
4 - Outcome of Consultation on the Review of the Future Regulation of Medical Education and Training -Annex A

Consultation Analysis

Introduction

1. In September 2007, in the final report of his independent inquiry into Modernising Medical Careers, Sir John Tooke recommended that 'PMETB should be assimilated in a regulatory structure with GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement'.
2. Although the merger will bring regulatory responsibility for the whole of medical education and training under one roof, this consolidation of functions will not, in itself, achieve the full benefits envisaged by Sir John Tooke's report.
3. To ensure that those benefits are realised the GMC, with support from PMETB, invited Lord Naren Patel to lead a review of the current arrangements for the regulation of medical education and training and make recommendations that would inform future policy developments by the GMC.

The review

4. The review has proceeded in three phases. Preliminary work during the latter part of 2008 concentrated on clarifying the scope and priorities for the review and gathering information. This began with a Chatham House style round table discussion and a series of interviews with individual stakeholders. The second phase involved consideration by a small working group of the views and information collected. The emerging views of the working group were then subject to debate within a wider reference group of stakeholders.
5. The public consultation on Lord Patel's draft report was the third and final stage of the review. The outcome of the consultation has been used to inform the final report which is to be submitted to the Council of the GMC at the end of March 2010. It will be for the GMC to decide how it wishes to take forward the review recommendations.

Methodology

6. We wrote to 300 organisations, mostly by email, on 12 January 2010. They included: patient and public representative groups, lay members of the GMC's Reference Community, NHS and other healthcare providers, medical schools and medical Royal Colleges, the Chief Medical Officers in all four countries of the UK, the Secretary of State for Health, shadow health ministers, interested parliamentarians, employers and doctors representative organisations, systems regulators and other healthcare regulators.
7. A reminder email was sent to 200 of these contacts on 16 February 2010.

8. A press release was issued on 19 January 2010, which resulted in coverage in professional and other health related journals, national and local newspapers and details were provided on the websites of a number of organisations.
9. An article publicising the consultation was placed in the January/February 2010 edition of *GMCtoday*, which was sent to all registered doctors in the UK.
10. The consultation made 27 recommendations. For each recommendation, respondents were asked to say whether they agreed with the consultation proposal, disagreed or were not sure. Respondents were also invited to provide further comments.
11. Those wishing to respond were able to do so by post, email or by using our online e-consultation facility. The analysis of the consultation responses provided in this report takes account of comments submitted via all of these means.
12. We have also taken account of comments received during a seminar held for past and present Foundation Programme trainees on 3 February 2010, but have not included these in the statistical breakdown which accompanies each recommendation in this report.

Breakdown of responses

13. Most of the responses we received were categorised as either: patients and the public; doctors; bodies representing doctors; NHS/health and social care organisations and other employers; medical schools; representative bodies; medical educators; postgraduate medical institutions; or regulatory bodies.
14. We received a total of 100 responses to the consultation. 57 responses were submitted on behalf of organisations and 43 were from individuals, most of whom were doctors. Table 1 below shows the breakdown of respondents with reference to the GMC's key interest groups.

Table 1: Consultation responses by category of respondents

Respondent category	Response #
Doctors	35
Medical schools or representative bodies	5
Medical Educators	7
Postgraduate Medical Institution	8
Body Representing Doctors	27
NHS/HSC organisations and other employers	8
Patients and Public	1
Regulatory Bodies	4
Other respondents	5
Total	100¹

¹ Two submissions were received after the closing date, and these are not included in the analysis by recommendation. However, we have summarised where these respondents were not sure about or disagreed with recommendations at the end of this report.

General comments

15. A number of respondents made general comments on the nature of the report and the review. Where possible these comments have been integrated into the analysis; however, some respondents have outlined issues that do not fall easily within the individual recommendations.

16. In terms of highly supportive comments, one medical educator states:

'I find myself incredibly reassured and relieved after reviewing the contents of this report. I would go as far to say that this is the most competent, relevant and pragmatic report on education and training I have reviewed for many years. I cannot identify any recommendation which causes me concern, but many recommendations that properly address issues that those working on the ground have recognised as being important for some time.'

17. However, five respondents (including the Department of Health, and several Royal Colleges) believed that the report did not sufficiently acknowledge the role of the Royal Colleges in medical education and training. In this respect, the Department of Health outlines that the GMC does not have the sole responsibility for setting standards in education and training, as this also involves Government and the Colleges.

18. A further respondent was concerned that there is nothing in this review about the national trainee surveys. They note that although a useful tool, there remain improvements that can be made. They suggest that a separate review, with academic input, is carried out with a view to making some refinements to content, methodology, governance, reporting and Deanery access to certain data to maximise their use.

19. Two more respondents made comments relating to the current financial climate. The BMA, for example, outlines its concerns that the current financial situation could adversely impact on the quality of medical education and training across the UK:

'Whilst we are aware of the challenging public spending climate, it is essential that the medical academic workforce does not decline if the delivery and standard of medical education is to be maintained.'

20. Another respondent, a medical educator, notes that the report does not address the specific challenges for doctors undertaking clinical academic training, which number around 5% of the total number of medical trainees.

Report section 6: Approach to education and training

21. This review looks at the role of the regulator in medical education and training. But the regulator is only one player in the complex healthcare environment required to develop and foster the skills and commitment of doctors throughout their careers. All those involved must fulfil their responsibilities if the UK is to provide first class training to support a first class health service. For its part, the GMC must enhance links with the other key interests. These include patients, the profession, the medical Royal Colleges, commissioners and providers of training, and other regulators.

Review draft recommendation 1:

The review welcomes the priority placed on protecting the public within the GMC's recent strategic plan. The GMC should set out how the merger of the GMC and PMETB will benefit patients and what steps are in place to realise these benefits within a fully integrated regulatory framework for doctors.

Summary statistics

Review draft recommendation 1:		
Answer Option	Response #	Response %
Agree	74	95
Disagree	1	1
Not sure	3	4
Further comment	26	N/A
Total	78	100

Discussion

22. 26 respondents submitted further comments in answer to Recommendation 1. Of these, 24 respondents agreed with our recommendation; and two were not sure.

23. There were 12 supportive comments, including the statements that 'Protecting the public has to be given the highest priority, especially with the merger of the GMC and PMETB taking place' [Royal College] and 'It is important to make sure training for future doctors is based on patient safety and... there should be vigorous assessment of training to make sure that all doctors are competent to do the job' [Doctor].

24. NHS Employers stated that:

‘There is full agreement that the GMC should seek to use the opportunity of creating a continuum of medical regulation from undergraduate to retirement and beyond to benefit patients and deliver effective regulation that represents value for money.’

25. Two key themes emerged from the comments:

- a. Need for a wider focus.
- b. Functions of PMETB maintained.

Need for a wider focus

26. Seven respondents framed their additional comments around the theme of the recommendation (or the GMC generally) needing a wider focus. This included more meaningful patient and public involvement, and how the merger would benefit not only patients, but also those undertaking medical training (two respondents), society (one respondent), and doctors and the profession (three respondents). The BMA noted that the priority on patients reflected the concerns of doctors: ‘The BMA welcomes the GMC’s priority on protecting the public, as this is also the priority for doctors.’

27. Although two organisations, an NHS organisation and a patient representative group, agreed with the recommendation, they suggested that there was a need for the GMC to make an early statement detailing how the merged organisation will benefit patients, and outlining what steps are in place to realise these benefits.

28. In the future work of the merged organisation, two respondents wanted greater involvement for the Royal Colleges in setting standards and quality assuring specialty specific training environments.

29. One respondent specifically questioned the statement in paragraph 43 of the draft report that withdrawing training recognition should be a last resort, and implied that there should be more graduated sanctions available to the GMC.

Functions of PMETB maintained

30. Two respondents (the BMA and the Scottish Medical Training Board) expressed concern that the merger would result in the functions of PMETB being given a lower priority compared with the existing GMC functions. For example, the BMA states:

‘It is important to ensure the functions of PMETB are not pushed into second place in a merged organisation in which GMC functions are given priority.’

Review draft recommendation 2:

In integrating education and training into the regulatory framework the GMC should demonstrate robust engagement mechanisms with the public.

Summary statistics

Review draft recommendation 2:		
Answer Option	Response #	Response %
Agree	63	84
Disagree	4	5
Not sure	8	11
Further comment	28	N/A
Total	75	100

Discussion

31. 28 respondents submitted further comments in answer to Recommendation 2. Of these, 24 respondents agreed with our recommendation; and four were not sure.

32. There were 10 supportive comments from respondents including that:

‘Providing assurance to the public of the robustness and appropriateness of medical regulation is a key requirement for the newly merged organisation.’
[NHS East Midlands]

33. Three key themes emerged from the comments:

- c. Engagement with other groups.
- d. Value of previous work.
- e. Lack of clarity.

Engagement with other groups

34. Many of the additional comments were framed around the need for the GMC, post merger, to engage with other groups as well as with the public; doctors and the profession were mentioned by five respondents. The Department of Health suggested that this engagement should also include employers and the service.

35. The Northern Deanery stated that 'engagement' is not enough; patients also need to be 'involved' in decision making, citing the Annual Review of Competence Progression (ARCP) panels as an example of best practice.

36. The BMA strongly agreed with the recommendation and suggested several principles to underpin the processes of engagement:

- a. Public involvement should be a collaborative process with all voices in discussion helping to develop partnerships.
- b. The process should be ongoing and not just a periodical or one-off exercise.
- c. Feedback mechanisms must be built in.
- d. Processes must be transparent.
- e. Involvement must be accessible to all relevant groups with efforts made to target hard to reach and marginalised groups.

37. Three respondents, including the Glasgow Medical School and East of England Deanery, noted the inherent difficulty of engaging with 'the public' as in practice this often means receiving the views of pressure groups.

Value of previous work

38. In terms of how to engage with other groups, the previous work of PMETB was mentioned by two respondents specifically, with the Scottish Medical Training Board (SMTB) commenting that the training surveys had been particularly useful in receiving the views of trainees. However, the SMTB cautioned that if a similar approach were to be taken to obtain the views of doctors, a careful cost benefit analysis would have to be undertaken.

Lack of clarity

39. Two respondents who were 'Not sure' suggested that there was a lack of clarity in the recommendation as written, mentioning "robust engagement mechanisms with the public" as an empty phrase with no meaning. One other respondent suggested that the terms 'the public' and 'patients' were unhelpfully being used interchangeably.

