For example:

- Where should PMETB position itself as a regulator? What is its role beyond its statutory functions? For example, does PMETB have a wider influencing/lobbying role alongside its statutory and developmental work?
- Should it take a prescriptive approach beyond setting standards?
- How should it work with other regulators?
- Are the powers PMETB has and the work it is doing sufficient to make a real and lasting difference?

As the work of The Role of the Regulator Working Group commenced in May 2007, it was guided by - although not restricted to - PMETB's statutory functions. After the Secretary of State decided to merge PMETB with the GMC, the scope of the discussions broadened in line with the long-term vision of the *Future Doctors* review, and the recommendations in this report are pertinent to any organisation regulating postgraduate medical education and training.

The membership of the working group included representatives of other healthcare professional regulators, postgraduate deans, clinicians (junior doctors, consultants and general practitioners), lecturers and the service. The full list of members can be found in the Annex to this document.

In addition to the review of the existing documentary evidence, research material and developments surrounding national policy, the work of the group has been informed by the outcomes of the other *Future Doctors* workstreams<sup>1,2</sup>, several stakeholder engagement events hosted by PMETB across the UK and two questionnaires aimed at providing an opportunity for trainees, patients, the public and the service to give their views about the future. Together, the events and the questionnaires contributed the views of nearly 600 individuals and organisations.

# Part 1: Regulatory Context

## 1.1 UK regulatory arena - devolution and diversity

In recent years there has been a major shift in the emphasis on regulation in the UK. Within healthcare, views have been significantly influenced by reports such as those into standards of surgery at the Bristol Royal Infirmary and the events surrounding the case of Dr Harold Shipman. PMETB's background paper explores how these and other developments contributed to changes in regulation of medical education<sup>3</sup>.

The broader context has been set by the Better Regulation Executive (BRE) which has the overall responsibility for the Government's commitment to reduce unnecessary regulatory and administrative burdens. It ensures that regulation and its enforcement comply with the five principles of good regulation, in being proportionate, accountable, consistent, transparent and targeted, as laid out in the Legislative and Regulatory Reform Act 2006. Thus, the BRE encourages the rationalising of the inspection and enforcement arrangements for both business and the public sector. The principles of good regulation are accepted by the four countries of the UK.

Building on these, the healthcare inspectorates in England and Wales have collaborated to support improvement of health services while eliminating any unnecessary burdens of external review through coordinating and streamlining their activities.

To support this approach, and in line with policies such as devolution, there is a drive to develop local infrastructures and new and enhanced lines of accountability<sup>4,5,6,7</sup>. This approach aims to recognise differences in the needs of the local population and to allow workforce structures and the education and training of professionals to be built around these needs. Thus, any central initiatives are expected to support and enable locally-led change 'whilst ensuring that universality, minimum standards and entitlements are retained and strengthened'<sup>4</sup>.

## 1.2 Coordination or fragmentation?

Therefore, postgraduate medical education and training takes place in an increasingly diverse environment. Regulatory and service changes create a range of local structures, and in turn a requirement for varied knowledge and a skill mix in the future workforce that will deliver care locally.

There are also a great number of organisations involved in strategic planning, oversight and organisation of medical training and its elements:

### Regulation and oversight

- Postgraduate Medical Education and Training Board (PMETB)
- General Medical Council (GMC)
- Care Quality Commission (CQC)
- NHS Quality Improvement Scotland (QIS)
- Healthcare Inspectorate Wales (HIW)
- Regulation and Quality Improvement Authority (RQIA) (Northern Ireland)
- The Council for Healthcare Regulatory Excellence (CHRE)
- Health Improvements Standards and Regulators Authority (HISRA)

### Policy development and delivery

#### National

- Four Departments of Health
- Medical Royal Colleges and Faculties
- Northern Ireland Medical and Dental Training Agency (NIMDTA)
- Conference of Postgraduate Medical Deans (COPMeD)
- Committee of General Practice Education Directors (COGPED)
- NHS Education for Scotland
- NHS Leadership Council (England)
- Centre of Excellence (England)
- NHS Medical Education England (MEE)
- Medical Schools Council
- MMC teams across the four nations

