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CONSULTATION PAPER ON THE CONTENT OF THE MAIN RULES GOVERNING THE OPERATIONS OF PMETB

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1. Introduction

1.1 The Postgraduate Medical Education and Training Board (PMETB) was established by the [General and Special Medical Practice \(Education and Qualifications\) Order 2003](#)¹ (“the Order”) to develop a single, unifying framework for postgraduate medical education and training across the UK.

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

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

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

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

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

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

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

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

1.4 When PMETB is fully operational it will become the competent authority for approving the specialist training of doctors and certifying that doctors have reached a level of competence to be included in the Specialist Register and the (future) Register of General Practitioners maintained by the General Medical Council. PMETB will take over those functions from the Specialist Training Authority (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

1.5 PMETB has asked UK Ministers to legislate to enable it to take on its full statutory responsibilities from [September 2005](#). Meantime, it has been working to establish basic principles to govern its work and to carry forward detailed planning in partnership with other organisations. PMETB has published:

¹ Statutory Instrument 2003 No 1250

[Principles for an Assessment System for Postgraduate Medical Training](#)

[Standards for Curriculum Development: Background Paper](#)

[What is Curriculum?](#)

[Standards for Curricula](#)

Those documents, and other information about PMETB, can be obtained from the PMETB's website (www.pmetb.org.uk).

1.6 Under the Order, PMETB has to make rules on several matters before it can take over its statutory responsibilities. The rules required are listed in [Annex A](#). This consultation paper invites views on the content of the four sets of rules which are most central to PMETB's main functions.

2. Rules

2.1 Rules are part of a hierarchy of documents governing the work of PMETB. First and foremost, PMETB is subject to primary legislation. Also binding are Statutory Instruments, including the Order establishing and governing PMETB. Next in importance are rules, which require a degree of due process and need to be “made” by the PMETB Board. Those cover the main principles and processes governing PMETB’s operational work, and the main rights of and requirements on those who use PMETB’s services. They in turn will be underpinned by more detailed documents, including information for doctors and the wider public and detailed instructions for staff.

2.2 The rules discussed in this paper will be generic, allowing for much of the necessary detail to be fleshed out in supporting documents. They must address the matters specified in the Order for them to cover. However, it would not be appropriate to put into rules detailed operational plans which are still under development and which may change.

2.3 The rules discussed here will reflect PMETB’s position on Day 1 of its operation as a competent authority. At the beginning, PMETB will need to pick up where the previous competent authorities (STA and JCPTGP) left off. PMETB is planning some changes from the outset, and is making clear its direction of travel which will lead to further developments later. But it has to be pragmatic in recognising the need to take over its functions smoothly, starting from where they are now, and avoid disruption of the service. PMETB’s planning has distinguished two timescales, the first of which extends until a year after it takes on its statutory functions, that is, to mid-2006. That is the timescale which the first rules are expected to cover. As planning develops for the longer term, PMETB expects to make new rules.

2.4 PMETB is not required by law to consult on its rules, but it is doing so as good practice, and in the light of its commitment to openness and transparency. One consultation is already under way²; others will take place early in 2005. This document covers four sets of rules which are central to the future work of PMETB. They are being considered together as all reflect common principles.

2.5 The rules covered by this document have not yet been drafted. What follows is a description of the policy design for each set – what PMETB wants the rules to say. The design will be amended in the light of comments received, and draft rules prepared. The timetable does allow a brief opportunity for those who wish to see the draft wording of the rules to do so before they are finalised. But it is hoped that the consultation on this document will be the main vehicle for those wishing to comment.

² On draft Appeals Rules (see www.pmetb.org.uk/consultations)

3. Rules on standards and requirements for postgraduate medical education and training (PME) (Article 4(3))

Extracts from the Order

3.1 Article 4 of the Order includes:

“Education and training leading to the award of a Certificate of Completion of Training [CCT]

4. - (1) Subject to paragraph (2), the Board shall from time to time establish the standards and requirements relating to postgraduate medical education and training necessary for the award of a CCT in general practice and in each of the specialties listed in Schedule 3.

(2) Standards and requirements established by the Board under paragraph (1) must comply with the minimum requirements for general practice and specialist training, set out in articles 5 and 6 respectively, but nothing in this Order shall prevent the Board from establishing additional requirements or higher standards under this article as it considers appropriate.

(3) The standards and requirements established under paragraph (1) shall be set out in rules. (emphasis added)

(4) The standards and requirements established under paragraph (1) shall include –

- (a) the standards required for entry to training;
- (b) the education and training curriculum to be followed for general practice and for each specialty listed in Schedule 3;
- (c) the outcomes to be achieved by that education and training, including the level of skill, knowledge and expertise required; and
- (d) the methods of assessment of progress during and upon completion of that education and training.”

3.2 Also relevant to these rules are Articles 5 and 6, which set out the minimum requirements for general practice training and specialist training, respectively:

“Minimum requirements for general practice training

5. - (1) The minimum requirements for general practice training referred to in article 4(2) are that -

- (a) the training shall comply with the requirements of article 31(1) of the Directive or, in the case of part-time training, article 31(1) together with article 34 (requirements for specific training in general practice);
- (b) subject to paragraph (3), the training shall include at least three years in full-time employment, and shall be supervised by the Board; and
- (c) the three year period specified in sub-paragraph (b) shall include -

(i) a period or periods amounting to at least 12 months employment as a GP Registrar which takes place with a general practitioner who has been approved by the Board for the purpose of providing training in accordance with article 4(5)(d), and

(ii) a period or periods amounting to at least 12 months employment in a post (or posts), in a specialty or specialties which the Board has prescribed for this purpose, that post or posts being in accordance with such other requirements as the Board may prescribe.

(2) Any period remaining under paragraph (1)(b), the minimum periods set out in paragraph (1)(c) having been met, shall consist of a period of employment in a post (or posts) falling within paragraph (1)(c)(i) or (ii).

(3) In relation to periods of part-time employment under paragraph (1)(c), the requirements of this article may be satisfied by periods of part-time employment of equivalent duration but it shall not be regarded as equivalent unless it includes at least two periods of full-time employment, each lasting not less than one week, one such period falling within paragraph (1)(c)(i), and one such period falling within paragraph (1)(c)(ii).

(4) A general practitioner who is approved by the Board under article 4(5)(d) for the purposes of providing training to a GP Registrar under paragraph (1)(c)(i) shall be known as a "GP Trainer".

(5) "GP Registrar" means a medical practitioner who is being trained in general practice by a GP Trainer whether as part of training leading to the award of a CCT or otherwise.

(6) Schedule 4 (which sets out the text of articles 30, 31(1) and 34 of the Directive as it had effect on the date this Order was made) shall have effect.

Minimum requirements for specialist training

6. - (1) The minimum requirements for specialist training referred to in article 4(2) are that -

(a) the training must constitute an entire course of training in the specialty in question and must, subject to paragraph (2) -

(i) comprise theoretical and practical instruction,

(ii) be full-time training,

(iii) be supervised by the Board,

(iv) be in a university centre, in a teaching hospital or, where the Board is satisfied that it is appropriate, in a health establishment approved for this purpose by the Board,

(v) involve the personal participation of the medical practitioner training to be a specialist in the activity and in the responsibilities of the establishments concerned,

(vi) comply with the requirements of point 1 of Annex I to the Directive (the characteristics of the full-time training of specialists), and

(vii) be at least as long as the relevant period (if any) specified in Schedule 3.

(2) Part-time specialist training is permitted where training on a full-time basis would not be practicable for well-founded individual reasons, and accordingly, the Board may approve part-time training which satisfies -

(a) any conditions imposed by the Board;

(b) the conditions set out in paragraph (1)(a)(i), (iii), (iv) and (v);

(c) the following conditions -

(i) the standard of training must not be lower than that of full-time training,

(ii) the total length of training in the specialty in question must not be less than that of full-time training in the same specialty, and

(iii) the training must comply with the requirements of point 2 of Annex I to the Directive (the characteristics of the part-time training of specialists).