Review draft recommendation 3:

Following the merger the GMC should clarify and strengthen its relationships with education and training providers and the systems regulators to ensure that it can fulfil its new responsibilities to be a robust and effective regulator across all stages of education and training.

Summary statistics

Review draft recommendation 3:		
Answer Option	Response #	Response %
Agree	80	96
Disagree	1	1
Not sure	2	2
Further comment	50	N/A
Total	83	100

Discussion

40. 50 respondents submitted further comments in answer to Recommendation 3. Of these, 47 respondents agreed with our recommendation; one did not and two were not sure.

41. There were 10 generically supportive comments from respondents, including the statement from a medical educator that

‘...at present providers feel powerless in influencing the process and feel that the issues they have to manage are not given any heed. Engagement will improve the motivation of LEPs [Local education Providers] to improve training standards within their organisations.’

42. The Council of Healthcare Regulatory Excellence (CHRE) ‘...applaud the recommendation to strengthen relationships with those organisations with responsibility for providing education and training and those with responsibility for regulating the health systems within which medical students and trainees are learning and providing care.’

43. Six key themes emerged from the comments:

- a. Need for dialogue.
- b. Engagement with Colleges.

- c. Relationships with others
- d. Valuing training.
- e. Need for effective sanctions.
- f. Lack of clarity.

Need for dialogue

44. Four respondents framed their additional comments around the need for an effective dialogue with a range of bodies and groups. One medical educator cautioned that there is a risk of the regulator simply dictating to the sector rather than entering meaningful discussions with stakeholders, and another doctor reiterated this in relation to quality assurance visits.

45. The Department of Health noted in their response that the Medical Act places a duty on the GMC to engage with other groups.

46. The Kent, Surrey and Sussex Deanery suggested that it will also be helpful for the GMC to enter into an effective dialogue with the other healthcare regulators.

Engagement with Colleges

47. Eight respondents suggested that engagement with the Royal Colleges is essential for fulfilling this recommendation. For example the Joint Royal Colleges of Physicians Training Board (JRCPTB) states that:

‘...regulation of training is improved if the Regulator positively engages with Colleges. This did not happen in the early days of PMETB, and regulation and PMETB's effectiveness suffered as a result. Generally the Colleges' overriding concern is that there should be high quality medical education in all locations.’

48. The Royal College of Anaesthetists went on to suggest that the role of the Colleges and faculties are so important that they should be mentioned specifically in the recommendation, and that ‘...the relationship that PMETB has worked hard to establish with the Medical Royal Colleges and Faculties following a difficult start should be reinforced.’

49. The previous work of PMETB is also specifically mentioned and valued by a further two respondents.

Relationships with others

50. Four respondents (including Royal College of General Practitioners (RCGP), East of England Deanery and NHS East Midlands) specifically mention the commissioner/provider split and the need to reflect this in the report and GMC post merger. To make this recommendation sustainable in the long term, the East of England Deanery suggested referring to ‘Commissioners and Providers.’

51. The London Deanery suggested that the GMC quality assure the ‘...commissioner, by seeking evidence that its planning, contracting, quality management and provider development processes are robust and are ensuring that the regulator's educational standards are met or surpassed for every student and trainee and in every setting where education and training takes place.’

52. The Board for Academic Medicine in Scotland suggests that the GMC should focus on building direct relationships with doctors and medical students and not just on building indirect relationships through training providers and systems regulators.

53. Royal Society of Medicine indicated its willingness to be involved in this work. The Academy Subject Centre for Medicine, Dentistry and Veterinary Medicine (MEDEV) suggests that the GMC consider aligning its guidance to that of the regulators of other professions and taking into account other stakeholders such as subject associations, the Higher Education Academy and Quality Assurance Agency to promote enhancement activities and innovation.

Valuing training

54. Three respondents (including one doctor, the British Association of Dermatologists, and a university hospital) who agreed with the recommendation, suggested that training needs to be valued more than it currently is, either through increases in funding or through educational commitments in consultant job planning and appraisal processes.

55. Similar comments were made by those who attended the seminar held for Foundation Programme trainees. Trainees argued that some Trusts do not understand the role of the F2 doctor and do not recognise the difference between F1 and F2, or between F2 and the previous senior house officer grade. They saw this as the root cause of many of the problems with the Foundation Programme. It was also noted that there is a need to raise the profile of education and training inside the NHS and that this will naturally increase the quality of its provision.

Need for effective sanctions

56. Four respondents commented on the current lack of, and future need for, effective sanctions. These respondents included three organisations (Royal College Physicians (RCP) of Edinburgh, Remedy UK, and NHS Education for Scotland) and one doctor. Remedy UK, which disagreed with the recommendation as written, stated that the power to decommission a poor training provider is essential and must be retained in the merged regulator. The RCP Edinburgh went on to state that it would ‘...encourage further review of the effectiveness of the quality monitoring of education providers to ensure education providers are held to account for their training responsibilities’.

Lack of clarity

57. The BMA sought clarification of the term 'system regulators' which was used in the consultation to refer to bodies such as the Care Quality Commission, Health Inspectorate Wales, the Regulation and Quality Improvement Authority and NHS Quality Improvement Scotland.

Report section 7: Understanding the 'continuum of medical education and training'

58. Although there are crucial differences in the stages of doctors' education and learning which need to be acknowledged, regulation should reach across and link those stages. One of the main challenges is to support doctors' transitions from one stage to another so that risks are minimised and learning maximised. This will require effective systems for the transfer of information across these different stages.

Review draft recommendation 4:

The GMC should establish a national working group of key interests to address issues arising from the transitions between the different stages of education and training, including the steps it might take with others to facilitate the more effective transfer and co-ordination of information about curricula, assessments and individuals across the different stages.

Summary statistics

Review draft recommendation 4:		
Answer Option	Response #	Response %
Agree	69	86
Disagree	2	3
Not sure	9	11
Further comment	45	N/A
Total	80	100

Discussion

59. 45 respondents submitted further comments in answer to Recommendation 4. Of these, 37 respondents agreed with our recommendation; one did not and six were not sure. One respondent provided comment but did not say whether they agreed or disagreed with our proposal.

60. The respondent who disagreed stated that the proposal could be achieved by the Royal Colleges in a more effective manner.

61. There were 14 supportive comments. The Royal College of General Practitioners (RCGP) stated that an ‘...overview of all stages of training is important. Trainees and young doctors are generally at their most vulnerable at times of transition, and additional guidance on managing transitions is welcome.’

62. Three key themes emerged from the comments:

- a. Previous work.
- b. Membership.
- c. Lack of clarity.

Previous work

63. Ten respondents mentioned that any working group must seek to build on previous work, variously citing the work of the UK Foundation Programme Office’s (UKFPO’s) Transfer of Information Process and the E-Portfolio specifically. Two respondents (the National Clinical Assessment Service and the UKFPO) emphasised the importance of transferring information, and stated that both positive and negative indicators should be passed on.

64. The Medical Schools Council, the UKFPO and the Department of Health, while supportive of the recommendation, noted that a Transition Group to address issues affecting this transition between different stages of education and training had already met. This group includes representatives from undergraduate and postgraduate medical education across the UK, including the GMC.

Membership

65. 14 respondents commented on the composition of any working group looking at transition issues. NHS East Midlands stated that

‘...the membership and terms of reference of this working group are critical, and the membership and TOR must reflect the need to look towards the future implications of the transition between the different stages of education rather than the present ones. This will allow the work of the regulator to support a process of development and change, within medicine, to address the needs of the population and the NHS as a whole.’

66. Two responses suggested that membership must include the Royal Colleges and Faculties, and another wanted representation for service deliverers. Representation was also sought for those commissioning or providing education and training. In addition, several organisations expressed interest in being included on the group: Royal Society of Medicine, BMJ Learning, NHS Education Scotland, BMA, the British Orthopaedic Association, the UKFPO and the Scottish Medical Training Board.

67. The Department of Health also stated that it would wish to work with the GMC on this issue.

Lack of clarity

68. Five respondents (including the Royal College of Paediatrics and Child Health (RCPCH) Training Committee and the National Institute for Health and Clinical Excellence) complained that that the recommendation contained no terms of reference or membership for the proposed group.

Review draft recommendation 5:

The GMC should work with others to identify and collect nationally agreed data sets to inform its processes and validate the outcomes of its regulatory activities. It should also consider how technology might be used to support this.

Summary statistics

Review draft recommendation 5:		
Answer Option	Response #	Response %
Agree	76	95
Disagree	2	3
Not sure	2	3
Further comment	44	N/A
Total	79	100

Discussion

69. 44 respondents submitted further comments in answer to Recommendation 5. Of these, 40 respondents agreed with our recommendation; two did not and two were not sure.

70. There were 15 generically supportive comments from respondents. For example, the Medical Protection Society welcomes

‘...the recommendations for improved continuity and transfer of information regarding learning and developmental needs throughout a doctor's career; and the collection of individuals' performance data to identify individual and systemic problems. If implemented, this would demonstrate a commitment to patient safety.’

71. Of those who disagreed or were unsure, three comments related to a lack of clarity. The remaining one respondent who disagreed with the recommendation stated that the development of data sets would add another layer of bureaucracy.

72. Three key themes emerged from the comments:

- a. Previous and future work.
- b. Data widely available.
- c. Lack of clarity.

Previous and future work

73. There was a general recognition from nine respondents that there had already been a great deal of work undertaken in this area and that it was essential to build upon and not duplicate past processes. The UKFPO's Transfer of Information process was mentioned specifically by one respondent, the E-Portfolio by two respondents, and the PMETB trainee survey by three respondents.

74. NHS East Midlands suggested that this may need careful planning with the Department of Health and Devolved Administrations.

75. Five respondents suggested specific ideas for how this might work in the future. East of England Deanery noted the effectiveness of the Danish model of compulsory surveys at the end of every placement – completion of which is a pre-requisite for progression.

76. The National Clinical Assessment Service (NCAS) suggested a 'passport model' wherein both positive and negative indicators are included. Expanding on this suggestion, the College of Emergency Medicine suggested that the data set should be agreed along the lines of *Good Medical Practice*, with the creation of a life long e-portfolio. The College states that '...this could be used from medical school through to CPD and revalidation and would allow easier identification of transferable skills for any future career moves.'

77. Two respondents (including the Academy of Royal Medical Royal Colleges) who were supportive of this recommendation cautioned for the need for extensive piloting prior to implementation.