#### Local

- Deaneries
- Strategic Health Authorities (England)
- NHS trusts, health boards and local education providers (LEPs)
- Employers' organisations
- Educational organisations such as specialty schools and universities

The involvement of a wide range of organisations providing regulatory, advisory and delivery roles can bring added value. However, there is also a danger that, without clear delineation of their responsibilities and coordination of policy and activities, the 'too many cooks' syndrome may prevail, resulting in the overall effectiveness of regulation being diluted.

The Department of Health (England) has attempted to define the roles and scope of responsibilities of different organisations, and lines of accountability through the *Next Stage Review* reports<sup>4,5</sup>. The decision to appoint a Director of Medical Education for England, with a remit covering the full continuum of medical education and training, is a welcome step forward but major challenges remain.

### 1.3 The European and wider international regulatory arena

The EU policy aims to remove barriers to the freedom of movement of professionals across the Member States by standardising the principles applicable across all professions and all countries. In medicine there is mutual recognition of diplomas, certificates and other evidence of formal medical qualifications<sup>8</sup>.

Background research for this review included the examination of the arrangements for medical regulation, including education and training, in some of the EU countries, Australia, Canada, Finland, Sweden, India, New Zealand and the United States of America.

Some regulatory regimes are based firmly in the national ministry of health; others are in separate government agencies or are systems of self-regulation subject to Government monitoring activity. Some systems operate at national level; others delegate regulation to regional authorities. Many regulators appear to delegate specialty standard setting and specialist certification function - the latter is voluntary in a number of countries - to professional bodies/colleges/boards.

The implications of each of the approaches for professional autonomy and standards, for health service planning and patient safety and for political control and cost effectiveness, are very different. The Chief Medical Officer for England<sup>9</sup> noted that there was no one model of medical regulation internationally accepted as best practice, but he made some overarching observations:

- Even in countries previously operating the more traditional model of self-regulation, there has been a decisive shift over recent years towards ensuring patient safety as being the core purpose of the regulator. The concept of self-regulation has become one of professionally-led regulation, with forms of co-regulation, or partnership regulation, becoming more common;
- The trend is for medical regulatory bodies to demonstrate more transparency in their processes and to become more accountable to external authorities;

- In an era when healthcare is often delivered by teams rather than individuals, a number of jurisdictions have developed a common framework of regulation for different groups of health professionals;
- There is a trend away from placing standard setting, the maintenance of the register, investigation, prosecution and adjudication all under the remit of one organisation.

#### **1.4 Factors influencing postgraduate medical education and training**

A great many demographic, social and political changes are taking place. Patients are becoming more informed and questioning; there is an increase in chronic conditions and complexity of presentations; the introduction of the European Working Time Directive (EWTD); and the increasing shift from individual to team healthcare delivery are changing the nature of the training environment. These trends and their impact on postgraduate medical education and training have been explored in detail in the other *Future Doctors* workstream reports<sup>1,2</sup>. As postgraduate medical education and training and the environment in which it takes place are changing, the regulator needs to be cognisant of and respond to such changes if it is to continue to serve the interests of patients, doctors and the service.

## Part 2: PMETB as the Regulator

Over the last few decades, against the background of some very high-profile cases, concern for patient safety has led to increased calls for direct public and service involvement in regulation and consistent standards across the spectrum of postgraduate medical education and training<sup>3</sup>. The Specialist Training Authority went some way towards introducing consistency, but its scope did not include General Practice, and membership was predominantly professional. PMETB was created by statute of Parliament in order to achieve this dual goal, and took up its responsibilities in 2005.