(3) Schedule 5 (which sets out the text of Annex I to the Directive as it had effect on the date this Order was made) shall have effect.”

3.3 The wording of the Order must be taken as given in discussion on the content of the rules to be made under it. It is not necessary for the rules on standards and requirements to repeat the content of Articles 5 and 6, but they must be consistent with it.

The policy context

3.4 Standards for specialist or general practice training need to be seen as part of the continuing development of a doctor, from medical school to beyond higher specialist training. The General Medical Council (GMC)'s publication "Good Medical Practice"³ sets out the requirements of a doctor under seven generic headings, which are reproduced at Annex B. PMETB will continue to use those as a template for setting standards for postgraduate education. The GMC's "The New Doctor"⁴, revised in December 2004, describes the qualities and competencies expected of a doctor at the point of full registration (for a UK-trained doctor, at the end of the Pre-registration House Officer year). In the future, doctors qualified in the UK will complete one year of foundation training before entering the GMC register, and a further year ("F2") before entering specialist training. PMETB's requirements for entry to specialist or GP training must reflect that that point is part of a longer career development pathway, and be consistent with the requirements of other parts of the journey,.

3.5 The rules on standards for PME will develop as PMETB's thinking develops. The documents mentioned in paragraph 1.5 above set out PMETB's

³ General Medical Council, London, 2001 [check] [insert web reference]

⁴ General Medical Council, London, 2004 [insert web reference]

principles for assessment and curricula. Those have been welcomed by many education providers and PMETB expects them to put them into practice as they revise and develop their curricula and assessment practices (including examinations). However, it will take time for those developments to work through, and from September 2005 PMETB's requirement will be a commitment to the principles.

3.6 In recognition of the need for pragmatism in ensuring a smooth transition to PMETB's operation as a competent authority, the Board decided that, **as a starting point, the standard for the award by PMETB of a Certificate of Completion of Training should be the same as that currently required for a Certificate of Completion of Specialist Training (for specialties other than general practice) and the standard required for summative assessment of general practitioners.** The rules under Article 4(3) need to reflect that decision. It should be clearly understood, however, that PMETB's thinking on this will develop and changed rules will be required in the future.

3.7 Article 14(5) of the Order, which provides an alternative route to the CCT for some doctors who have trained outside the UK, requires them to be assessed against a generic standard expressed as "a level of knowledge and skill consistent with practice as a consultant in the NHS". PMETB is developing a description of that standard, as applied in different areas of practice. **In the cause of consistency and equity between doctors trained in different countries, PMETB has resolved that that standard should be the same as is required for a CCT and covered by these rules.**

3.8 PMETB has resolved on the principle of **applying consistent standards to all doctors, whether in general practice or another specialty.** Increasingly, PMETB wishes to develop similar practices for its standard-setting, quality assurance and accreditation processes for all, although initially it will have to recognise that it is starting from a different base.

Definitions

3.9 There are differing views about what is meant by "standards" and "requirements". There is no relevant statutory definition, and PMETB therefore proposes stipulative definitions for the purposes of these rules. They are as follows:

"Standard" denotes a defined level of attainment. It should be possible to say whether or not a standard has been attained. Standards for PME should include levels of competence (including knowledge, skills and behaviour) and attitudes, structured around the headings of the GMC's "Good Medical Practice" (see Annex B). "Requirement" denotes a defined mandatory standard. If a requirement for a CCT is not met the CCT cannot be awarded. Hence, from a range of standards, some could be requirements and others more discretionary.

The matters to be covered by the rules

(Art 4(4)(a)) The standards required for entry to training leading to the award of a CCT

3.10 The rules should provide that requirements for entry to training leading to a CCT shall include possession of a primary medical qualification and being on the Medical Register maintained by the GMC. The standards for entry to the Medical Register are set out in the GMC's publication "The New Doctor"⁵. Other requirements, and standards to be met by those entering specialist training shall be those prescribed by a relevant authority recognised for the purpose by PMETB. In practice, the "relevant authority" may be a postgraduate deanery or individual Colleges and Faculties.

3.11 The rules should empower PMETB to make general statements about the requirements for entry to specialist programmes. Those might include, for example, a requirement of satisfactory completion of foundation training in the UK, or satisfactory demonstration of equivalence of training and experience obtained in the UK or elsewhere at the point of entry to specialist programmes. PMETB should also be able to require success in an assessment or examination specifically designed to test an applicant's suitability for entry to the specialist training programme. This option would be helpful in providing for those who wish to enter GP or other specialist training, but have not done any previous post-registration training and/or have unusual histories.

(Art 4(4)(b)) The education and training curriculum to be followed for general practice and for each specialty listed in Schedule 3.

3.12 The rules should provide that the curriculum to be followed should comply with any requirements published by PMETB for this purpose. From September 2005, PMETB will expect providers of specialist training to recognise and work towards the PMETB's published "Standards for Curricula" (see paragraph 1.5 above). PMETB has commissioned research to compare current curricula and examinations with the PMETB standards.

Although the findings have been very positive, it is not proposed that the rules should require all curricula to conform to all the standards by September 2005, as it is realistic to allow time for further development. The rules should be flexible enough to enable PMETB to increase its requirements over time without having to make new rules each time.

(Art 4(4)(c)) The outcomes to be achieved by that education and training, including the level of skill, knowledge and expertise required.

3.13 The rules should allow PMETB to approve the outcomes set by a relevant body approved for the purpose. From September 2005, the standard for a CCT in specialties other than general practice will be the same as that currently applied for a CCST in the same specialty (see paragraph 3.6 above).

⁵ GMC, revised December 2004

There is no central description of that standard, other than successful completion of the curricula published in manuals and regulations by the relevant Colleges and Faculties.

3.14 The rules should provide that the outcome to be achieved for a CCT in general practice is having passed summative assessment by an authority recognised for the purpose by PMETB. The competencies to be tested by summative assessment are set out in Schedule 2 to the National Health Service (Vocational Training for General Medical Practice) Regulations 1997⁶:

- “1. factual medical knowledge which is sufficient to enable the practitioner to perform the duties of a general practitioner;
2. the ability to apply factual medical knowledge to the management of problems presented by patients in general practice;
3. effective communication, both orally and in writing;
4. the ability to consult satisfactorily with general practice patients;
5. the ability to review and critically analyse the practitioner's own working practices and manage any necessary changes appropriately;
6. clinical skills; and
7. the ability to synthesize all of the above competencies and apply them appropriately in a general practice setting.”

3.15 The rules should also enable PMETB to develop further its own description of the outcomes to be achieved for the award of a CCT. Paragraph 3.7 refers to the work undertaken by PMETB to describe the generic knowledge and skill of a consultant in the NHS. PMETB has resolved to apply consistent standards for all the routes to eligibility for the Specialist and General Practice Registers. As those standards are developed, PMETB should be able to use them as a basis for setting standards for the award of a CCT. In time individual Colleges and Faculties would be required to ensure that the outcomes which they were prescribing were consistent with PMETB's generic standards. The same standards would be applied by PMETB in assessing, under other parts of the Order, doctors qualified or trained overseas.

(Art 4(4)(d)) The methods of assessment of progress during and upon completion of that education and training

3.16 The rules should provide for PMETB to impose requirements on those carrying out assessments leading to the award of a CCT. In the first instance, PMETB intends to require assessing bodies to recognise and work towards be committed in principle to PMETB's published “Principles for an Assessment

⁶ S.I. 1997 No 2817

System for Postgraduate Medical Training “ (see paragraph 1.5). Those principles have been welcomed by Colleges and other assessing bodies, but it will take several years for changes to work through. As they do, PMETB may wish to require methods of assessment to conform to the principles.

Conclusion

3.17 The first rules on standards and requirements for a CCT will need to be able to operate from September 2005. For reasons set out in this paper, that means that they need to allow PMETB to start by applying the standards currently required for the award of a CCST or passing summative assessment. PMETB has already published principles for curricula and assessment. It intends to work with providers of training to apply the principles, thus leading to improved standards in future. The more generic the rules, the less they have to be revised as this evolutionary process proceeds. Against that, the rules need to be sufficiently specific to meet the requirements of the Order. PMETB will take legal advice on the degree to which the standards to be applied in September 2005 need to be specified in rules, in the hope that the rules can be as generic as possible. PMETB is committed to openness and transparency in its work and to working in partnership with other organisations. It will continue to involve outside organisations and individuals, including trainees and providers of training and assessment, as it develops its thinking on standards and requirements for training leading to the award of a CCT.