78. CHRE noted that they have recently released a report in which they considered the issue of whether outcomes from student fitness to practise committees should be shared with regulators.

Data widely available

79. Six respondents noted the importance of this data, and the need to ensure that it would become widely available. The UKFPO stated the data would help them '...project trends, help with workforce planning and be able to review and validate the outcomes of its regulatory activities.' Medical Education England also agreed that the availability of better quality information in this area would greatly assist with workforce planning.

80. MEDEV goes on to suggest that if effective data sets were shared, it may lead to improved quality of provision in education and a substantial and growing data set for research and development purposes, which has a clear benefit in the long term.

81. The General Optical Council suggests that it would also be useful if all of the healthcare regulators were able to agree a common set of data to facilitate inter-regulatory consistency of processes.

Lack of clarity

82. Five respondents felt that the recommendation lacked clarity; two querying what data sets are to be collected, and another two asking which 'others' the GMC would work with in this area.

Report section 8: Begin at the beginning: selection into medical school

83. Medicine is a vocation. It demands more than the acquisition and practice of a set of knowledge and technical skills. Some of those interviewed during the scoping phase of the review said that entering medicine should involve giving a commitment to that vocation. Some interviewees argued that careful consideration should be given to strengthening the GMC's role in the arrangements for selection into medical schools.

Review draft recommendation 6:

The GMC should not seek to extend its regulatory role into selection for undergraduate training.

Summary statistics

Review draft recommendation 6:		
Answer Option	Response #	Response %
Agree	51	65
Disagree	17	22
Not sure	11	14
Further comment	40	N/A
Total	79	100

Discussion

84. 40 respondents submitted further comments in answer to Recommendation 6. Of these, 21 respondents agreed with our recommendation; 12 did not and five were not sure. Two respondents provided comments but did not say whether they agreed or disagreed with our proposal.

85. However, it is worth noting that the use of the word 'not' in the recommendation led to some respondents to misunderstand what was being proposed, so a purely statistical analysis may be misleading.

86. There were six generically supportive comments.

87. Three key themes emerged from the comments:

- a. Difficulty of selection.
- b. The GMC should have a role in setting standards for selection.
- c. The GMC should not be involved in selection.

Difficulty of selection

88. Eight respondents acknowledge the inherent difficulties in selection processes and several note the consequent risk in terms of patient safety. Three respondents (including the BMA, NCAS, and NHS East of England) also note that current selection processes are heavily reliant on cognitive predictors which can impact adversely on the breadth of social, cultural and ethnic backgrounds from which medical students are selected.

89. One medical educator states that the '... problem here is that we simply don't yet know the best way of selecting medical students. Perhaps the best role for the GMC might first be to support better research.' The desire for further research in this area is supported by a further two respondents, the MEDEV and NHS East Midlands.

The GMC should have a role in setting standards for selection

90. A large number of responses (14) suggested that the GMC should have some role in setting standards for selection to medical school.

91. Many of these responses noted that although final responsibility should rest with the individual medical schools, there was some value in having UK wide selection criteria. The Royal College of Pathologists states that there are variable standards of understanding of basic medical science among some new graduates.

92. The BMA references the GMC's guidance *Gateways to the Professions* and states that 'The BMA would welcome similar guidance for admissions deans to ensure equitable access and adequate support for groups that are currently under-represented in UK medical schools.'

93. Five respondents who agreed with the recommendation suggested that the GMC should have a role in quality assuring selection processes to ensure that they are fair and transparent. The Department of Health agreed that it was not for the regulator to be involved in selection, but felt that there is a need for scrutiny of selection processes so as to take account of issues such as fair access.

The GMC should not be involved in selection

94. Among those who supported the recommendation, the reasons given were that the current systems are adequate, selection is the responsibility of universities and medical schools, and that selection is an educational not a regulatory decision. Referring to the quality assurance of selection processes, the Medical Schools Council states: 'This decision is particularly welcomed by the Medical Schools Council. As set out in the report the GMC should continue to satisfy itself that selection processes used by Schools are appropriate, fair and transparent.'

Report section 9: Undergraduate Years

95. Medicine is both a profession and a vocation. Its practitioners need to understand what it means to be a professional and to make a personal commitment to the standards and values that this implies. One of the goals of undergraduate medical education is to instil a culture of professionalism, and to begin the process of induction into the profession, that will inform doctors' practice throughout their careers.

96. It has been argued that the current undergraduate experience does not always achieve this and that student registration could be one way of fostering professionalism and a sense of professional identity. However, we are not convinced this is the only way and it may not be the most cost-effective. The GMC should evaluate the effectiveness of its existing arrangements for engaging with students and how professional identity and values are fostered by medical schools.

Review draft recommendation 7:

The GMC should evaluate the effectiveness of its existing arrangements for engaging with students and patients.

Summary statistics

Review draft recommendation 7:		
Answer Option	Response #	Response %
Agree	65	81
Disagree	4	5
Not sure	11	14
Further comment	39	N/A
Total	80	100

Discussion

97. 39 respondents submitted further comments in answer to Recommendation 7. Of these, 30 agreed with our recommendation and eight were not sure. One respondent provided comment but did not say whether they agreed or disagreed with our proposal.

98. There were 15 generically supportive comments from respondents. For example, the Patients Association states:

'With regard to patients, we support a wider active engagement with patients, and patient groups, and the public so that its work is better understood... With regard to students, they should understand from day one the ramifications of 'vocation' and 'profession' so that bad habits do not take hold.'

99. Three key themes emerged from the comments:

- a. Student registration.
- b. Exit degrees.
- c. Engagement with others.

Student registration

100. Student registration was mentioned by 15 respondents, both in a supportive and negative way.

101. Those supportive of at least re-examining the debates around student registration included the Board for Academic Medicine in Scotland, UKFPO, and the London Deanery. However, one medical educator cautions that 'If students are already registered then the GMC will need to be prepared to act at any point through medical training to remove registration and not just wait until graduation before making a decision.'

102. The Medical Schools Council (MSC) argued that student registration is not necessary at this time. However, they acknowledge that it may need to be revisited if the combined efforts of the MSC and GMC do not have the desired results.

103. The Royal College of Physicians of Edinburgh also welcomed the perceived move away from student registration and agreed that there should be an evaluation of student engagement.

104. The BMA strongly opposed student registration as it would not overcome the lack of a uniform definition of student fitness to practise or the difficulties that can arise from university disciplinary regimes which regard academic competence as more important than issues of professionalism and the public interest. The BMA states that '...it is far more important that medical students have the chance to engage with the GMC at road shows and other events and that they have senior doctors acting as positive role models, to help instil the values and principles needed to be a good doctor.'

105. The Medical Protection Society disagreed that student registration would foster a sense of professionalism, as they believe this is achieved more by learning by example and from working with more experienced colleagues.

106. Trainees who attended the Foundation Programme Seminar had mixed views on the value of student registration with some attendees placing value on registration later in training (4th or 5th year) while others argued that there were other ways of inculcating professionalism.

Exit degrees

107. Exit degrees were mentioned by two respondents. The Board for Academic Medicine in Scotland stated that most if not all medical schools offer the option to leave medical studies early with a Bachelor of Science degree. However, there was a need to standardise the classification of this degree, its timing and requirements, across the UK and this should be investigated further. The BMA also argued for guidance on exit degrees and better careers advice.

Engagement with others

108. The RCPCH Trainees Committee, the Academy Trainee Doctors Group and the Academy of Medical Royal Colleges agreed with the recommendation and suggested that engagement be extended to trainees as well as students. NHS Education for Scotland noted that much can be learned from the experience of PMETB in relation to trainees and PMETB's use of the trainee survey.

109. Two respondents, including the General Optical Council, wanted the GMC to share the results of its evaluation more widely.

Report section 10: Outcomes and entering the profession

110. Newly qualified doctors need to be able to deliver the same standard of care regardless of where they qualified. Until now the GMC has set high level standards and allowed medical schools considerable flexibility in the way those standards are met. The revised edition of *Tomorrow's Doctors*, published in 2009, is much more detailed in terms of the content and outcomes required of undergraduate medical education. The GMC must evaluate the effectiveness of the new requirements in delivering outcomes that are consistent and reliable to determine whether further measures are needed to achieve these ends.

Review draft recommendation 8:

The GMC should evaluate the impact of the 2009 revision of *Tomorrow's Doctors* with a view to considering the need to enhance the consistency of outputs from undergraduate medical education and, if appropriate, how that should be achieved. It should also consider whether the changes introduced in undergraduate training as a consequence of *Tomorrow's Doctors* have impacted on the needs and requirements of Foundation training.

Summary statistics

Review draft recommendation 8:		
Answer Option	Response #	Response %
Agree	66	83
Disagree	3	4
Not sure	11	14
Further comment	49	N/A
Total	80	100

Discussion

111. 49 respondents submitted further comments in answer to Recommendation 8. Of these, 37 respondents agreed with our recommendation, two did not and nine were not sure. One respondent provided comment but did not say whether they agreed or disagreed with our proposal.

112. There were eight generically supportive comments, which included the following from the Royal College of General Practitioners:

'The GMC should look more closely than hitherto at the impact of its recommendations. Some of our members do express concerns over the consistency of outputs from undergraduate medical education.'

113. Three key themes emerged from the comments:

- a. National exam.
- b. Lack of skills in graduates.
- c. Comments related to the Foundation Programme.

National exam

114. The need for a national exam was mentioned by 18 respondents, in a supportive, negative or more deliberative way.

115. Most comments in support of a national exam were framed around the current variability of graduates. Seven respondents supported the introduction of a national exam. These included the Kent Surrey and Sussex Deanery, NHS Education for Scotland, and Imperial College London. The Royal College of Physicians stated:

‘The service and patients require that doctors in Foundation training should have achieved the necessary knowledge requirements to work as F1 doctors in the NHS. Experience has clearly shown that recruitment systems to Foundation Programmes cannot consistently do this. There is a clear need for a test of core medical knowledge to confirm the fitness of doctors to work in the NHS.’

116. Six comments were also received in clear opposition to a national exam. The College of Emergency Medicine stated that it is very unlikely that a test of knowledge at the end of the undergraduate curriculum would be helpful for their specialty. The Academy Trainee Doctors Group states that trainees in general are not in favour of a national examination to determine entry into foundation training. The Board for Academic Medicine in Scotland believed that at this stage it is premature to recommend a national assessment of medical students.