### 2.1 PMETB's statutory remit

The Board's statutory responsibilities are set out in the *General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003*<sup>10</sup> (referred to as the Order). The functions it carries out to meet these responsibilities are summarised below:

PMETB's statutory responsibilities under the Order	The functions undertaken in respect of these responsibilities
<p>Establishing standards and requirements for postgraduate medical education and training, including:</p> <ul style="list-style-type: none"> <li>• Standards for entry to training;</li> <li>• Curriculum standards for General Practice and Schedule 3 (of the Order) specialties;</li> <li>• Outcomes to be achieved, including the level of skill, knowledge and expertise required;</li> <li>• Methods of assessment of progress during and upon completion of education and training.</li> </ul>	<p>PMETB has established a set of standards and mandatory requirements that underpin them. These must be met by postgraduate medical and training providers at all levels and locations, and comprise:</p> <ul style="list-style-type: none"> <li>• <i>Generic standards for training (2008)</i><sup>11</sup>;</li> <li>• <i>Standards for curricula and assessment systems (2008)</i><sup>12</sup>;</li> <li>• <i>Standards for deaneries (2008)</i><sup>13</sup>;</li> </ul> <p>These documents amalgamate a set of standards, principles and requirements issued by PMETB between 2004 and 2008.</p>

<b>PMETB's statutory responsibilities under the Order</b>	<b>The functions undertaken in respect of these responsibilities</b>
<p>Making sure these standards and requirements are met:</p> <ul style="list-style-type: none"> <li>• Awarding Certificates of Completion of Training (CCTs) to registered medical practitioners who have successfully completed education and training programmes approved by the Board;</li> <li>• Assessing equivalence of qualifications, training and/or experience of doctors seeking a statement of eligibility to apply for entry to the Specialist or General Practice Registers of the General Medical Council;</li> <li>• Approving postgraduate medical education and training programmes and posts, courses including examinations, assessments, tests of competence, institutions and persons for provision of education and training leading to the award of a CCT;</li> <li>• Awarding certificates of acquired rights.</li> </ul>	<p>PMETB ensures that these standards are maintained by undertaking the following:</p> <ul style="list-style-type: none"> <li>• Issue of CCTs;</li> <li>• Issue of Certificates of Eligibility for Specialist/General Practice Registration (CESRs and CEGPRs);</li> <li>• Visits to deaneries;</li> <li>• Post, GP trainer and programme approval;</li> <li>• Curriculum (including assessment system) approval;</li> <li>• Yearly national trainee and trainer surveys;</li> <li>• Triggered visits and responses to concerns;</li> <li>• Quality Assurance of Foundation Programmes (with the GMC);</li> <li>• Approval of new sub-specialties and work with the Department of Health in relation to new specialties;</li> <li>• Issue of certificates of acquired rights.</li> </ul>
<ul style="list-style-type: none"> <li>• Developing and promoting postgraduate medical education and training.</li> </ul>	<ul style="list-style-type: none"> <li>• The Quality Framework<sup>14</sup> focuses on improvements in quality, as much as assurance.</li> <li>• Major three-year Future Doctors Review of content and outcomes of specialty training.</li> </ul>

## 2.2 Areas outside PMETB's regulatory scope

PMETB's remit does not extend to:

- Undergraduate education;
- Continuing professional development;
- Recruitment and selection in postgraduate medical education training (including the application process and scoring system) other than ensuring that the recruitment processes are fair and transparent (see *Generic standards for training*, Domain 4);
- Workforce planning and determining or setting the number of training posts.

## Part 3: Roles of the Regulator

PMETB has already achieved much<sup>15</sup>, but there is room for further consolidation and improvement that it can bring to the sector.

Regulation is not about ticking boxes. Neither is it about creating over-prescriptive and inflexible processes that restrict growth or innovation - for example by applying a blanket prescription or micro-managing the specialty content of curricula.

- So where should PMETB position itself as a regulator? How should it use its current regulatory levers to best effect?
- Are the powers PMETB has and the work it is doing sufficient to make a real and lasting difference?
- Does PMETB have a wider lobbying role alongside its statutory and developmental work? How should it work with other regulators?