4. Rules on approval of postgraduate medical education and training (Art 4(10))

Extracts from the Order

4.1 Under Art 3(2), the principal functions of PMETB include:

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

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

4.2 Article 4 (“Education and training leading to the award of a Certificate of Completion of Training”) includes:

“4. - (1) the Board shall from time to time establish the standards and requirements relating to postgraduate medical education and training necessary for the award of a CCT in general practice and in each of the specialties listed in Schedule 3.

(5) In performing the function mentioned in article 3(2)(b), the Board may approve -

(a) a course of postgraduate medical education and training (or part of such a course) which the Board is satisfied meets or would meet the standards and requirements established under paragraph (1);

(b) a programme of postgraduate medical education and training (or part of such a programme) which the Board is satisfied meets or would meet the standards and requirements established under paragraph (1);

(c) a training post which the Board is satisfied meets or would meet the standards and requirements established under paragraph (1);

(d) a general practitioner, whom the Board considers to be properly organised and equipped for providing the training specified in article 5(1)(c)(i);

(e) examinations, assessments or other tests of competence.

(6) In connection with paragraph (5), the Board may approve postgraduate medical education and training taking place outside the United Kingdom.

(7) In exercising its functions under paragraph (5), the Board may attach conditions to any approval it gives or has given including, if the Board considers appropriate, a period of time for which that approval is valid.

(8) The Board may at any time withdraw approval where it is satisfied that -

(a) any conditions imposed under paragraph (7); or

(b) any standards or requirements established under paragraph (1),

are not being met.

(9) The Board shall cause to be published from time to time (electronically or otherwise) a list of the education and training it has approved which shall specify -

(a) any course or programme (or part of such a course or programme), training post, general practitioner, examination, assessment or other test of competence that it has approved pursuant to paragraph (5);

(b) the date on which that approval was given;

(c) any conditions to which that approval is subject pursuant to paragraph (7);

(d) where relevant, the date on which that approval was withdrawn; and

(e) such other matters as the Board may specify in rules made under paragraph (10).

(10) The Board shall make rules about the procedure to be followed for giving, withdrawing, and attaching conditions to, approval under this article. [emphasis added]

(11) Subject to the minimum requirements specified in articles 5 and 6, rules made under paragraph (10) may provide that of the categories specified in paragraph (5), only certain categories will be approved by the Board in respect of general practice or a specialty listed in Schedule 3.”

The policy context

4.3 The principles already published by PMETB (see paragraph 1.5 above) will be developed further to develop criteria to be used by the Board in exercising its statutory function of approving specialist and postgraduate training in the future. That work is still in progress, but the kinds of criteria might include, for example: entry criteria, educational capacity, curricula standards, assessment principles, standards for the educational environment (including, for instance, local faculty, teaching and learning methods, educational resources, programme management and internal quality assurance).

4.4 PMETB has decided as a matter of principle that, out of the units of approval listed in Art 4(5) (courses, programmes, posts, trainers, GPs...), it will want to move to approving programmes. Under Art 4(11), the Board has powers to select from the list of categories in Art 4(5), and it intends to select “programmes” from that list, while reserving the power to approve other items if necessary. Some of the other items, eg examinations and assessments, might be included among the aspects of a programme that PMETB intended to approve; in the same way some courses integral to a programme might be approved within the unit of the programme. The definition of “programme” is discussed further below.

4.5 PMETB has also decided that normally the level at which it engages with education providers for purposes of approval will be that of the postgraduate deanery. That does not preclude subsequent engagement with individual courses or training posts supervised by the deanery, and the arrangements for that are under consideration. One source of evidence for

approvals – though not the only source - will be visits, and the rules governing visits are discussed in section 5 (below).

4.6 Under the Order, PMETB may delegate its functions to Committees of the Board or to members of its staff, but the Board is advised that it cannot delegate to any other person or organisation. It may, however, contract with other bodies (such as Colleges or Faculties) to make recommendations for decision by PMETB, and PMETB will need to work in this way when approving training programmes.

4.7 Under Schedule 8 of the Order (paragraphs 2 and 10), all existing approvals (of posts, courses etc) by the STA and JCPTGP will be deemed to be approved by PMETB. In the first period after PMETB assumes its statutory responsibilities it will need to ensure a smooth transition, and make sure that it considers in time those posts or courses whose approval was subject to a time limit which is about to expire. That may require a degree of pragmatism in the first few months, and the rules must allow for that.

4.8 Article 4(9) requires the board to publish, from time to time, lists of the education and training it has approved. The rules under Art 4(10) do not require to cover what shall be included in the lists, but PMETB will need to plan how they are to be compiled and maintained, and how to respond for requests for information about approvals which PMETB will be deemed to have made, and which have been inherited from decisions by the STA or the JCPTGP.

Definitions

4.9 PMETB has defined “programme” as “a defined period of managed, supervised training”. In “Modernising Medical Careers: The next steps”⁷, the UK health departments discuss what is meant by “programme” from the perspective of the various stakeholders in Foundation Programmes. That discussion includes:

“Most importantly, training is set within a legal context and it will be for the GMC and PMETB to approve and quality assure Programmes. In which case the best definition of a Programme is in terms of a ‘unit of approval’ composed of a series of rotations and placements which is educationally viable and convenient to manage. Such units of approval will have the capacity to encompass a number of trainees. These sentiments apply equally to Specialist Training Programmes.”⁸

This account is consistent with PMETB’s definition. A “course” is a component of a programme and may vary in length.

4.10 Elsewhere in the Order, in the context of provision for applications for certification from doctors who have trained outside the UK, there is a statutory definition of “specialist training”:

⁷ Department of Health, April 2004

⁸ Ibid, paragraph 15.

(Art 4(7)) “In paragraphs (4) and (5), "specialist training" means specialist medical training that -

- (a) comprises of theoretical and practical instruction in a post specifically designated as a training post;
- (b) takes place in a university centre, a teaching hospital or other health establishment;
- (c) is supervised by an appropriate authority or other body; and
- (d) involves the personal participation of the person training to be a specialist in the activity and in the responsibilities of the establishment concerned.”

As far as possible, PMETB will bring the same definition of “specialist training” to its approvals under Article 4(5).

Matters to be covered by the Rules

The procedure for giving approval

4.11 The rules should provide that PMETB may give approval under any of the categories listed in Art 4(5) (programmes, courses, training posts, GPs, assessments...). The intention is to move to approval of programmes, but the rules need to allow for different categories of approval, particularly in the early months when there will be a need for continuity and when PMETB will inherit past approvals from the STA and JCPTGP.

4.12 The rules should provide that a decision to approve a programme (or other unit) is a Board decision. Responsibility may be delegated by the Board to its statutory Training Committee, and that that Committee may sub-delegate categories of approval (to members of the Committee or PMETB staff) or seek advice (from other persons or organisations) as it deems appropriate. The rules should, however, allow the Board itself to make decisions on approvals. It is expected that most, if not all, approvals would be delegated, but exceptionally a matter may be of such importance that it requires to be considered at a Board meeting.

4.13 The decision should be informed by such evidence as shall be determined by the Board or the Training Committee. It is envisaged that that would include written material and any relevant reports by PMETB visiting panels (as established under Article 7). The Board or the Training Committee may also consider advice from organisations such as a Royal College or Faculty or an NHS organisation. (Under Art 3(4)(c) one of PMETB’s objectives is to “ensure that the needs of employers and those engaging the services of specialists and general practitioners are met by the standards it establishes..”)

4.14 The procedure for approvals should provide that applications for approval may be considered from any source recognised for that purpose by the Board (in order to cover a mix of inherited arrangements from September 2005). In future, however, it is expected that applications for approval will come normally from postgraduate deaneries. The rules should allow for PMETB to

approve a programme, course etc on the Board's own initiative, without having received an application.