117. The BMA is also opposed to any proposal that would lead to a national examination. It took the view that:

- a. A national exam would shift the focus away from a broad-based educational experience and lead to a concentration on teaching the skills needed to pass examinations, rather than the skills needed to be a good doctor; and
- b. A national exam would remove the autonomy of medical schools and stifle the diversity and innovation that make UK medical education world renowned.

118. The BMA suggests that instead of a national exam, the GMC should enhance the QABME process to achieve greater consistency between medical schools.

119. The previous work of the Medical Schools Council on a national examination was noted by three respondents. The MSC itself notes other work currently underway that fulfils the objectives of a national exam:

- a. 15% of questions for finals will be drawn from a common question bank, mapped against the outcomes in *Tomorrow's Doctors 2009*.
- b. A national assessment in Prescribing Skills to assess the outcomes relating to prescribing outlined in *Tomorrow's Doctors 2009*.

120. Five respondents, without indicating a clear preference, suggest that a review of the need for a national exam should at the very least take place. These respondents include NHS East Midlands, Glasgow Medical School, the Academy of Medical Royal Colleges, and the London Deanery.

Lack of skills in graduates

121. Eight respondents commented on areas of deficiency in current graduates entering the Foundation Programme. Areas mentioned included prescribing, laboratory medicine, anatomy, physiology and pharmacology, imaging, legal medicine, confidentiality, dermatology, and soft skills (for example patient involvement, consent). One respondent stated that basic medical science had been devalued in *Tomorrows Doctor's 2009*.

122. Two respondents also suggested that a similar piece of work needs to be addressed in relation to overseas medical graduates.

Comments related to the Foundation Programme

123. Ten respondents commented on the effect that this recommendation could have, or should have, on the Foundation Programme.

124. One medical educator states that a major omission from the draft report is its failure to comment on the role that the Foundation curriculum has had on the development of professional skills and competencies.

125. Two commentators (both doctors) suggest that if the outcomes of *Tomorrows Doctors* result in better graduates, there should also be a review of the Foundation Programme to ascertain whether its length can be reduced to one year, and whether certain topics need not be re-visited.

126. The Northern Deanery states that it is also important that the issue of non-UK Foundation Programme trainees is addressed within the limits of EC law. The Royal College of Physicians of Edinburgh also agrees that there is a need to ensure that all doctors entering Foundation Year 1 meet the required standards of knowledge and ability, citing patient safety as a key driver.

127. The UKFPO also believes that the GMC should also look into the timing of final exams, the timing of re-sits and the remedial training offered to medical students. They go on to state that while there is a lack of comparative data examining the outcomes of medical students who failed exams in different schools, they believe that there is significant variation in practice.

Report section 11: Foundation training

128. Regulatory responsibility for the Foundation Programme is currently split between the GMC and PMETB. Although the two organisations have worked well to co-ordinate activities, the forthcoming merger will provide opportunities for rationalisation of the regulatory regime and adoption of appropriate practice.

129. However, other anomalies with the regulation of the Foundation Programme remain to be addressed. Doctors in the first year of their foundation training may be working many miles from the medical school which is formally responsible for their training. This leads to an unsatisfactory lack of clarity over responsibilities. Equally unsatisfactory is the lack of any clear regulatory outcome required from the second year of the Foundation Programme.

Review draft recommendation 9:

Having brought the regulation of the foundation years under one regulator, the GMC should review the quality assurance process to ensure the benefits of the merger are given effect in the Foundation Programme.

Summary statistics

Review draft recommendation 9:		
Answer Option	Response #	Response %
Agree	70	93
Disagree	0	0
Not sure	5	7
Further comment	34	N/A
Total	75	100

Discussion

130. 34 respondents submitted further comments in answer to Recommendation 9. Of these, 31 respondents agreed with our recommendation and three were not sure.

131. Of the 32 comments, 16 were generically supportive:

'Common themes and processes should exist through all stages of training. This should enable smooth transfer of knowledge and skills between different stages of training and specialities.' [Medical educator]

132. Of those that were unsure about the recommendation, two made comments in relation to the current uncertainty around responsibility for the Foundation Programme and the other believed that the recommendation was weakly written.

133. Two key themes emerged from the comments:

- a. Responsibility.
- b. Await the review of the Foundation Programme.

Responsibility

134. Although implied in many submissions, four respondents specifically framed their comments around issues to do with responsibility. NHS East Midlands welcomed the recommendation, but felt that it did not go far enough:

'[we] would have preferred a statement of intent to establish a unified quality assurance process for the totality of Foundation programme training which would link directly to common standards for the remainder of postgraduate medical education and training.'

135. Two respondents note the current issues with medical schools having to sign-off doctors at the end of F1 due to the constraints of European law. One medical educator suggested that there is a need for more robust and immediate feedback from Foundation doctors to their medical schools to allow quick improvements to be made to undergraduates' final year education and training.

Await the review of the Foundation Programme

136. Four respondents stated that action on the recommendation must await the outcomes of the reviews of the Foundation Programme.

137. Three other respondents noted that the GMC should aim to build on existing processes that have worked well; the QAFP process is mentioned by two of these and the PMETB visits to Deaneries process by the other.

138. Both the Northern Deanery and the Academy of Medical Royal Colleges suggested that the point at which full registration is granted should be revisited alongside the review of the Foundation Programme. Another respondent (a doctor) argued that there is no logic in full registration not occurring at the end of F2. The College of Emergency Medicine suggests that the F2 year is moved to the first core year of each specialty programme.

Review draft recommendation 10:

The GMC should consider whether further steps are required to ensure that processes for signing off trainees for full registration are robust.

Summary statistics

Review draft recommendation 10:		
Answer Option	Response #	Response %
Agree	71	89
Disagree	5	6
Not sure	4	5
Further comment	44	N/A
Total	80	100

Discussion

139. 44 respondents submitted further comments in answer to Recommendation 10. Of these, 37 respondents agreed with our recommendation, four did not and three were not sure.

140. There were 17 generically supportive comments from respondents, including the comment by an individual doctor that there ‘... have been concerns over the years that PRHOs and now FY1 are signed off even when there is serious doubt about their suitability because individuals are reluctant to criticise junior colleagues. A more robust system is essential.’

141. At the Foundation Programme seminar, attendees noted that there is a lack of communication between medical school, F1, F2 and specialty training programmes. In addition, there was a perception that there was no common thread linking these stages together.

142. Of those who disagreed with this recommendation, two believed that existing processes are already robust enough and another suggested that there were more important areas to focus on, including mechanisms for addressing struggling trainees.

143. Three key themes emerged from the comments:

- a. Suggested models.
- b. Responsibility for the Foundation Programme.

- c. The point at which registration is granted.

Suggested models

144. Although implicit in many submissions, seven respondents suggested possible ways to remedy the current situation. Five of these respondents suggested some kind of standardised assessment at the end of the Foundation Programme.

Responsibility for the Foundation Programme

145. Eight of those who agreed with this recommendation, noted particular difficulties with responsibility for Foundation Year 1.

146. Four respondents noted that particular difficulties existed for those trainees who move away from their graduating medical school. The UKFPO stated: 'Since up to 40% of students now wish to move outside their locality to train in the Foundation Programme, there remains some confusion about the signing off process for trainees for registration.'

The point at which registration is granted

147. The RCPCH Trainees Committee and the Academy Trainee Doctors Group questioned the rationale for granting full registration half way through Foundation Programme training. The Scottish Medical Training Board and NHS Education for Scotland also questioned whether it is necessary to have two distinct regulatory points so close together at an early stage of a doctor's career. They suggest that this is an area where further thought is required once the foundation reviews have been completed.

Review draft recommendation 11:

Subject to the outcome of the current review of the Foundation Programme, the GMC should define the outcomes required to complete the second year of the Programme, in the same way as it defines outcomes for undergraduate medical education.

Summary statistics

Review draft recommendation 11:		
Answer Option	Response #	Response %
Agree	65	81
Disagree	5	6
Not sure	10	13
Further comment	38	N/A
Total	80	100

Discussion

148. 38 respondents submitted further comments in answer to Recommendation 11. Of these, 29 respondents agreed with our recommendation, one did not and seven were not sure. One respondent provided comment but did not say whether they agreed or disagreed with our proposal.

149. There were 17 generically supportive comments from respondents. For example, Picker Institute Europe stated ‘...that all medical education and training programmes should have clearly defined and coherent outcomes, and that these should include outcomes that directly speak to the patient experience of care.’

150. NHS employers also supported this recommendation: ‘Foundation training must be kept generic but should be robustly assessed at the end of each year to ensure competency to progress.’

151. One respondent who disagreed, stated that it is not the responsibility of the GMC but of deaneries.

152. Three key themes emerged from the comments:

- a. Suggested models.
- b. Point at which full registration is granted.

- c. Await the review of the Foundation Programme.

Suggested models

153. Five respondents suggested models in response to this recommendation. Two suggested an exam at the end of F2, one reiterated the importance of ongoing assessment through Workplace Based Assessments, and one suggested a greater focus on 'soft skills' such as consent, confidentiality, and the duty of a doctor.

154. The British Orthopaedic Association suggested that outcomes be developed in consultation with specialty associations to ascertain whether it is possible to identify 'fast track trainees' who might be entered into a programme which matches their abilities.

The point at which full registration is granted

155. Five respondents commented on elements of registration with the GMC. The UKFPO suggested that, depending on the outcome of the review of the Foundation Programme, consideration should be given to moving full registration to the end of F2. They argue that that this would provide greater coherence to the programme and allow greater flexibility in the development of programmes to meet the needs of trainees and the service.

156. The BMA, however, is wary of shifting full registration to the end of F2: 'some duties undertaken by doctors in Year 2 require them to be fully registered, such as detaining a patient using an Emergency Detention Certificate under the Mental Health Act. If Year 2 doctors were not fully registered it could have significant implications for rotas and, therefore, patient care.'

157. The College of Emergency Medicine argues that the second year of F2 should be the first year of core training.

Await the review of the Foundation Programme

158. Five respondents agreed that action must await the outcomes of the reviews of the Foundation Programme.

Report section 12: Postgraduate education and training

159. The regulation of postgraduate education and training has improved considerably in recent years. Following an initial period of turbulence, PMETB has established well regarded curricula for specialist (including general practice) training. The review found little appetite fundamentally to overhaul this work.

160. Nevertheless, there remain important areas which should now be taken forward. The report argued that the GMC should develop a framework for the accreditation of trainers. The GMC should also look at the case for accrediting the environments in which education and training take place, in addition to approving posts and programmes as currently undertaken by PMETB.