A wide range of issues was debated by the working group. There was consensus that PMETB was well positioned to undertake both negative regulation - explicit statutory powers to approve or not against minimum standards - and positive regulation - the broader role for influencing the relevant constituencies to drive up standards and deliver change which may be necessary in postgraduate medical education and training. In other words, the *push* and *pull* factors for change.

To make better sense of how all of this activity fits together, the working group have identified four platforms which describe the scope of PMETB's - and indeed that of its successors - current and potential role as a regulator. These are:

- Guardian and promoter of standards;
- Enabler of innovation and improvement;
- Broker and a force for collaboration, engagement and partnership;
- Influencer and campaigner.

The four platforms are interlinked and are to a large extent embedded in, and could be enforced by, the statute governing PMETB. A number of mechanisms have already been established and activities are taking place across the four platforms. Recommendations from the other workstreams of the *Future Doctors* review provide practical examples of how PMETB's regulatory duties for setting and maintaining standards and developing and promoting postgraduate medical education and training can be taken further.

## 3.1. Regulator as a guardian and promoter of standards

### Already in place

PMETB's role in setting and ensuring maintenance of standards is statutory. In addition to establishing the first ever, in the history of postgraduate medical education and training, *Generic standards for training and Standards for curricula and assessment systems*, more recently PMETB introduced *Standards for deaneries*, and *Standards for trainers* built into the *Generic standards*. While *Standards for deaneries* serve to identify and measure activities of deaneries - which are accountable to PMETB for quality management of training in their areas - *Standards for trainers* are designed to address the issue of improved trainee/trainer relationship.

Strengthening this relationship was one of the major themes in the Educating Tomorrow's Doctors Working Group's report. Rightly, *Standards for trainers* place certain obligations not only on trainers but also on training organisations to support them. They are significantly high-level due to the wide range of training roles and responsibilities and diverse local arrangements, but serve the purpose in the context of the Quality Framework. Full compliance with *Standards for trainers* will be expected from January 2010 (to allow local adjustments to take place).

### Scope for future development

Having put in place standards, and mechanisms to quality-assure them, there are a number of next steps that might be taken to strengthen both standards and their implementation.

### Defining roles

A regulator might wish to seek more clarity over the roles and support for those who are responsible for managing the processes that underpin the standards. The Educating Tomorrow's Doctors Working Group recommended that trainers should be selected and Educational Supervisors accredited (with a view to extending accreditation, over time, to other training roles), and adequate recognition should be given to training responsibilities in their job plans. Similar arrangements are already in place in respect of GP trainers, and are embedded in the statute. This approach could go a long way towards addressing the tensions in the hospital training environment by facilitating sufficient trainer support and recognition.

The group also raised<sup>1</sup> an interesting point about embedding the deaneries' responsibility to PMETB for quality management of education and training in the statute. Whether the current arrangements through *Standards for deaneries* enable sufficiently robust accountability arrangements needs to be explored further. The relationship between the Quality Framework and the parallel lines of responsibility and accountability in England, set out by the *Next Stage Review*<sup>4,5</sup>, also needs to be considered.

## Patient and public voice

The Patient's Role in Healthcare Working Group highlighted the very important issue of patient-doctor partnership and the need for the regulator to facilitate increased involvement of patients and the public in all aspects of education, training and assessment of junior doctors. So far this task has proved difficult.

- First of all, there does not appear to be a UK-wide or even nationally universal patient/public liaison network in place that local education providers (LEPs) or deans could draw upon. Patient links vary, and are better in some regions than others.
- Secondly, the patients, public and carers involved in training and assessment would need to receive appropriate training and support to undertake this role effectively.

To be successful, the regulator needs to encourage development of appropriate mechanisms, for example through strengthened patient and public involvement elements across all of its standards and requirements, including local delivery of training. This will build and promote awareness of the direct link between quality of medical education and quality of the future patient care services.