4.15 Applications for approval of a new programme/course etc should be made to PMETB (normally by the deanery) with such evidence as the Board (or the Training Committee on behalf of the Board) deems is required. The rules should not set a time limit for the Board to consider applications.

4.16 An application for approval of an amended programme/course etc would normally come from a deanery (although the rules should allow it to be received from another organisation or person deemed appropriate by PMETB). The rules should allow the response to such requests to be delegated as the Board (or the Training Committee on behalf of the Board) considers appropriate. The rules should also allow discretion to PMETB not to require notification of minor changes (however defined).

4.17 Approvals should be valid until they are withdrawn. However, they should be subject to review by PMETB. It is envisaged that the programmes overseen by a particular deanery will be reviewed periodically (say, every 3-5 years) but the rules should not require every approval by the Board to be subject to conditions limiting its duration.

4.18 Approvals of examinations, assessments or other tests of competence (Art 4(5)(e)). Where those are undertaken by the Board, it may delegate this role to a different Committee or individuals than other approvals. (In practice, any delegation of this function would probably be to the statutory Assessment Committee, which might delegate to members of the Committee or PMETB staff). However, the intention would be to incorporate consideration of examinations, assessments etc in the overall consideration of a training programme

4.19 Applications for approval of new, or amended, examination or assessments would normally be received from a College or Faculty, although occasionally individual deaneries or groups of deaneries might also be involved. It is envisaged that changes to the structure of examinations or assessments might require PMETB approval, but that approval would not be required for detailed changes to questions or content.

4.20 Article 4(6) empowers PMETB to approve postgraduate medical education and training taking place outside the UK. The Board will consider further how and whether PMETB's powers in this category might be exercised, and would welcome views from consultees. Some UK deaneries currently have overseas posts (including some in the Channel Islands and the Isle of Man) that are part of formal specialist training schemes or GP vocational training schemes. The Board may need to use its powers under Article 4(6) to continue to approve those posts for the time being. At this stage, the rules need only provide that a decision to exercise the Board's powers under Art 4(6) may be made by the Board or delegated to the Training Committee. The procedure to be followed should be at the discretion of the Board or the Committee.

Attaching conditions to approval (Art 4(7))

4.21 The rules should enable, but not require, PMETB to attach conditions to approvals of programmes, courses etc. Those could include a requirement for review after a stipulated time (normally 3-5 years) but there should be scope for other conditions at PMETB's discretion. In imposing conditions, PMETB would have to ensure that its actions were consistent with its statutory objective under Art 3(4)(c) of ensuring that its standards meet the needs of NHS employers.

Withdrawing approval (Art 4(8))

4.22 Normally, any decision to withdraw approval from a post would be made following an adverse report by a Visiting Panel or other organisation and subsequent inability to address the issues raised within a reasonable time. The relevant deanery and the NHS employing or contracting organisation concerned would be informed of the possibility of withdrawing approval and given reasonable time to comment before a decision is made. A decision to withdraw approval should be able to be made by the Board or delegated to the Training Committee or specified Board members or members of PMETB staff.

4.23 However, the rules must allow for more rapid decisions to be made, for example, where patients or trainees are at risk. The rules can create an expectation that processes of the kind described in the previous paragraph would be followed. Any decision to move more quickly would have to be justified in terms of the health or safety of the public or trainees.

4.24 Article 21(2) ((a)-(b)) provides a right of appeal for any organisation with a substantial interest in a decision by PMETB not to approve a programme/course, to attach conditions to any approval or to withdraw approval. The detailed procedure for those and other appeals will be in the Appeals Rules (made under Article 21(6)). Draft Appeals Rules are currently out for consultation, and can be viewed on PMETB's website (www.pmetb.org.uk/publications/consultations).

Procedure for receiving and considering reports of visiting panels

4.25 The rules about visiting panels are discussed in section 5 (below). PMETB will take advice on whether the procedure for receiving and considering reports on visits should be contained in the Approval of PME rules (discussed in this section) or in the rules about visiting panels. Either way, the relevant rules need to recognise that reports following visits may draw on material obtained from other sources than the visit itself. The rules should provide for PMETB to nominate a designated member of staff to receive draft reports from the Chairman of the visiting panel. The PMETB office should be responsible for showing the report in draft to the deanery concerned and, so far as is practicable, to NHS organisations affected by the findings and recommendations, and for feeding any comments to the Chairman who will have discretion to amend the draft report in the light of comments received.

Although PMETB will set standards for the time taken to complete reports following visits, it is not proposed that those should be included in the rules.

4.26 The reports will be considered, together with any other evidence, by the Board or the committee or other persons to whom it has delegated responsibility for decisions on approval of posts (see paragraph 4.10(above)). When the decision on approval has been made, the report should be finalised, taking into account any comments made by the Board or its committee. The final version should be sent to the members of the visiting panel, the College(s) involved, the deanery and the NHS organisations visited. It should be available to the public on demand (Art 7(4)). PMETB should be required to make public – for example, through its website – the means by which members of the public may obtain copies of reports. PMETB will comply with its statutory duties under the Freedom of Information Act 2000 and with best practice as advised by the Information Commission when dealing with requests for access to reports.

5. Rules about PMETB visiting panels

Extract from the Order

5.1 Article 7 of the Order empowers PMETB to appoint visiting panels and sets a number of conditions that must be met if panels are appointed:

“Visiting panels

7. - (1) The Board may, if it thinks fit, appoint a panel of persons (a "visiting panel") to visit any hospital, institution, general practitioner or other person by whom, where or under whose direction or management -

(a) any postgraduate medical education or training leading to the award of a CCT is, or is proposed to be given;

(b) any sub-specialty training is, or is proposed to be given.

(2) A visiting panel must include at least one person who is not and never has been a registered medical practitioner and who does not hold any qualification that is registrable under the Medical Act.

(3) Where a visiting panel visits any hospital, institution, general practitioner or other person in the exercise of its functions under this article, it shall be the duty of the visiting panel to prepare a report to the Board on the visit.

(4) The Board shall, following a request by any person, make available such reports.

(5) Subject to the requirements of this article, the Board shall make rules in relation to visiting panels and such rules shall include provision as to -

(a) the composition of visiting panels;

(b) the areas or matters to be covered by a report to the Board under paragraph (3);

(c) the frequency with which visiting panels shall visit the persons or bodies specified in paragraph (1);

(d) the manner in which such visits are to be conducted;

(e) the payment of allowances to persons appointed to visiting panels, including the payment of allowances to employers of persons appointed to visiting panels for the purposes of enabling visitors to perform functions under this article; and

(f) the reimbursement of such expenses as persons appointed to visiting panels may reasonably have incurred in the course of the panel carrying out its functions under this article.”

This legislation needs to be accepted as given when developing more detailed rules about visiting panels and when PMETB considers, with Colleges and others, practical plans for visits after September 2005.

The policy background

5.2 The approach which PMETB is developing towards approval of training programmes is discussed in section 4 above. PMETB expects that one source of evidence used (but not the only source) will be reports from visits. Although PMETB is not required to arrange for visits to be carried out, the Board will wish to do so, as they are an important source of information and means of quality assurance. It will also be necessary to allow for some visits being risk-driven and arranged at short notice in response to concerns raised with PMETB or another organisation.

5.3 The provisions of Article 7 will take effect immediately after PMETB takes on its full statutory functions. That means that after September 2005 any visits for the purpose of approving posts must be PMETB visits and all the requirements of Article 7 must be met – for example, each visiting panel must include a lay person (Art 7(2)), and all reports of visiting panels must be submitted to the PMETB Board (Art 7(3)) and be available to the public on demand (Art 7(4)). PMETB may – and will - ask other organisations (eg Colleges) to carry out visits for PMETB and make recommendations. PMETB intends to work closely with the Colleges and other organisations in planning and carrying out visits, as there is no better source of specialist expertise. However the visits will bear the PMETB “badge” and responsibility for decisions taken on them will be PMETB’s .