161. The draft report also concluded that the GMC should develop a regulatory framework for the education and training of doctors in career posts. This would not only be in the interests of the doctors concerned (who are often disadvantaged by limited access to training and CPD opportunities), it would also provide reassurance that these doctors are meeting national standards overseen by the regulator.

Review draft recommendation 12:

Having implemented the standards for trainers and evaluated their role and effect, the GMC should develop a framework for the accreditation of trainers.

Summary statistics

Review draft recommendation 12:		
Answer Option	Response #	Response %
Agree	64	75
Disagree	8	9
Not sure	13	15
Further comment	65	N/A
Total	85	100

Discussion

162. 65 respondents submitted further comments in answer to Recommendation 12. Of these, 48 respondents agreed with our recommendation, six did not and 11 were not sure.

163. There were 19 generically supportive comments, including the following:

‘There is currently wide variation in the quality of trainers, and an accreditation framework is likely to improve overall standards.’ [Academy Trainee Doctors Group]

‘This is the most important issue. Not everyone can be good trainers. Difficult trainers contribute as much to the difficult trainees. It is important that there is a robust system to ensure the accreditation of trainers.’ [Doctor]

164. Two respondents who disagreed with the recommendation stated that accreditation was not the responsibility of the GMC, but of the Colleges and Deaneries respectively. A further three who disagreed framed their comments around the additional burden that accreditation would place on trainers.

165. Four key themes emerged from the comments:

- a. Previous and future work.
- b. Valuing training.
- c. Potential difficulties.
- d. Burden on trainers.

Previous and future work

166. Nine respondents noted that there had been a great deal of work already undertaken in this area. The work of PMETB in developing standards for trainers was noted by several respondents. Eight of those that mentioned previous work noted that the Department of Health had commissioned work by the Academy of Medical Educators on developing standards for trainers. The UKFPO were emphatic in their support of this work:

‘We would very much like the Academy of Medical Educators work to form the foundation of any further work that the GMC should wish to undertake with regard to this accreditation and indeed we hope that the GMC would look to the Academy of Medical Educators as an active partner in the establishment of the accreditation of trainers.’

167. The previous work of the Royal College of General Practitioners (RCGP) in accrediting trainers is supported by the Royal Society of Medicine and the Picker Institute Europe in their responses. The RCGP itself indicates its willingness to share its experiences: ‘The RCGP has much experience in this area, and would be keen to work with the rest of the profession in developing these.’ However, another Royal College states that the nature of an effective training environment is very specialty specific and generic guidelines alone are likely to be insufficient.

168. Three respondents (including the MSC, the Board for Academic Medicine in Scotland and one medical school) suggest that consideration should also be given to a framework for accrediting teachers in undergraduate medicine.

Valuing training

169. Fourteen respondents framed their additional comments around the need to value training and trainers.

170. Twelve of these respondents stated that training needs to be better recognised in job plans, programmed activities, and in the allocation of time and resources, as well as through a general culture shift inside the NHS. The response from the Royal College of Physicians sums up many of the comments:

‘However, this should not be implemented until proper recognition of educational supervision activities has been achieved in job plans in all secondary care training locations... Adequate job planning and support for... [trainers] skill development coupled to recognition of effort and reward, are required for everyone involved in training. The framework used for primary care could be applied to secondary care and require that all trainers are accredited. That is one approach to recognition but changing the culture of recognition within local Trusts is what is required.’

Potential difficulties

171. Six respondents highlighted potential difficulties in implementing this recommendation. It was noted that accreditation would be difficult where training takes place outside the NHS. Other obstacles included service implications, cost and the range of those providing training.

172. The Department of Health pointed to a lack of clarity in the recommendation about who was meant by ‘trainers’.

173. Although NHS Employers agreed that the recommendation merits further attention, they advised caution:

‘In developing accreditation at the same time as introducing revalidation there could be unhelpful duplication of activity in the assessment of individual senior doctors, at least in respect of their training activity which will also be revalidated.’

Burden on trainers

174. Eight respondents (two who supported the recommendation, three who disagreed and three who were unsure) expressed concern that this recommendation would place a significant burden on trainers. Comments included phrases such as ‘overloading trainers’ and ‘undue burden’.

175. Two respondents who supported the recommendation nevertheless highlighted the risk of excluding part of the teaching workforce. This was further supported by another respondent who was unsure:

‘...the bureaucratic burden of becoming an accredited trainer should not be so great as to put off good trainers from becoming accredited nor should accreditation become the preserve of those good at filling in the appropriate paperwork rather than good at training.’

Review draft recommendation 13:

The GMC should explore the benefits and weaknesses of accrediting or approving the education and training environment in addition to approving posts and programmes.

Summary statistics

Review draft recommendation 13:		
Answer Option	Response #	Response %
Agree	65	80
Disagree	7	9
Not sure	9	11
Further comment	46	N/A
Total	81	100

Discussion

176. Forty-six respondents submitted further comments in answer to Recommendation 13. Of these, 34 agreed with our recommendation, five did not and seven were not sure.

177. There were 14 generically supportive comments.

178. Three key themes emerged from the comments:

- a. Involve others in future work.
- b. Value training.
- c. Risk of increased burden.

Involve others in future work

179. Eight respondents, while supportive of this recommendation, suggested involving with other groups such as the Specialist Advisory Committees (SAC), the Royal Colleges, Local Education Providers and Deaneries.

180. Five respondents who disagreed with the recommendation argued that what was being proposed was a Deanery/Regional/SHA quality management function which could only be undertaken effectively at a local level. They considered the task too large and complex to be done at national level.

181. Six respondents noted that there was a raft of previous work that could help inform this process, with five of these respondents specifically mentioning the work undertaken by PMETB in developing standards.

182. The Board for Academic Medicine in Scotland suggested that there could be a possible overlap with undergraduate medical education.

183. The Picker Institute Europe, who were unsure, felt that the recommendation did not go far enough: ‘...rather... the GMC should proceed directly to exploring mechanisms for successfully introducing an accreditation mechanism for training environments.’

Value training

184. Seven respondents framed their comments around the need to value training. These comments mentioned the need for appropriate allocation of time and resources.

Risk of increased burden

185. NHS East Midlands and the BMA were both unsure about this recommendation and highlighted the risk of imposing unnecessary additional regulatory burdens.

186. The Scottish Medical Training Board supported of this recommendation, but noted that it will be important to take account of the service implications. However, one doctor states: ‘The GMC's role in training would be to ensure that doctors are trained to the required standard, and this should not be compromised by concerns over service provision.’

Review draft recommendation 14:

The GMC should develop a regulatory framework for education and training for doctors in career posts and not currently in specialist (including general practice) training programmes leading to a CCT.

Summary statistics

Review draft recommendation 14:		
Answer Option	Response #	Response %
Agree	67	81
Disagree	8	10
Not sure	8	10
Further comment	53	N/A
Total	83	100

Discussion

187. 53 respondents submitted further comments in answer to Recommendation 14. Of these, 44 respondents agreed with our recommendation, five did not and four were not sure.

188. There were 17 generically supportive comments: the UKFPO states that they:

‘...whole heartedly support the GMC's desire to develop a regulatory framework for education and training for doctors in career posts. We believe the governance for doctors in career posts not currently in specialist training programmes should be robust and be the same as those doctors in training posts.’

189. Most of the comments that disagreed with, or were unsure about, the recommendation were themed around the risk of different routes to the CCT.

190. Three key themes emerged from the comments:

- a. Involve others.
- b. Non-career grade doctors performing valuable role.
- c. Credentialing.

Involve others

191. Nine respondents, all of whom agreed with the recommendation, suggested that it will be essential for the GMC to involve others in the implementation of this recommendation.

Non-career grade doctors performing valuable role

192. There was a general recognition of the importance of the doctors carrying out these roles. 'Career post doctors have substantial responsibilities for front-line service delivery and considerable influence over patients' experiences of healthcare.' [Picker Institute Europe]

193. However, while recognising the importance of this recommendation, seven respondents argued that there are significant resource implications for Colleges and Deaneries arising from its implementation.

194. Four respondents (two who were not sure about the recommendation and two who disagreed with it) argued that its implementation would devalue the CCT by providing separate pathways to the CCT.

195. The Department of Health stated '...that doctors working in the career grades are subject to the same regulatory framework as other doctors, even though they are not in formal training posts.' One respondent who disagreed with the recommendation also argues that CPD and revalidation will provide a sufficient regulatory framework for these doctors.

Credentialing

196. Four respondents who agreed with the recommendation mentioned credentialing in relation to non-career grade doctors. For example, NHS Employers noted that:

'There is strong support for the development of a standardised system of recognition, or 'credentialing', which would, in time, support doctors to better evidence their skills when applying for entry to the specialist register via the CESR/CEGPR route and achieve greater autonomy of practice where their competence has been accredited.'

Review draft recommendation 15:

Following merger, the GMC should review the processes leading to the award of CESRs and CEGPRs to ensure they are fair, efficient and fit for purpose, and that the processes continue to ensure standards are maintained.

Summary statistics

Review draft recommendation 15:		
Answer Option	Response #	Response %
Agree	69	88
Disagree	3	4
Not sure	6	8
Further comment	35	N/A
Total	78	100

Discussion

197. Thirty-five respondents submitted further comments in answer to Recommendation 15. Of these, 30 respondents agreed with our recommendation, two did not and three were not sure.

198. There were 15 generically supportive comments, including the statement from NHS Employers that:

‘Increasingly employers would like to make use of these standards and assessment processes in developing alternatives to prescribed training, perhaps for more rapid training in shortage specialties for example. It is important therefore that the competencies and requirements set are clearly understood.’

199. The Royal College of General Practitioners also ‘...agree strongly, as we feel the processes are not at present working as intended...’ and the Faculty of Occupational Medicine at the Royal College of Physicians states that ‘...The current process is complex and labour intensive...’

200. One respondent who was unsure about this recommendation advised caution as such processes are linked to specialty curricula.

201. Two key themes emerged from the comments:

- a. Role of others and future research.

b. Previous work.

Role of others and future research

202. Ten respondents said that the GMC should involve others in any such review. Several of these respondents noted the previous experience of the Royal Colleges in developing guidance. For example, the Academy of Medical Royal Colleges states:

‘Any such review should involve those involved in assessing CESR applications, the Colleges’ role in the process is key and they should form part of the review process.’