## Defining outcomes

The findings of the *Future Doctors* review to date have also recommended a number of areas of knowledge and skill common to all specialties that current postgraduate curricula may not adequately cover<sup>1,2</sup>. This poses a question about whether standards should prescribe content to any significant detail. The current *Standards for curricula* already require the areas of the GMC's *Good Medical Practice* to be addressed. While this is a sound basis, there is a view that in balancing the different needs of the stakeholders the regulator should be more prescriptive in defining the outcomes expected of doctors at the completion of training.

The recent edition of *Tomorrow's Doctors*<sup>16</sup> has developed this approach for undergraduate education, with defined outcomes around three areas:

- The doctor as a scholar and a scientist;
- The doctor as a practitioner;
- The doctor as a professional.

The debates over the period of the *Future Doctors* review have suggested that the regulator should be prescriptive around the common elements of what it means to practise as consultant in the UK, for example communication, leadership and management, core research and teaching/learning skills, patient safety and quality and safety improvement. Over the period of the review there has been a lively debate with the healthcare and medical community about the role of the doctor, which is yet to be translated into the role of the CCT holder<sup>17,18,19</sup>.

The regulator's role in setting standards should remain around WHAT is expected, with a primary focus on best patient care, rather than HOW.

### Recommendation 1

PMETB's regulatory function as a standard setter would be strengthened through:

- a) Strengthening the PMETB's *Standards for trainers* by introducing accreditation of all specialist, as well as GP, trainers;
- b) Introduction of generic outcomes for postgraduate medical education and training;
- c) Reviewing standards and requirements with a view to facilitating increased patient and public involvement in education, training and assessment.

## 3.2 Regulator as an enabler of innovation and improvement

There are several dimensions to this function, but most of them have a key core dilemma: enabling the regulator to ensure achievement of a set standard while allowing flexibility in a way the standard is reached so that innovation and diversity are not stifled. A number of views of regulation stress the importance of this area. For example, one of the five key principles of strategic regulation outlined by the Institute for Public Policy Research, an independent think-tank<sup>20</sup>, is that 'Regulation should be aimed at improvement'. Regulators, PMETB included, are often unfairly criticised for inflexibility.

In undertaking its functions, PMETB needs to endeavour to regulate in a way that not only allows for but also encourages improvement and striving for excellence. In part this is about ensuring that the regulatory framework, including standards, is set at an appropriate level. It should focus on outcomes as well as process, and recognise the value of innovation in a rapidly changing society.

### Already in place

All of PMETB's standards are generic; that is, they apply across all training environments and all specialties. Therefore, they are set at a significantly high level to enable specialties, deaneries and local education providers to develop training in a way that suits local circumstances and specialty needs - as long as consistent outcomes are achieved.

PMETB's Quality Framework supports the exchange of good practice and quality improvement as well as assurance, for example by means of publication of the deanery action plans and identification of notable practice in the reporting. As this is a very important function of the regulator, the effectiveness of the arrangements in terms of quality improvement will need to be monitored over time.

## Scope for future development

### Developing PMETB beyond the standards

PMETB could consider increasing the use of guidance to supplement its mandatory standards and requirements. At times PMETB has included developmental standards within its standards and requirements documents. Recently it has published guidance for implementing workplace-based assessments<sup>21</sup>. While the working group favoured the idea of both core and developmental standards, measuring compliance with the latter is indeed complex. The regulator would need to be clear about how developmental standards fit within the quality assurance framework.

One approach would be for the regulator to take a lead in providing events and networks to encourage innovation and the sharing of notable practice. Events such as annual conferences and regional workshops should be given a much higher priority and should be considered part of the basic function of the regulator.

### Freedom and flexibility

Common to the debate about the future of postgraduate medical education is a desire for greater flexibility, which often goes hand in hand with concern about junior doctors gaining the necessary experience and the core knowledge and skills. PMETB's standards and requirements need to balance these prerequisites whilst not prescribing the working patterns of junior doctors.

One option considered by the Educating Tomorrow's Doctors Working Group was for PMETB to develop, communicate and promote the apprenticeship-based model of graded responsibility. This model is a formalised succession of agreements for increasing a trainee's range of responsibilities for patient care. Now that training programmes have moved away from only time-based criteria; wide and consistent implementation of the graded responsibility model could enable greater flexibility by allowing trainees to progress through their training at varying rates.