5.4 PMETB is a signatory to the Concordat established by the Healthcare Commission and involving the main healthcare inspection, review and audit bodies in England. Its aim is “to help reduce the regulatory burden put on frontline healthcare staff while continuing to support the improvement of services for patients”⁹. PMETB is in discussion with the Healthcare Commission about a similar agreement in Wales. This commitment involves working with other regulators to avoid duplication and to take into account the impact on the service of multiple inspection visits.

5.5 PMETB wishes to learn from best practice in the grouping and management of visits, and in the recruitment, training and use of members of visiting panels with different backgrounds. It has not yet decided what will be covered by the concept of a “visit” and what the roles of panel members will be in the future. Meantime, for the period immediately after September 2005, PMETB has asked the JCPTGP to continue with its planning for deanery visits (which involve a lay visitor and a published report), and those will be taken over by PMETB. For visits in other specialties, a priority will be to ensure continuity of service, and that no approvals inherited from Colleges expire by default. Enquiries from Colleges indicate some 800 separate visits (mainly to hospitals) planned for the year after PMETB “goes live”. In taking over from the Colleges responsibility for visits for purposes of approving programmes/courses/posts etc, PMETB will need to examine closely the inherited programme and seek to prioritise and group the proposed visits as much as possible, both in terms of

⁹ Healthcare Commission press release, 24 June 2004 (available on www.healthcarecommission.org.uk)

location, different grades of posts being visited simultaneously and also across related specialist areas.

5.6 PMETB has not yet developed detailed plans for how visiting panels will operate in the longer term. As with other areas of the Board's operations, the rules governing visits will need to allow PMETB some flexibility, particularly in the months immediately following September 2005, when there will be a need for pragmatism in the transition from College visits to PMETB visits.

Matters to be covered by the rules

(Art 7(5)(a) The composition of visiting panels

5.7 The rules should allow PMETB discretion regarding the number of people on a visiting panel. Normally, for visits based on a "programme", PMETB envisages a team of up to four, including a chairman, two appropriately qualified doctors and a lay person (defined in the Order as a person without a medical qualification). PMETB will also seek an appropriate means to involve trainees in plans for visits. It should be possible for panels to co-opt additional people for all or part of their work. Panels might also seek non-medical professional expertise – for example, from an educationist. It should not be necessary for all members of a panel to be involved in all parts of a visit. The rules should provide a minimum of two members (one medical, one lay), but , should allow for panels to split up and for individuals to undertake parts of visits.

5.8 The appointment of people for involvement in visiting panels will be the responsibility of PMETB, although it may ask other organisations, such as Colleges, to identify individuals for particular visits, and it may invite people already involved in related work in other organisations to be considered for involvement in PMETB visiting panels. All such individuals will have to have received training in the visiting process. PMETB is in discussion with Colleges with a view to taking action early in 2005 to identify lay people who might be trained for this role. PMETB hopes to engage with those who carry out comparable functions at present, including those appointed by the JCPTGP.

5.9 It will be important for visiting panels to have a Chairman who is appropriately trained and understands the responsibilities and concerns of PMETB. PMETB does not have a view on the necessary background of the Chairman (for example, on whether there should be a requirement for him or her to be medically qualified), and would welcome views on consultees.

(Art 7(5)(b)) The areas or matters to be covered by a report to the Board under paragraph (3)

5.10 The primary objective of visits, as part of the evidence gathering for decisions on the approval of programmes/courses/posts, should be to protect the health and well-being of patients (Art 3(4)). Other objectives include securing the maintenance of PMETB's standards and requirements (Art

3(2)(b)). Visits should contribute to the evidence base for decisions by the Board and provide quality assurance of evidence from other sources, such as written reports. Other purposes served by visits are also important, including sharing good practice and providing an opportunity for front-line staff (including trainees) to feed their views directly to people with national roles.

5.11 The rules should allow PMETB discretion to consider a report, even if it lacks all the elements normally included. They should also allow visiting panels discretion to include in their report any matter that they consider relevant to the objectives in the previous paragraph.

5.12 Normally, a report would be expected to cover the same matters that are specified in Section 4 (above) as relevant to the approval of programmes, courses etc. Those include: entry criteria, educational capacity, curricula standards, assessment principles, standards for the educational environment (including, for instance, local faculty, teaching and learning methods, educational resources, programme management and internal quality assurance).

5.13 The rules should provide that reports must include recommendations on whether the programme/course/posts visited should be approved or not, and on any conditions that should be placed on approval. PMETB should be able to stipulate the minimum that must be covered by all reports, and to vary that requirement from time to time. For example, PMETB might require that all reports should include:

- a description of the local system visited
- the criteria used
- evidence of areas where improvement is needed, and of good practice (matched with supporting evidence, where available)
- recommendations, covering:
 - whether the programmes/courses/posts should be approved or not (with reasons)
 - actions required (with timescales)
 - recommended period for review.

However, the rules should not include such an amount of detail, as PMETB's approach will develop with experience, and it will be necessary to allow for some variation in reports in the early months.

(Art 7(5)(c) The frequency with which visiting panels shall visit the persons or bodies specified in paragraph (1))

5.14 PMETB would prefer the rules to allow the Board discretion to vary the frequency of visits. The expectation would be for approval of programmes to last for 3-5 years, but it would be necessary to allow for conditions recommending a revisit in shorter time, and for visits in response to indicators of risk to patients. If legal advice requires some timescale to be provided by the

rules, it could be that normally visits for purposes of approving programmes should take place at least two years after the previous visit, unless (a) the previous visit recommended a further visit sooner; or (b) the Board has reason to believe that an earlier visit would be in the interest of the health and safety of patients.

(Art 7(5)(d)) “The manner in which such visits are to be conducted”

5.15 PMETB would welcome views on what might be covered by rules on this. In the interests of consistency, fairness and transparency, PMETB would want to establish a common procedure and framework for visits, and make this available publicly and to those who are to be visited. It would also wish to ensure that those visited received feedback and that the manner of questioning by panel members was open, non-attributable and free from bias. It might be sufficient for the rules to require PMETB to make available to those visited and to anyone else on demand information in writing about the structure and timetable of visits, the kinds of evidence to be collected and the criteria used.

(Art 7(5)(e)) The payment of allowances to members of visiting panels

5.16 The rules should provide that PMETB may pay to members of visiting panels such allowances as may be authorised by the Board. PMETB is aware that of those currently involved in College visiting many professionals do so unpaid, although there is increasing pressure from NHS employers for payment to backfill posts vacated for such work, and GPs involved in JCPTGP visits are recompensed for the cost of arranging locum cover. In due course, PMETB expects to establish a consistent system for all PMETB visits, which will involve reimbursement in appropriate form for all visitors. Detailed proposals are still under consideration, and it is recognised that some of the former arrangements will need to continue beyond September 2005. It should be sufficient for the rules to enable PMETB to authorise payments to be made.

(Art 7(5)(f)) The reimbursement of expenses

5.17 At present there are a variety of arrangements for reimbursing the expenses of members of visiting panels. Some (for example, expenses incurred on JCPTGP visits) are met by deaneries, some by NHS Trusts or other NHS organisation. PMETB will need to decide, in collaboration with the other organisations concerned, how the expenses of visiting panels should be met after September 2005. At this stage it should be sufficient for the rules to provide that PMETB shall make arrangements to ensure that the reasonable expenses of visiting panel members shall be repaid.

6. Rules about making and considering applications for certification

Extracts from the Order

6.1 Article 8 of the Order covers procedures for the award and withdrawal of a Certificate of Completion of Training (CCT). It includes:

“8. - (1) The Board shall award a CCT to any person who applies to the Board for that purpose (and pays any fee specified by the Board in rules) if the Board is satisfied that he has satisfactorily completed education and training, approved by the Board in accordance with article 4.

(2) A CCT may be awarded only to a registered medical practitioner, and a CCT in the specialty of oral and maxillo-facial surgery may be awarded only to a person who is also a registered dentist.

(3) Subject to paragraph (4), a CCT may be awarded only to a person who has been appointed to a course of training intended to lead to the award of a CCT and has successfully completed that course of training.