203. The College of Emergency Medicine suggested a need for a longitudinal study to see if there is any difference in eventual outcome between CESR and CCT doctors who obtain specialist registration.

204. Several respondents commented on overseas doctors in relation to this recommendation. One stated that some rationalisation and simplification of these processes would be helpful in the context of high quality academic candidates who wish to undertake clinical practice in the UK.

Previous work

205. NHS East Midlands suggests that a review may be premature at this time given that CESR and CEGPR are very new processes which have only recently been established: ‘As a consequence there may be some benefit in delaying this review for two or three years to allow these systems to bed down...’ Three respondents also noted that there had been a recent review of these processes undertaken by PMETB.

Review draft recommendation 16:

The GMC should note the recommendations of the Selection into Specialty Training Working Group report.

Summary statistics

Review draft recommendation 16:		
Answer Option	Response #	Response %
Agree	47	65
Disagree	7	10
Not sure	18	25
Further comment	29	N/A
Total	72	100

Discussion

206. Twenty-nine respondents submitted further comments in answer to Recommendation 16. Of these, 17 agreed with our recommendation, six did not and six were not sure.

207. Two respondents commented on the Selection into Specialty Training Working Group report, with one noting that it was poorly argued and had looked at the issues 'through the wrong end of a telescope'.

208. One theme emerged from the comments:

- a. GMC responsibility.

GMC responsibility

209. Four respondents (including the Royal College of Physicians of Edinburgh) commented that the GMC should have a broad oversight of the assessment methods used in selection, but not in the selection of specific trainees.

210. However, four of the respondents who disagreed with this recommendation argued that it is not the responsibility of the GMC at all and should be left to Deaneries and specialty organisations. NHS East Midlands point out that

‘... this recommendation seems at odds with recommendation 6 where the GMC seeks not to extend its regulatory role into the selection for undergraduate training. This is despite the fact that the process of selection to undergraduate training is considerably less rigorously evaluated and implemented than those processes associated with specialty training.’

211. The Department of Health also argued that this recommendation seems to contradict Recommendation 6.

Review draft recommendation 17:

The GMC should consider the outcomes of PMETB’s review of subspecialties once its Subspecialty Training Task and Finish Group has completed its work.

Summary statistics

Review draft recommendation 17:		
Answer Option	Response #	Response %
Agree	61	82
Disagree	1	1
Not sure	12	16
Further comment	25	N/A
Total	74	100

Discussion

212. Twenty-five respondents submitted further comments in answer to Recommendation 17. Of these, 22 respondents agreed with our recommendation, and three were not sure.

213. There were 11 generically supportive comments. NHS Employers ‘...agree, a more formalised approach to the planning, training and regulation of subspecialties is urgently needed.’

214. Three key themes emerged from the comments:

- a. Current arrangements inadequate.
- b. Credentialing.
- c. Role of others.

Current arrangements inadequate

215. Six respondents specifically commented that current arrangements around subspecialties are inadequate.

216. One postgraduate medical institution stated that it is concerning that it is almost entirely the gift of the specialty as to whether subspecialty status is sought for defined areas of specialist training. They went on to identify issues related to the difficulty of quality management of such programmes for Deaneries and Colleges. The Northern Deanery and the East of England Deanery echoed these comments by stating the current situation is increasingly problematic for deaneries to adequately support.

217. One doctor who was unsure cautioned that 'Any sub-specialist registration must not become overly prescriptive or restrictive. It must be recognised that some treatments or procedures that may have been considered sub-specialist only 10 years ago have become the preserve of the generalist [and vice versa].'

Credentialing

218. Two respondents (including NHS East Midlands and one member of the public) suggested that the GMC consider subspecialty training issues in the wider context of credentialing.

Role of others

219. Two Royal Colleges emphasised that the role of the Colleges needs to be explored in relation to this work. NHS Employers stated that service views needed to be integrated from the very beginning.

220. The Department of Health agreed with this recommendation, but said that it must be taken forward in partnership with others as it touches on the definitions of specialty, subspecialty and credential, which they note will also be considered as part of Medical Education England's 'Shape of Training' project.

Report section 13: EU and international medical graduates

221. The public and employers must have confidence in the medical registers, and in the fitness to practise of doctors entering those registers. One factor militating against this is the lack of equivalence between the standards required of UK and EEA doctors entering the specialist and GP registers. The GMC should explore how this might be addressed. In particular, it should consider whether there is a case for uncoupling the completion of specialist (including general practice) training from the decision to allow a doctor onto the specialist or GP register.

Review draft recommendation 18:

To provide the public and employers with greater confidence in the fitness for purpose of the registers, and in the fitness to practise of the doctors on the registers, the GMC should explore how it might ensure greater equivalence in the standards of doctors entering the specialist and GP registers and the uncoupling of this from the certification process.

Summary statistics

Review draft recommendation 18:		
Answer Option	Response #	Response %
Agree	52	64
Disagree	20	25
Not sure	9	11
Further comment	51	N/A
Total	81	100

Discussion

222. Fifty-one respondents submitted further comments in answer to Recommendation 18. Of these, 28 agreed with our recommendation, 13 did not and seven were not sure. Three respondents provided comments but did not say whether they agreed or disagreed with our proposal.

223. There were 10 supportive comments from respondents including that NHS East Midlands:

‘...strongly supports this recommendation, and would be anxious to see as much information as possible made available to the public with respect to not only a doctor's fitness to practice but also those areas in which that fitness to practice is confirmed.’

224. Two respondents (one doctor and the RCPCH Trainees Committee) who disagreed with this recommendation raised concern that this would devalue the CCT.

225. The British Association of Dermatologists argued strongly against this recommendation:

'It is difficult to understand how uncoupling certification from entry onto the specialist register will enhance the system from the point of view of ensuring greater equivalence. There may be the possibility for a conflict of interests between Trust service needs, individual job plans and views of the 'Responsible Officer'. Until there is a clearer understanding of the consequences of this, whether beneficial or detrimental, we cannot support this.'

226. Three key themes emerged from the comments:
- a. Sub-consultant grade.
 - b. EEA doctors and equivalence.
 - c. Other options should be considered.

Sub-consultant grade

227. Seventeen respondents, of whom nine disagreed with the recommendation and three were not sure, believed that this recommendation was suggesting the establishment of a 'sub-consultant grade'. Comments included the following from doctors:

'The GMC has no role in creating a new grade of doctors that is not wanted by the profession.'

'This MUST NOT be used as a back-door means of creating a sub-consultant grade amongst UK CCT holders by denying them automatic inclusion.'

228. The BMA is also strongly opposed to the creation of a sub-consultant grade:

'It is our view that there are already sufficient grades within hospital medicine and that consultants bring 'added value' to the health service that should be recognised and must not be undermined. We would be extremely disappointed if NHS employers were able to introduce a sub-consultant grade via the uncoupling of the registers and certification.'

229. The Royal College of Physicians of Edinburgh suggests that the uncoupling would create an unnecessary barrier to the specialist register for UK trainees and would '...be unwelcome and de-motivating for UK trainees...'

EEA doctors and equivalence

230. Seventeen respondents (nine of whom agreed with the recommendation) expressed concern about the lack of equivalence to UK standards among doctors entering the UK from the EEA. Six of these respondents specifically framed their concerns through the lens of patient safety.

231. The NMC noted that the issue of EEA graduates entering the UK was not an issue unique to medicine.

232. Two respondents, both doctors, suggested that one solution might be for all applicants, including UK graduates, to undergo an assessment of their competence and use of English. Some form of testing was supported by several other respondents. The Medical Protection Society recommended that any doctor practising in the UK must pass a competence test which should include a language test and a test of knowledge of local social and organisational structures.

233. This was reiterated by the Medical Schools Council: 'The Medical Schools Council would also argue for a test of clinical communication for non-UK graduates, which we have been advised is permissible within EU law.' Although commenting specifically in relation to entry to the GP register, one doctor argues that if necessary there should be primary legislation to require all foreign nationals to sit for a qualification prior to being placed on the register.

234. One organisation stated that the case for a change of this sort would be stronger if a higher rate of problems were identified at revalidation for specialists and GPs trained in other EEA countries.

Other options should also be considered

235. Although NHS Education for Scotland and the Scottish Academic Medicine Board support this recommendation, they suggest the mention of 'uncoupling' be removed as it is only one of a number of options that should be explored.

236. The BMA argued that rather than implementing this recommendation, the GMC should improve and strengthen the current Annual Review of Competence Progression (ARCP) process and introduce a requirement for an enhanced induction for new consultant and locum roles. There should also be a requirement for appropriate supervision for those taking up locum appointments when not on the specialist register. This is framed as a means to further ensure patient and public safety.

237. Three respondents (two of whom disagreed with the recommendation, and one who was not sure) raised the issue of revalidation.. The Picker Institute Europe and the BMA argued that they would not support the use of medical revalidation to limit entry to the specialist register.

Report section 14: Locums

238. The draft report proposed that the GMC should examine, with the Department of Health, the current legislative anomaly that makes it possible for doctors not on the specialist register to take up locum consultant posts.

Review draft recommendation 19:

Subject to consideration of the recommendation in section 13, any doctor undertaking a locum consultant post in the UK health services should have been accepted on to the specialist register. This should also ensure that there is consistency between specialist and GP registration.

Summary statistics

Review draft recommendation 19:		
Answer Option	Response #	Response %
Agree	57	70
Disagree	13	16
Not sure	12	15
Further comment	48	N/A
Total	82	100

Discussion

239. Forty-eight respondents submitted further comments in answer to Recommendation 19. Of these, 29 respondents agreed with our recommendation, nine did not and 10 were not sure.

240. There were 18 supportive comments. For example, the Royal College of Surgeons of England:

‘...supports the recommendation that all consultant appointments, substantive or locum, should only be open to doctors on the specialist register. This would provide greater clarity for patients and employers and would bring greater assurances for patient safety.’

241. Most of those who either disagreed or were not sure framed their comments around the need for ‘acting up’ and the effect on service provision.

242. Two key themes emerged from the comments:

- a. ‘Acting up’.

b. Effect on service provision.

Acting up

243. Fourteen respondents mentioned the position of senior trainees 'acting up' as consultants. Of these, five agreed with the recommendation, five disagreed, and three were not sure. In general, 'acting up' was seen as a valuable part of a trainee's experience. Respondents who agreed with the recommendation nevertheless believed that its implementation should not prevent 'acting up'.