However, experience shows that mainstream implementation of the model would require a number of changes in the training environment. As flexible progress through training carries workforce-planning implications, the Educating Tomorrow's Doctors Working Group argued that, to fully enable progress through the curriculum at varying rates, dependency of the service on trainees should be reduced. As PMETB has no power over workforce planning or funding, it can only seek to achieve this through its influencer and campaigner roles, as covered in section 3.4. The trainee/trainer relationship must also be strengthened (see section 3.1).

The graded responsibility model, although different in nature and purpose, is one of a number of areas which may ultimately be supported by credentialing<sup>5</sup>. The scope for credentialing is being explored as a separate piece of work by PMETB and others as a mechanism for recognising doctors' expertise and providing information and assurance to the public and employers through a more transparent and comprehensive register.

## Recommendation 2

Working with partners and utilising all its functions as a regulator to maximise its influence, PMETB and successors should aim to encourage and promote innovation and improvement in medical education and training, for example by:

- a) Increasing the use of guidance to supplement standards;
- b) Facilitating exchange of notable practice aimed at quality improvement;
- c) Responding actively to changes in training by promoting and facilitating consistent implementation of the model of graded responsibility, which underpins effective learning at individual pace while providing safe patient care;
- d) Providing a range of conference, networking and workshop events for the sector to share information and encourage innovation.

### 3.3 Regulator as a broker and a force for collaboration, engagement and partnership

In undertaking its functions, PMETB has a statutory duty to engage with the key groups whose interest it is to protect - service users, trainees and employers. PMETB also has a duty to work alongside the other regulators aiming to develop and improve patient care as a whole. The issue is how far should the regulator seek to solely rely on its powers and its quality assurance tools to meet its responsibilities, or should it go further and encourage and sponsor work, networks and projects that will help bring about improvement? To what extent should PMETB aim to lead policy development in those matters that affect its areas of responsibility?

#### Already in place

One of the priorities for PMETB has been to develop and maintain effective partnerships with other regulators; those involved in the development and delivery of postgraduate medical education and training and wider stakeholders representing patients, trainees and the service. To that end, PMETB has made progress. It has played an active role in two healthcare concordats which seek to share information amongst regulators to minimise disruption to healthcare providers and duplication of activity in quality assurance. PMETB has taken the lead on and is involved in some important debates including credentialing, clinical leadership and the *Future Doctors* review. It has also developed longer-term consultative networks with patients, trainees and the service.

The Board established and continues to enjoy effective working relationships with the GMC on a number of levels - for example policy development issues such as credentialing, certification/registration of doctors and quality assurance of the Foundation Programmes. The two organisations have recently launched the joint *Medical Education and Training Regulation* review, led by Lord Naren Patel, with reference to the GMC's regulatory function across the continuum of medical education and training following the merger.

Furthermore, PMETB is signed up to memoranda of understanding with the Academy of Medical Royal Colleges and the Conference of Postgraduate Medical Deans (COPMeD). PMETB and COPMeD collaborated on the delivery of the yearly National Survey of Trainee Doctors, which continues to be a key resource for all involved in postgraduate medical education and training. PMETB has worked with representatives of the service, via NHS Employers, as part of the curricula review process in 2006.

## Scope for future development

### Alignment amongst regulators

Whilst PMETB has built good partnerships with regulators, particularly at the level of gathering and sharing information, there may be significant further gains to be made from strengthening these links. For example, the quality of training of health-care staff is inherently connected to quality of the current and future patient care services. The main national healthcare regulators, such as the Care Quality Commission (CQC), the Regulation and Quality Improvement Agency (RQIA), Health Inspectorate Wales and NHS Quality Improvement Scotland, have the interest in and the power to influence the training environment, and could promote high quality training through their performance indicators. Education and training of staff is now formally embedded in CQC's registration requirements, but methodologies for mapping across the clinical governance and educational issues are still to be developed<sup>22</sup>. Such collaboration between service and training regulators could not only support and complement PMETB's standards; it could also provide an additional incentive to training providers and facilitate training quality improvement.