(4) Nothing in this article shall prevent the Board from awarding a CCT to a person when exercising its competent authority functions under article 8 of the Directive as set out in article 20(3)(a) of this Order.

(5) The Board may only award a CCT in general practice, or in a specialty listed in Schedule 3.

(6) A CCT shall state -

(a) the date on which it was awarded;

(b) that it was awarded in general practice, or, where applicable, in which specialty it was awarded;

(c) the name of its holder;

(d) his primary medical qualifications and where those qualifications were awarded; and

(e) his registration number in the register of medical practitioners kept by the Registrar of the GMC under section 2 of the Medical Act (establishment and maintenance of registers),

and where more than one year of the training to which the CCT attests took place outside the EEA, the CCT shall make clear that this was so, and shall state the length (in aggregate) of such training.

(7) A CCT shall be signed by the chair of the Board or by such other persons as the chair has nominated for this purpose.

(8) The Board shall make rules as to the procedure to be followed in relation to and by persons wishing to apply to the Board for a CCT, including rules as to the evidence it requires in support of an application for a CCT. [emphasis added]

(9) Subject to paragraph (10), for the purposes of article 30 of the Directive (which requires EEA States to institute specific training in general practice), the vocational training certificate issued in the United Kingdom is the CCT in general practice.

(10) The following are also vocational training certificates -

- (a) a certificate of prescribed experience; and
- (b) a certificate of equivalent experience that has been annotated in accordance with regulation 12(7) of the Vocational Training Regulations, regulation 12(7) of the Vocational Training Regulations (Scotland) or regulation 12(7) of the Vocational Training Regulations (Northern Ireland) (which relate to certificate of equivalent experience).

(11) For the purposes of article 4 of the Directive, the diploma, certificate or other evidence of formal qualifications in specialised medicine in the United Kingdom is the CCT, awarded in a specialty listed in Schedule 3.

(12) Where the Board is satisfied that a CCT has been fraudulently procured or incorrectly awarded, it shall -

- (a) direct that the CCT shall be withdrawn; and
- (b) notify the GMC that it has withdrawn that person's CCT.”

6.2 PMETB’s legal advice is that the rules under Art 8(8) should also cover procedure relating to Art 8(12) (CCTs fraudulently procured or incorrectly awarded), and PMETB proposes that the rules should cover those matters.

6.3 Article 11 of the Order (“General practitioners eligible for entry in the General Practitioner Register”) reads:

“11. - (1) A person is an eligible general practitioner for the purposes of article 10(2)(b) [eligibility for the General Practice Register other than through holding a CCT or through acquired rights under an EEA Directive]if he holds -

(a) a vocational training certificate or a certificate of acquired rights issued in an EEA State other than the United Kingdom in accordance with Title IV of the Directive, and he is -

- (i) a national of an EEA State, or
- (ii) a person who for the purposes of access to and the practice of the medical profession is entitled to be treated in the same way as such a national in order to enable an enforceable Community right to be exercised;

(b) a certificate of prescribed experience; or

(c) a certificate of equivalent experience.

(2) A person is also an eligible general practitioner for the purposes of article 10(2)(b) if he was exempt from the need to have acquired the prescribed experience by virtue of regulation 5(1)(a), (b), (c), (d) or (f) of -

(a) the Vocational Training Regulations (exemptions);

(b) the Vocational Training Regulations (Scotland) (exemptions); or

(c) the Vocational Training Regulations (Northern Ireland) (exemptions),

but if a restricted services principal is eligible for inclusion in the General Practitioner Register only by virtue of an exemption under regulation 5(1)(d) of the regulations set out in sub-paragraphs (a), (b) or (c), the Registrar of the GMC shall ensure that the restriction on his right to practice as provided for in article 10(7) is indicated in that person's entry in the General Practitioner Register in such manner as the Registrar thinks fit.

(3) A person is also an eligible general practitioner for the purposes of article 10(2)(b) if he does not fall within paragraph (1) or (2) but he has -

(a) undertaken training in general practice; or

(b) been awarded qualifications in general practice,

and he satisfies the Board that that training is, or those qualifications are, or both when considered together are, equivalent to a CCT in general practice.

(4) If a person falls within paragraph (3) and -

(a) he is also a person falling within sub-paragraph (a)(i) or (ii) of paragraph (1), and he has qualifications in general practice awarded outside the EEA which have been accepted by another EEA State as qualifying him to practice as a general practitioner in that State; or

(b) he has acquired experience or knowledge in general practice, wherever obtained,

the Board shall, when considering whether it is satisfied as mentioned in paragraph (3), take account of that acceptance or of that experience or knowledge.

(5) If the Board is not satisfied, having taken into account the matters specified in paragraph (4) (where applicable), that a person's training, qualifications, or both when considered together are equivalent to a CCT in general practice, the Board shall give reasons as to why it is not satisfied, and, in particular, shall inform the person of -

(a) the period of additional training that the person must undertake, and the fields to be covered by it;

(b) any examination, assessment (including a specified period of assessment) or other test of competence that the person must complete to the Board's satisfaction,

in order to satisfy the Board under paragraph (3).

(6) In respect of any application under paragraph (3), the Board shall notify the applicant of its decision (and, where relevant, of the matters set out in paragraph (5)), in accordance with its duty under article 16(4).

(7) If the Board is satisfied, pursuant to paragraph (3), that a person's training, qualifications, or both when considered together are equivalent to a CCT in general practice, it shall, if the person so requests, issue to that person a written statement

attesting to the fact that the person has satisfied the Board that he is eligible for entry in the General Practitioner Register ("statement of eligibility for registration").

(8) The Board shall make rules as to the procedure to be followed in relation to and by persons applying to the Board under paragraph (3), including rules as to the evidence it requires in support of such an application. [emphasis added]

6.4 Article 12 of the Order ("Acquired rights of general practitioners") covers the exercise of the power under the European Directive to grant certain doctors the right to practice as GPs without the need for a certificate of vocational training. The various categories of doctors in the UK who have been identified as entitled to an acquired right are set out in Schedule 6 to the Order. Article 12 includes:

"12.- (2) If -

(a) a person is included in the General Practitioner Register under article 10(2)(c) only by virtue of an acquired right under paragraph 1(d) of Schedule 6; or

(b) a restricted services principal is included in the General Practitioner Register only by virtue of paragraph 1(a) of Schedule 6,

the Registrar of the GMC shall ensure that the restriction on his right to practice as provided for in article 10(6) or (7) (as appropriate) is indicated in that person's entry in the General Practitioner Register in such manner as the Registrar thinks fit.

(3) The Board shall, if a person so requests in writing, issue a certificate of acquired rights to him if it is satisfied that he has an acquired right to practice by virtue of Schedule 6.

(4) The Board may make rules as to the procedure to be followed and the evidence it requires in support of a request made by a person under paragraph (3) (emphasis added)"

6.5 Although the Board is not required to make rules under Art 12(4), it proposes to do so, as part of the rules covering all certification procedures.

6.6 Article 13(2) provides that the Specialist Register shall contain the names of (a) persons who hold a CCT in a specialty listed in Schedule 3; and (Art 13(2)(b)) "other eligible specialists as specified in Article 14". Article 14 describes routes to eligibility for the Specialist Register, other than through the acquisition of a CCT. It includes:

"14.- (4) A person is also an eligible specialist for the purposes of article 13(2)(b) if -

(a) he does not fall within paragraph (3) [which applies to a national of an EEA state or a person with recognised EEA rights and a recognised specialist qualification]; but

(b) he has -

(i) undertaken specialist training, or

(ii) been awarded specialist qualifications,

in a specialty listed in Schedule 3, and he satisfies the Board that that specialist training is, or those qualifications are, or both when considered together are, equivalent to a CCT in the specialty in question.

(5) A person is also an eligible specialist for the purposes of article 13(2)(b) if -

(a) he has -

(i) undertaken specialist training, or

(ii) been awarded specialist qualifications,

outside the United Kingdom in a medical specialty not listed in Schedule 3; or

(b) he has knowledge of or experience in any medical specialty derived from academic or research work,

and he satisfies the Board that these give him a level of knowledge and skill consistent with practice as a consultant in the National Health Service.