244. Of the five who disagreed with the recommendation, their concern was that it would prevent an important part of training. For example, the College of Emergency Medicine states:

'Currently many of our trainees act up as locum consultants and find this a very valuable part of their final training experience... We would not wish to lose this experience for our trainees, who by definition are not yet on the specialist register.'

245. One Royal College also noted that this proposal may affect those who wish to change subspecialty. Doctors have previously have been able to do this by taking up locum posts.

Effect on service provision

246. Thirteen respondents noted that this recommendation could adversely affect service provision. Of these, four supported the recommendation, four were opposed, and five were not sure. One Royal College noted that the implementation of this recommendation could potentially deplete the pool of potential locums and would have implications on service delivery.

247. NHS Employers opposed the recommendation, stating:

'Employers do not see this as an anomaly but rather a flexible response to the filling of posts at senior doctor level, with corresponding limitations on the length of appointments. If entry onto specialist registers is a requirement for locum consultants it may make it more difficult for trusts to employ locums for short term cover...'

248. The Scottish Medicine Training Board saw potentially adverse consequences for small services with posts that were difficult to fill.

Report section 15: Continuing practice

249. At the conclusion of specialty or GP training, doctors have most of their careers ahead of them. Participation in CPD is therefore key to maintaining and further developing competence and performance. In 2004, the GMC issued guidance on CPD, but its regulatory role to date has been largely passive.

250. Revalidation will provide a new focus for ensuring effective and appropriate CPD for all doctors, but this will require the GMC to re-examine its role in this area. The draft report concluded that, at the very least, the GMC should provide clear guidance on what doctors will be required to do to keep up to date for the purposes of revalidation and the role of CPD within that. At the same time, the GMC will have to be careful to recognise the individual nature of CPD and avoid rigid requirements which may undermine what is most valuable for individual professionals.

Review draft recommendation 20:

The GMC should update its 2004 CPD guidance and re-examine how the regulatory role in CPD should be exercised so as to support doctors in meeting the requirements of revalidation and providing high quality care for their patients, whilst preserving the value of CPD for individual professionals.

Summary statistics

Review draft recommendation 20:		
Answer Option	Response #	Response %
Agree	69	84
Disagree	2	2
Not sure	11	13
Further comment	42	N/A
Total	82	100

Discussion

251. Forty-two respondents submitted further comments in answer to Recommendation 20. Of these, 31 respondents agreed with our recommendation, one did not and nine were not sure. One respondent provided comments but did not say whether they agreed or disagreed with our proposal.

252. There were 13 generically supportive comments. For example, the Royal College of Physicians ‘...agree that the regulator has a legitimate interest in [the] outcome and effectiveness of CPD, but not in the detailed content and means of achieving this.’

253. Three key themes emerged from the comments:

- a. Need to involve others.
- b. Suggested models.
- c. Revalidation.

Need to involve others

254. Eleven respondents commented that it will be necessary for the GMC to involve other organisations in the development and implementation of CPD.

255. The Academy of Medical Royal Colleges Directors of CPD (DoCPD) points out that the GMC should begin its review by considering the considerable work already being undertaken by the Colleges in this area. It recommends that the GMC maintains an ongoing relationship with the Colleges through the DoCPD. The DoCPD continues that:

‘It is expected that the regulator will have a legitimate interest in the outcome and effectiveness of CPD but not in the details of how this should be achieved.’

Suggested models

256. Three respondents suggest that the development of CPD guidance will need to be specialty specific and closely involve the Colleges and specialty organisations.

257. BMJ Learning feels that the role of accrediting bodies should be re-examined and that the traditional form of accrediting meetings is not well suited to accrediting new forms of CPD. They argue that new forms of accreditation should be considered, including accrediting providers rather than accrediting individual pieces of learning.

258. The Medical Protection Society suggests the GMC should consider having unified criteria for CPD as exists in the US and in some other professions.

259. The BMA agrees with the recommendation and notes the particular needs of less-than-full-time doctors, as these doctors need to achieve the same CPD standards as full-time doctors but have fewer working hours in which to do so.

260. NHS Employers suggests that its guidance on CPD, which was issued alongside the new specialty doctor contract, could form a useful starting point for the review.

Revalidation

261. Six respondents note that this work is closely related to the GMC's work on revalidation. The General Optical Council suggests that the review of CPD could be dealt with in conjunction with the development of revalidation.

262. The Department of Health suggests that reference be made to PMETB's Credentialing Steering Group which has been considering whether credentialing would be a useful tool to support revalidation.

Report section 16: Quality assurance

263. The draft report noted that the merger of PMETB with the GMC should enable the consolidation of the good practice from both organisations and that the GMC would no doubt want to build on this. In particular, it noted a need to consider whether there are adequate mechanisms for identifying and addressing emerging problems in training institutions; the way in which quality assurance needs to develop to reflect the recent changes to *Tomorrow's Doctors*; the important role of employers in quality assurance; and the funding model for quality assurance.

264. More broadly, the GMC should re-examine the current focus on assuring the quality of the processes used for training doctors. Instead, it should consider placing greater emphasis on outcomes and the quality of the individual trainees produced by those processes.

Review draft recommendation 21:

The GMC should have greater legislative flexibility in the way it is able to satisfy itself that standards and outcomes are being met.

Summary statistics

Review draft recommendation 21:		
Answer Option	Response #	Response %
Agree	41	57
Disagree	9	13
Not sure	22	31
Further comment	34	N/A
Total	72	100

Discussion

265. Thirty-four respondents submitted further comments in answer to Recommendation 21. Of these, 17 agreed with our recommendation; three did not and 13 were not sure. One respondent provided comment but did not say whether they agreed or disagreed with our proposal.

266. There were 8 generically supportive comments in relation to this recommendation.

267. Two key themes emerged from the comments:

- a. Potential risks.
- b. Lack of clarity.

Potential risks

268. Eight respondents outlined potential risks to the GMC in having greater legislative flexibility.

269. The General Optical Council cautioned that too much flexibility could lead to inconsistencies of approach and increase the risk of a successful judicial review of quality assurance or accreditation process.

270. Another respondent agreed with this recommendation subject to appropriate consultation on the legislation, consistency across the four countries of the UK and the avoidance of additional regulatory burden.

271. The Department of Health supported the idea of greater operational flexibility in principle, but noted that the Government would need to consider the detail of any proposed changes to legislation carefully.

Lack of clarity

272. Eleven respondents criticised this recommendation for a lack of clarity. The BMA stated that without further clarification as to what legislative changes were envisaged, they were unable to support the recommendation.

273. Two Royal Colleges supported the recommendation but cautioned of the need to consult others when developing proposals.

274. Three respondents suggested that the GMC should have greater legislative flexibility only in certain areas. The Quality Assurance Agency for Higher Education (QAA) supported the ability for the GMC to recognise individual undergraduate programmes rather than whole institutions.

Review draft recommendation 22:

The GMC should consider whether the existing mechanisms for identifying and addressing emerging problems between QABME visits could be enhanced.

Summary statistics

Review draft recommendation 22:		
Answer Option	Response #	Response %
Agree	50	72
Disagree	2	3
Not sure	17	25
Further comment	25	N/A
Total	69	100

Discussion

275. Twenty-five respondents submitted further comments in answer to Recommendation 22. Of these, 22 agreed with our recommendation and three were not sure.

276. There were 10 generically supportive comments on this recommendation.

277. One key theme emerged from the comments:

- a. Previous and future work.

Previous and future work

278. Four respondents specifically referred to the QABME Enhanced Annual Return as an existing mechanism for achieving the aim of this recommendation. Two of these respondents refer to risks associated with an increased regulatory burden on schools through an increase in QABME activity.

279. Another respondent, in response to Recommendation 24, supported the statement that quality assurance processes should measure 'the things that will matter most and not just the things that are most easily measured'. However, they were not convinced that all of the data required for the current annual QABME process meets this criterion.

280. One Royal College and the Academy of Medical Royal Colleges suggested that QABME may benefit from adapting some of the PMETB Quality Framework principles and practices which are now well established.

281. NHS Education for Scotland and the BMA suggest that this recommendation should be picked up through the forthcoming QABME Review.

282. Two respondents suggest that triggering mechanisms for visits should be made more explicit.

Review draft recommendation 23:

The GMC should consider further whether the current focus of its quality assurance activities upon institutional processes provides sufficient assurance of the quality of outcomes and individual trainees produced by those processes, and of their progress through training.

Summary statistics

Review draft recommendation 23:		
Answer Option	Response #	Response %
Agree	62	79
Disagree	2	3
Not sure	14	18
Further comment	40	N/A
Total	78	100

Discussion

283. Forty respondents submitted further comments in answer to Recommendation 23. Of these, 29 respondents agreed with our recommendation, one did not and eight were not sure. Two respondents provided comment but did not say whether they agreed or disagreed with our proposal.

284. There were 20 generically supportive comments from respondents. For example, one medical educator states that 'Quality feedback to training institutions of the performance of the 'product' of the training should enable an improvement in the performance which can then be monitored.' The Royal College of Physicians also

'...agree that quality assurance should extend to consideration of the quality of individual trainees and the degree of robustness of assessment processes and their ability to identify trainees with difficulties.'

285. Two key themes emerged from the comments:

- a. Potential risks.
- b. Suggested models.

Potential risks

286. Seven respondents noted potential risks. These included cost effectiveness and the increased regulatory burden versus benefits to patients. For example, NHS East Midlands were concerned that too much focus on individual progression might establish circumstances in which the regulatory burden exceeded the realised benefits.

287. Five respondents who agreed with this recommendation noted the importance of engaging with the Royal Colleges and specialty associations in the GMC's quality assurance activities. Several of these responses noted that in the past this engagement had not been utilised enough. Given the specialty specific nature of quality assurance, another respondent specifically suggested an increased role for Specialist Advisory Committee (SAC) visits.

288. Two respondents suggested that further research was needed to produce outcomes data and metrics.

Suggested models

289. One doctor suggested that the RCPCH pilot assessment may be one way of addressing the focus on process rather than the outcomes.

290. The QAA maintains that confidence in processes that produce an outcome should provide some guarantee that outcomes will be maintained in the immediate future. They argue that, in contrast, outcomes can only give a snap shot. The QAA suggests that

'Recognising the difference in context between specific disciplines/professions and QAA's approach to quality assurance of the institutional management of academic standards and quality, a balance between quality assurance activities based on assessing processes and based on outcomes would seem to be appropriate for the GMC.'