The working group saw PMETB's role extend to promoting clarity of vision across regulators and ensuring alignment among them. Regulation will be most effective if it delivers a coherent, unified message. This requires communication and cooperation between regulatory and other bodies: there are a number of factors that, while being of more direct relevance to other organisations, still impact on postgraduate medical education and training and the Board's functions.

Therefore, the group would wish to see PMETB maintain, improve and strengthen relationships with deaneries, colleges and other curricula developers, and other regulators of healthcare and medical education, as well as regulators of other professions covering the wider multidisciplinary team.

### Merger

Following the announcement by the Secretary of State for Health (England) in February 2008, PMETB will merge with the GMC in 2010. The merger, and the policy development around it, provides an opportunity to realise the benefits of a single regulator across the continuum of medical education, and facilitate maximum coordination of the different stages of medical education. The merger will also ensure much stronger links between education and the other functions of the GMC such as relicensure and recertification.

### Recommendation 3

A regulator's strength and impact is significantly enhanced by joining forces with other organisations to achieve shared aims. PMETB and its successors should act as a broker and a force for collaboration, engagement and partnership. They should actively influence all matters that serve the interests of patients and the public through maintaining and enhancing the quality of medical education and training. This can be undertaken on a number of levels, such as:

- a) Aligned standards and policies;
- b) Flexible scope of information gathering in order to maximise benefit;
- c) Shared intelligence and best practice among the regulators of all healthcare professionals.

### 3.4 Regulator as an influencer and campaigner

And finally, the area that is important but perhaps not traditionally associated with the regulator's role: active engagement in debate, lobbying and campaigning.

It is right that, as an independent regulator, PMETB should have the freedom to comment on and enter into the debate on policy development that has direct or indirect impact on the quality of postgraduate medical education and training. This is often government policy work but other bodies, such as the BMA and the NHS Confederation, bring forward proposals that suggest significant change in the wider environment.

The complexity of the arrangements for medical education and training in the clinical environment, in the context of patient care, blurs the barriers between matters falling within and outside the scope of PMETB's immediate regulatory intervention. For example, there remains the danger that training standards could be impeded by inadequate investment in education and training to the extent that there would be excessive reliance on trainees for service delivery. Issues of this magnitude fully justify the involvement of the regulator in highlighting concerns, contributing to and influencing debate and campaigning to protect the sector where this is appropriate. Clearly the regulator must always be mindful of the requirement to be independent and balance differing interests of stakeholders.

#### Already in place

While PMETB's primary focus to date has been its immediate statutory responsibilities, as expected of a relatively recently established body, it has engaged in campaigns concerning quality of training and patient care safety<sup>23,24</sup>. It publishes the outcomes of its Quality Framework, such as surveys and deanery visit reports, and more recently deanery action plans. The Educating Tomorrow's Doctors Working Group viewed the latter as an important element of influencing training providers to place education and training higher on their agendas and thus promoting the value of education and training.

## Scope for future development

### Advocating for education and training

However, there is valuable potential in further developing this platform. One of the major tasks for the regulator would be to ensure that the value of training is fully recognised by the service. This includes recognition of the contribution junior doctors make to service delivery as they consolidate their skills, and the importance of support being available to them and their trainers. It also involves promoting high quality of training as one of the key components of the high quality of patient care offered by training providers, both from the perspective of developing the future generation of skilled doctors, and the quality of care offered by junior doctors in training.

Aligned to this is resource availability. The Educating Tomorrow's Doctors Working Group made a recommendation to PMETB to open a dialogue with the Departments of Health to ensure that adequate training resources are available and used for the purpose intended. The working group would support this recommendation, because appropriately allocated and sufficient funding is crucial to availability of sufficient support for trainees and trainers. As part of this, the progress and implications of the review of funding flows in England, as part of the *Next Stage Review*<sup>25</sup>, must be monitored and, if necessary, challenged.