(6) If a person falls within paragraph (4) or (5) and -

(a) he is also a person falling within sub-paragraph (a) or (b) of paragraph (3), and he has specialist qualifications awarded outside the EEA which have been accepted by another EEA State as qualifying him to practice as a specialist in that State; or

(b) he has acquired specialist medical experience or knowledge, wherever obtained,

the Board shall, when considering whether it is satisfied as mentioned in paragraph (4) or (5), take account of that acceptance or of that experience or knowledge.

....

(8) If the Board is not satisfied, having taken into account the matters specified in paragraph (6) (where applicable), that -

(a) under paragraph (4), a person's specialist training, or specialist qualifications, or both when considered together, are equivalent to a CCT in the specialty in question; or

(b) under paragraph (5) -

(i) a person's specialist training, or specialist qualifications, or both when considered together, give him the required level of knowledge and skill, or

(ii) a person's knowledge of, or experience in, any medical specialty derived from academic or research work, give him the required level of knowledge and skill,

paragraph (9) shall apply.

(9) Where this paragraph applies, the Board shall give reasons as to why it is not satisfied, and, in particular, shall inform the person of -

(a) the period of additional training that the person must undertake, and the fields to be covered by it;

(b) any examination, assessment (including a specified period of assessment) or other test of competence that the person must complete to the Board's satisfaction,

in order to satisfy the Board under paragraph (4) or (5).

(10) In respect of any application under paragraph (4) or (5), the Board shall notify the applicant of its decision (and, where relevant, of the matters set out in paragraph (9)), in accordance with its duty under article 16(4).

(11) If the Board is satisfied -

(a) pursuant to paragraph (4), that a person's specialist training, specialist qualifications, or both when considered together, are equivalent to a CCT in the specialty in question; or

(b) pursuant to paragraph (5) that -

(i) a person's specialist training, specialist qualifications, or both when considered together, give him the required level of knowledge and skill, or

(ii) a person's knowledge of, or experience in, any medical specialty derived from academic or research work, give him the required level of knowledge and skill,

it shall, if the person so requests, issue to that person a written statement attesting to the fact that the person has satisfied the Board that he is eligible for inclusion in the Specialist Register ("statement of eligibility for registration").

(12) The Board shall make rules as to the procedure to be followed in relation to and by persons applying to the Board under paragraph (4) or (5), including rules as to the evidence it requires in support of such an application. [emphasis added]

6.7 The rules described in this section of the consultation paper shall cover the procedures to be followed by applicants for certification under those provisions, the procedure to be followed by the Board in considering the applications and the evidence to be required. PMETB proposes to have common and consistent approaches to all applications, and to commission a set of rules common to them all. Those rules will therefore be covered by:

- Art 8(8) [CCT]
- Art 11(8) [GPs without a CCT]
- Art 12(4) [GPs with acquired rights]
- Art 14(12) ["other eligible specialists"]

The rules do not need to repeat the detail in the various relevant Articles of the Order, but they must be consistent with them.

The policy context

6.8 PMETB has developed a documented draft “certification process” which it intends to be common to all the routes under the Order, and founded on consistent principles whether the applicant is a GP or from another specialty and regardless of his country of training. As has been discussed in section 3 (above), PMETB intends to ensure consistency between the standards and processes applied to applications for a CCT under Article 8, and those for applications by doctors trained overseas, under Article 11 and 14. If there are differences between the processes followed, those must be justified, and the underlying principles must be consistent.

6.9 As discussion in paragraph 3.6 (above), PMETB has decided that, as a starting point, the standard for the award of a CCT should be the same as that currently required for a Certificate of Completion of Specialist Training (CCST) (for specialties other than general practice) and the standard required for summative assessment of general practitioners. The standard applied to applications under Articles 11 and 14 must be consistent with that standard. The procedures followed, and the evidence required to support applications, must be able to support the application of that standard from September 2005.

6.10 Although the rules will govern the procedures to be followed by the Board, and the requirements to be met by doctors applying for certification, important roles in the processes will also be played by other organisations, notably Colleges and Faculties and postgraduate deaneries. PMETB can and must make rules about the evidence it requires, but the provision of that evidence will in many cases require work by Colleges and/or deaneries and trainers. PMETB will need to make clear to those organisations, through service level agreements and other communications, what they are being asked to do to enable PMETB to make a decision. The rules discussed in this section will have implications for Colleges, faculties and deaneries, but will not apply directly to them.

6.11 Schedule 8 of the Order contains transitional provisions which ensure that PMETB inherits the outcomes of decisions on certification made by the STA and JCPTGP. It also contains safeguards for doctors who have been given written advice by the STA or JCPTGP about their training: In considering any future applications by those doctors, PMETB must take the past advice into account.¹⁰

Matters to be covered by the rules

Submission of initial application

6.12 The rules should provide that PMETB will make available information to all applicants for certification, including an application form requesting information supported by evidence. The rules should require all applicants for

¹⁰ Schedule 8(7) (GPs) and 8(19) (other specialties)

certification to submit an application, using the prescribed form, either electronically or on paper, unless PMETB specifies that particular evidence (for example, originals of certificates) must be provided on paper.

6.13 The rules should enable applications to be submitted before training is completed in circumstances stipulated by PMETB. In the case of applications for a CCT under Article 8, the intention is to allow applications to be submitted up to a month before training is complete, and for PMETB to start processing the applications before the training is complete. That could enable the CCT to be ready to be awarded as soon as PMETB obtained confirmation of satisfactory completion of training from the training body responsible.

6.14 Applicants under the various statutory routes will be required to pay a fee, which will be payable at the time the application is submitted. Details of the fees charged, and the permissible means of paying them (including electronic means) will be in the Fees Rules, proposals for which will be put out for consultation early in 2005.

6.15 The rules should allow for PMETB to pass the application to another organisation recognised by PMETB for the purpose (such as a College or Faculty) to review the application against the agreed standards and criteria and advise the applicant, if appropriate, that further evidence, references etc will be required.

Evidence required

6.16 The rules should require PMETB to stipulate the evidence it will require from applicants and to publish its requirements in a form accessible to applicants (such as the internet). There should be scope for PMETB to vary its requirements without having to revise the rules each time. By way of illustration (though the rules should not restrict PMETB to those examples or require them all), PMETB has considered what should constitute an illustrative list of acceptable evidence of qualifications, training and experience for Articles 8 [CCT], 11 and 14 and 20 (3)(a) [EEA] of the Order.

6.17 PMETB will follow best practice on the appropriate evidence of *identity* that should be required, including the possibility of requiring a photograph. Views would be welcomed.

6.18 Evidence of *qualifications* might include:

- The original of the certificate of primary medical qualification
- The original of the certificate of specialist qualification(s).
- Authenticated evidence that the qualification was awarded after examination or on the basis of evaluation of course work.
- An original or authenticated certificate of qualification completed in an EEA Member State

6.19 Evidence of *training* might include:

- Original or authenticated documentary evidence of the course of training followed and the methods and frequency of assessment and evaluation from the body which conducted the training.
- A copy of documentary evidence from the regulatory body responsible for approving the training and evidence of completion of training.
- An original certificate confirming completion of training
- An original certificate of training completed in an EEA Member State
- A training log book
- Evidence of audit/continuing professional development

6.20 Evidence of *experience* might include:

- Employment record listing for each post name/type of post, name and type of workplace, with details of such factors as size, number of staff. Number of patients seen, facilities, and specialties represented etc, start and finish dates.
- Evidence of individual posts authenticated by medical director or other appropriate official.
- An original certificate of experience completed in an EEA Member State

6.21 The rules should provide for PMETB to set and promulgate a standard for the number and nature of *references* to be provided by applicants, but the rules should not themselves prescribe how many references must be provided. Some or all of the references should cover recent work by the applicant, but PMETB has decided not to set a mandatory time-limit.