Review draft recommendation 24:

The GMC should consider the implications of the changes to *Tomorrow's Doctors* for the future focus and methodology of its QABME programmes.

Summary statistics

Review draft recommendation 24:		
Answer Option	Response #	Response %
Agree	52	78
Disagree	1	1
Not sure	14	21
Further comment	16	N/A
Total	67	100

Discussion

291. Sixteen respondents submitted further comments in answer to Recommendation 25. Of these, 12 respondents agreed with our recommendation, and four were not sure.

292. There were 10 generically supportive statements. For example, the UKFPO states that the 'changes to *Tomorrow's Doctors* almost certainly mean a review of the QABME programmes.'

293. Given the small number of responses to this recommendation, there are no identifiable themes.

294. One Royal College, in support of this recommendation, suggested that Colleges and Faculties should be consulted on what outputs are required from undergraduate medical education to make the young doctor 'fit for purpose'.

295. Two respondents, who were not sure, would have agreed with the recommendation if it suggested that *Tomorrow's Doctors* must reflect the requirements of a modern health service against core principles of probity, professionalism, transparency and honesty.

Review draft recommendation 25:

The GMC should work with the systems regulators to ensure that those organisations providing education and training are held to account for meeting the required standards and outcomes.

Summary statistics

Review draft recommendation 25:		
Answer Option	Response #	Response %
Agree	72	91
Disagree	2	3
Not sure	5	6
Further comment	38	N/A
Total	79	100

Discussion

296. Thirty-eight respondents submitted further comments in answer to Recommendation 24. Of these, 34 respondents agreed with our recommendation and four were not sure.

297. There were 16 generically supportive comments from respondents. One doctor states: 'Education will not be taken seriously by NHS Trusts until performance in education features in systems regulators reports.'

298. Three key themes emerged from the comments:

- a. Engagement with others.
- b. Targets and NHS Performance Indicators.
- c. Increased burden and proportionate regulation.

Engagement with others

299. Eight respondents, six of which agreed with the recommendation, noted the need for the GMC to engage with other groups as this work develops. Named organisations included providers and commissioners of education, the Colleges and specialty organisations.

Targets and NHS Performance Indicators

300. Five respondents, all of whom agreed with the recommendation, commented on the need for targets for education and training, citing the NHS performance indicators. For example the Board for Academic Medicine in Scotland states:

‘It is crucial that the NHS understand their obligations and meet the required standards and outcomes. If they do not meet standards, they must be held to account. This may require the inclusion of teaching and training in performance indicators for NHS bodies and their senior managerial staff.’

301. Six respondents endorsed the need for effective sanctions. However, two were not clear what sanctions could be applied to encourage organisations to comply with training requirements, other than the removal of training recognition.

Increased burden and proportionate regulation

302. NHS East Midlands supported this recommendation in principle but were concerned about possible unintended consequences. It pointed to the possible effect on continuing safe service provision and the danger of an overly intrusive regulatory and performance management framework.

303. Two other respondents also referred to concerns about an increased regulatory burden and resource implications. The British Orthopaedic Association notes that ‘Resourcing the deanery to collect the information is not the same as resourcing the local programme to actually deliver the training programme.’

304. NCAS was unsure about this recommendation. They recognised that an outcome of the review may be that fewer people enter recognised training posts. They state that better training for fewer people may be positive, but the GMC needs to consider the consequences of taking a more visible role in workforce planning.

Review draft recommendation 26:

For there to be confidence in quality assurance processes and outcomes, representatives of all key stakeholders must be involved. As the main recipient of trainees from medical school, the UK health services have an important role in the quality assurance of medical education and training.

Summary statistics

Review recommendation 26:		
Answer Option	Response #	Response %
Agree	68	87
Disagree	4	5
Not sure	6	8
Further comment	32	N/A
Total	78	100

Discussion

305. Thirty-two respondents submitted further comments in answer to Recommendation 26. Of these, 27 agreed with our recommendation, two did not and three were not sure.

306. There were 11 generically supportive comments from respondents. For example:

‘This is strongly agreed by employers who have a shared interest in ensuring good quality training and supply of future doctors.’ [NHS Employers]

‘Training must reflect the requirements of service and must not occur without the context. However the standards set by the Regulator can be both aspirational and realistic. There is no doubt that these standards should be nationally applicable and deliverable.’ [Academy of Medical Royal Colleges]

307. Three key themes emerged from the comments:

- a. Role and responsibility.
- b. Risk of employers taking over training agenda.
- c. Lack of clarity.

Role and responsibility

308. Twelve respondents framed their comments around the roles and responsibilities of the various stakeholders involved in education and training.

309. Both the Royal College of Radiologists and the Academy of Medical Royal Colleges suggest that the word responsibility be added to this recommendation:

‘As the main recipient of trainees from medical school, the UK health services have an important role and responsibility in the quality assurance of medical education and training’

310. The QAA notes that this recommendation is in line with best practice. Their Code of Practice states that in making use of external participation at key stages for the approval and review of programmes, institutions can draw on useful contributions from a range of external stakeholders who can provide, for example, relevant information and guidance on current developments in the workplace.

311. One doctor noted that the QABME process already has defacto employer involvement through lay representation, which has included a Trust Medical Director, a former Chief Executive of a Trust, a non-executive director of an NHS Trust and a member of the Care Quality Commission.

312. The QAA noted that students are an important stakeholder in this process and should also be involved in the quality assurance of medical education. This was reiterated by the BMA.

313. Four respondents noted that there is a need to increase the profile of education and training with employers and several suggested that this could be achieved through setting NHS performance indicators related to education and training.

Risk of employers taking over training agenda

314. Four respondents noted the potential risk with the employer (and specifically the NHS) usurping the training agenda. One doctor states that employers should not directly take part in the setting and regulating of any standards in education and training: ‘It is important to keep the distinction between a body setting standards and the main employer.’

Lack of clarity

315. Two respondents felt unable to agree with the recommendation due to a lack of clarity. For example, NHS Midlands states that be helpful to have the concept of quality assurance described in more detail.

Review draft recommendation 27:

The merger of PMETB with GMC will necessitate a review of the funding arrangements for the quality assurance of medical education and training. The starting point for that review should be the principle that ‘the beneficiary pays’.

Summary statistics

Review draft recommendation 27:		
Answer Option	Response #	Response %
Agree	36	47
Disagree	11	14
Not sure	29	38
Further comment	53	N/A
Total	76	100

Discussion

316. Fifty-three respondents submitted further comments in answer to Recommendation 27. Of these, 21 agreed with our recommendation, 5 did not and 25 were not sure. Two respondents provided comments but did not say whether they agreed or disagreed with our proposal.

317. There were nine generically supportive comments, including that the Royal College of General Practitioners:

‘...entirely agree with the principle that ‘the beneficiary pays’...The bottom line is that patients are the ultimate beneficiaries of good quality medical education, and the cost to the government of poor clinical care will far outweigh the cost of any quality assurance system of medical education.’

318. Two key themes emerged from the comments:

- a. Who is the ‘beneficiary’?
- b. Royal Colleges and the GMC cannot absorb the cost.

Who is the ‘beneficiary’?

319. Among those providing additional comments on this recommendation, most (37) felt that there was a lack of clarity about who benefited from medical education and training. In general, there is a sense that not enough detail was provided in the report for respondents to give a weighted view – this has resulted in most of those being ‘unsure’ about the proposal.

320. However, ten of the 37 respondents that provided further comment on this theme agreed with the principle that the beneficiary should pay for the system for quality assurance.

321. The following groups were identified as potential beneficiaries of medical education and training: patients (20), public (14), society (6), colleges (1), NHS/Trusts/service/employers (14), DH/Government (4), and doctors/trainees/students (11).

322. The Department of Health noted that they:

‘...would wish to work with the GMC in taking forward a review of the funding arrangements for the quality assurance of medical education and training. We would of course want to give careful consideration to the detail of any proposals.’

323. This theme was also noted at the Foundation Programme Seminar, with some trainees being concerned that they, the trainees, would have to pay for the quality assurance of training.

Royal Colleges and the GMC cannot absorb the cost

324. Six respondents argued that the GMC would be unable to, and should not, continue to fund quality assurance as it had done in the past through the annual retention fee levied on all doctors. It was also noted that there would be a risk in raising the fee to cover this new expense:

‘...it is clear that the cost should not be borne [sic] by the GMC and those that fund the GMC through an annual retention fee.’

Report section 17: Legislation

325. This report contains 27 recommendations. Some of them point to a clear course of action. Others invite reflection by the GMC or offer options for further work. If adopted, a number of the recommendations will require changes to UK legislation. It will be important to ensure that the statutory framework within which the GMC must operate gives it the flexibility to innovate and adapt to changing needs.

Comments on legislative changes

326. The draft report contained no specific proposals for future legislative change. Nevertheless, several respondents (including the Department of Health (England) and two Scottish educational bodies) commented in relation to proposed legislative changes.

327. The Department of Health notes ‘...that amending legislation will be for Ministers to decide in the four UK Health Departments, rather than for the GMC to determine.’

328. The Scottish Medical Training Board and NHS Education for Scotland both note that UK legislative changes can lead to a need for consequential legislative changes in the devolved countries and continued engagement will be essential for this to occur.

329. On the merger of the GMC and PMETB, NHS East Midlands states that it is

‘...critically important that the move to a unified legislative framework is completed as soon as possible to ensure the best elements of both, and to address the current problems with some of the unintended consequences of providing a too detailed legislative framework for the establishment of PMETB and its critical functions with respect to postgraduate medical education and training.’

Late submissions

330. We received late submissions from the Royal College of Paediatrics and Child Health (RCPCH) and the Royal College of Psychiatrists (RCPsych). Comments from these two submissions have not been included in the above analysis. However, both submissions substantially agreed with our recommendations. The main areas of disagreement or uncertainty are noted below.

331. The RCPCH:

- a. Believe that the GMC should have a role in offering guidance on student selection and support to those responsible for this role in medical schools (recommendation 6).
- b. Disagreed that the GMC should be involved in the accreditation of trainers as this is a professional responsibility (recommendation 12).
- c. Believe that the progression of individuals through training programmes is currently and should remain within the responsibility of education providers (recommendation 23).
- d. Questioned who was the beneficiary of medical education (recommendation 27).

332. The RCPsych only disagreed with recommendation 18 (uncoupling inclusion in the GP and specialist register from the certification process). They argued that a different solution should be sought in collaboration with employers.