### Policy development

Most regulators maintain some form of policy development function, often to support internal policy work and to enable the regulator to monitor and comment on proposed changes within the wider policy community.

But the role may go wider than the regulator's immediate work; there may be scope for the Board to facilitate smoother networks among all those involved in training, for example in order to support the shift of training into primary care (in England) to follow the service delivery, as suggested by the Educating Tomorrow's Doctors Working Group.

More broadly, PMETB should seek to influence the wider policy picture as it affects the training of doctors, for example looking to contribute to debates about the education and training culture within the NHS.

#### Recommendation 4

There is a role for the regulator to get involved in wider debate and campaigning in order to influence issues falling outside its direct statutory responsibilities where these impact on the regulator's responsibilities.

PMETB and successors should aim to raise the profile and ensure due recognition of the value of high quality education and training in the service environment. Key issues for consideration will be the need to ensure availability of adequate training resources, and the encouragement of the financial incentives to provide high quality training.

## Conclusion

PMETB was established in the wake of calls for, first of all, increased public and service involvement in healthcare regulation, and, secondly, a coherent, robust and accountable approach to and consistent standards for specialist and GP training. This was reflected in PMETB's statutory functions and objectives.

The working group believe that the legislation, as set out currently, also places PMETB in a position to achieve its strategic vision of being 'more than a regulator' by leading and influencing improvement across the sector. In the four years since it assumed its statutory powers, the Board has undertaken a broad range of activities relevant to its core responsibilities. It has also established a challenging body of innovative engagement work - such as the *Future Doctors* review - aimed at positioning PMETB as the hub and a resource for postgraduate medical education and training.

These achievements provide a unique platform which the Board over the next few months, and the GMC following the merger in 2010, should build upon. There are unparalleled opportunities for the regulator, be it PMETB or the GMC, to adopt and apply a model of regulation which is both proactive and reactive, and both negative (ensuring a baseline standard) and positive (encouraging advancement). The challenge will be utilising these opportunities through a complementary four-dimensional approach set out in this report.

The merger of PMETB with the GMC presents additional benefits, such as increased coordination of the various stages of medical education and training, from medical school to retirement. The future role of the GMC as the regulator is currently being explored by Lord Patel's review of medical regulation. A coordinated approach across the four regulatory platforms will ensure that the regulator is not only a standard setter and keeper but also an advocate of medical education and training, a promulgator of good practice and a prominent force in the drive for excellence in medical education.

## Annex

### Membership of The Role of the Regulator Working Group

(and affiliations and positions held during the course of the working group's tenure)

<b>Professor Sir Ian Kennedy (Chairman)</b>	Chair, Healthcare Commission
<b>Dr John Jenkins</b>	Board Member, PMETB Consultant Paediatrician and Senior Lecturer in Child Health, Queen's University Belfast
<b>Mr Ian Cumming</b>	Board Member and Deputy Chair, PMETB Chief Executive, North Lancashire PCT
<b>Dr Amit Malik</b>	Training Committee, PMETB SpR in Psychiatry, Nottingham
<b>Ms Rosemary Macalister-Smith</b>	Acting Chief Executive, Council for Healthcare Regulatory Excellence
<b>Professor Elisabeth Paice</b>	Chair, COPMeD Dean Director, London Deanery
<b>Dr Terry McMurray</b>	Chief Executive/Postgraduate Dean, NIMDTA
<b>Professor Rudy Bilous</b>	Professor of Clinical Medicine, The James Cook University Hospital
<b>Professor Kieran Walshe</b>	Professor of Health Policy and Management, University of Manchester
<b>Professor Aidan Halligan</b>	Chief Executive, Elision Health
<b>Professor David Haslam</b>	Board member, PMETB President, Royal College of General Practitioners
<b>Professor Neil Douglas</b>	Board member, PMETB President of the Royal College of Physicians of Edinburgh

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