6.22 PMETB has also considered the evidence which might be required from general practitioners with acquired rights applying under Article 12 (see paragraph 6.4 above). Following discussions with JCPTGP, PMETB believes that it would be pragmatic and fair for PMETB to make the same requirements as JCPTGP regarding evidence to be provided. JCPTGP's current evidence requirements under this category are reproduced at Annex C to this document. JCPTGP have some flexibility which PMETB should maintain, especially when records are unavailable and employer is not contactable. For more recent, post-1994 experience in particular, there should be less flexibility;

6.23 The rules should provide for PMETB to require evidence of this kind. PMETB would welcome comments from consultees on the illustrative examples given here of the kinds of evidence which might be required.

Processes to be followed by PMETB

6.24 The rules should provide for the responsibility for decision on applications to be delegated by the Board to a member of staff. The rules should not stipulate which member of staff will have that role – under the current plans for the organisation it is envisaged that it would be the “Head of Certification” (a key senior management post) but job titles may vary in future. The Board should be empowered to authorise procedures for deciding on escalation criteria, by reference to which some cases may require expert or clinical advice and some may be considered by a panel appointed for the purpose by PMETB. At this stage, PMETB has decided on principle to allow for those levels of escalation, but the precise criteria for each have not yet been decided, and should not be stipulated in rules. As PMETB is committed to transparency, it seems appropriate for the rules to require the criteria to be published.

6.25 Certificates should be signed by a member of staff given delegated authority to do so by the Board. As a matter of good practice, that should normally be the same person as the delegated decision-maker.

6.26 Successful applicants under Article 11 (for eligibility to the General practice register, other than by obtaining a CCT) are to receive a “statement of eligibility for registration” (Art 11(7)). The same phrase is used in Article 14(11) to describe what doctors are to receive if they apply under Article 14(4) or (5) and PMETB decides that they meet the requirements to be entered on the GMC’s Specialist Register under the category of “other eligible specialist” (Art 13(2)(b)). PMETB would welcome views on what information should be contained in “statements of eligibility”, particularly in the cases of doctors who successfully applies under Article 14(5) in a non-standard specialty. PMETB has some concerns about the possibility that its statements by PMETB might be seen as an end in themselves (for example, in support of applications for employment overseas), rather than as a means for doctors to enter the Specialist Register, and would welcome the views of consultees about this.

Art 8(12) CCT's fraudulently procured or incorrectly awarded

6.27 Fraud: The rules should provide that if there appears to be fraud, evidence should be considered by a member of staff with delegated authority from the Board. If the evidence supports the appearance of fraud, it should be put before a group of Board members (“a panel”) or other persons designated for that purpose by the Board (this might be a sub-set of one of PMETB’s statutory committees, but the rules should not stipulate which). The panel will either make a decision based on the evidence submitted or seek additional evidence. The person accused of fraud should have an opportunity to make representations to the panel, in person or in writing

6.28 If the panel decides that the CCT has been fraudulently obtained, PMETB should be empowered to require the certificate to be returned and to notify any appropriate authority (such as the police and/or the General Medical Council and registration authorities in other countries).

6.29 Error: A decision that a certificate has been incorrectly awarded, for example through a clerical error, should be the responsibility of a member of staff of PMETB with delegated authority from the Board. That might be the Chief Executive, but the rules should not stipulate that it must. The designated member of staff should have power to withdraw the award of the certificate and require it to be returned. As a matter of good practice, PMETB should take any management action needed to prevent a recurrence of the mistake.

7. Conclusion and how to submit comments

7.1 This consultation paper reflects PMETB's current thinking on the main operational responsibilities which it will be undertaking from September 2005. The rules which the document covers will be intended to be in force for at least eighteen months after that period, and should be sufficiently generic to cover practices from Day 1 (often the same or similar to current practices, unless changes are required by law) but also allow scope for PMETB to change its practice as its thinking develops.

7.2 Views would be welcomed on all sections of this consultation paper. Please specify the paragraph in the paper on which you are commenting. If your organisation would like to request a meeting to discuss the document in detail, please contact PMETB (at the address below).

7.3 Written comments should be sent (by letter or E-mail) to:

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by **Friday, 18 February 2005.**

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ANNEX A

Rules required by the General and Specialist Practice (Education, Training and Qualifications) Order 2003

Where mentioned in the Order	Subject	Status, as on 31 December 2004
Article 4(3)	Standards and requirements for postgraduate medical education and training	Proposals in this document
Article 4(10)	Procedure to be followed for approving courses and programmes	Proposals in this document
Article 7(5)	Visiting panels	Proposals in this document
Articles 8(1) and 24(5)	Fees ¹¹	In preparation: consultation in 2005
Article 8(8), 11(8), 12(4) and 14(12)	Procedure for making and considering applications for certification	Proposals in this document
Article 21(6)	Appeals	Draft rules issued for consultation on 19 November 2004 (available on www.pmetb.org.uk)
Schedule 2, para 2(3)	Removal of Board members ¹¹	[Rules made on 14 December 2004. (available on www.pmetb.org.uk)]
Schedule 2, para 9	Complaints about the Board	In preparation: consultation in 2005
Schedule 2, para 13(1)	Committees and subcommittees	In preparation: consultation in 2005.

¹¹ Required to be approved as Statutory Instruments by the Secretary of State for Health after consulting Scottish Ministers, the Department of Health, Social Services and Public Safety in Northern Ireland and the National Assembly for Wales.

The 7 headings of the GMC's "Good Medical Practice"¹²

1. **Good clinical care**
Providing a good standard of practice and care
Decisions about access to medical care
Treatment in emergencies
2. **Maintaining good medical practice**
Keeping up to date
Maintaining your performance
3. **Teaching and training, appraising and assessing**
Making assessments and providing references
Teaching and training
4. **Relationships with patients**
Obtaining consent
Respecting confidentiality
Maintaining trust
Good communication
Ending professional relationships with patients
5. **Dealing with problems in professional practice**
Conduct or performance of colleagues
Complaints and formal inquiries
Indemnity insurance
6. **Working with colleagues**
Treating colleagues fairly
Working in teams
Leading teams
Arranging cover
Taking up appointments
Sharing information with colleagues
Delegation and referral
7. **Probity and health**
Providing information about your services
Writing reports, giving evidence and signing documents
Research
Financial and commercial dealings
Conflicts of interest
Financial interests in hospitals, nursing homes and other medical organisations
If your health may put patients at risk

¹² GMC, May 2001

Acquired Rights 'Evidence' (Current JCPTGP Requirements)

Acquired Rights Applications

Of the different types of acquired rights there are three that are most common. These are explained below. The certificates issued are identical, however the documentation required in order to process the three types differs.

Exempt Principals

Exempt principals must provide evidence that they were included on a Medical List on the prescribed day of 15 February 1981. This evidence should take the form of their original 'Certificate of Inclusion on a Medical List on the Prescribed Day' or an original statement from the health authority with which they were in contract. This statement must include the following:

- Full name
- GMC number
- Confirmation that they were included on the Medical List of the Health Authority as a principal GP and the dates involved which must cover 15 February 1981

or

- Specific confirmation that they were on the Medical List of the Health Authority on 15 February 1981
- The statement must be on original headed paper and signed

Alternatively, if employed in the Armed Services, the applicant must submit a Statement of Exemption from the Director General of Medical Services confirming employment on 15 February 1981.

The applicant must also provide a covering letter confirming that they are applying for a certificate of acquired rights on the basis that they were a Principal GP on 15 February 1981 and a copy of their current annual registration certificate with the GMC.

If the applicant was not working as a Principal on 15 February 1981 but was included in the Medical List prior to that date and re-entered the Medical List before 15 February 1990, he or she must provide statements of inclusion, as detailed above, to confirm this.

Regulation 5(1)(a) refers to doctors who are entitled to an acquired right because they were practising as principals in general practice in the NHS on 31 December 1994. This is a grandfather clause and should be read in conjunction with the 1979 Regulations. Doctors who are eligible under Regulation 5(1)(a) must have complied with the 1979 Regulations in order to be practising as a principal in 1994. Regulation 5(1)(a) is therefore an amendment rather than a fourth category of exemption.