EXPLANATORY MEMORANDUM TO

THE GENERAL AND SPECIALIST MEDICAL PRACTICE (EDUCATION, TRAINING AND QUALIFICATIONS) ORDER 2010

2010 No. 234

1. This Explanatory Memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Purpose of the instrument

2.1 This Order abolishes the Postgraduate Medical Education and Training Board (PMETB) and provides for its functions to be performed by the General Medical Council (GMC). This change implements recommendations made by the report of the Tooke inquiry into Modernising Medical Careers (MMC) that there should be far-reaching reforms to the structure of medical education and training in the UK.

2.2 The Order also contains provision to allow a GP to be automatically re-included on the GP Register where he has been temporarily re-registered as a doctor in an emergency pursuant to section 18A of the Medical Act 1983 (the "1983 Act").

3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None

4. Legislative Context

4.1 The Order transfers PMETB's statutory functions to the GMC by incorporating the provisions of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 ("the 2003 Order") relating to those functions into the 1983 Act. It also inserts powers into the 1983 Act allowing certain detail relating to the performance of those functions to be prescribed in subordinate legislation. This Order is the first in a sequence of SIs. A further piece of legislation, the Postgraduate Medical Education and Training Order of Council 2010 ("the Order of Council"), was consulted on at the same time as the 2010 Order. However, as it relies on powers taken in the 2010 Order, it cannot be made until the 2010 Order becomes law itself. The Order of Council is attached at Annex A for information.

4.2 The Order provides the overarching statutory framework within which the oversight of postgraduate medical education and training occurs. In relation to detail which may be subject to adjustment from time to time, it was felt appropriate to take powers in the 1983 Act to prescribe that detail in subordinate legislation, so change could take place relatively easily, and enable the GMC to keep up to date with changes in the system of medical education and training.

4.3 The Order provides for the GMC to set standards and requirements for postgraduate medical education and training; to approve courses and programmes relating to such education and training and the procedures to apply where such programmes are not to be approved or approvals are to be withdrawn. It prescribes the criteria to be satisfied before a doctor can be awarded a Certificate of Completion of Training (CCT) as a general practitioner or a specialist and makes provision for specialties and training for those specialties to be recognised by Order of Council.

4.4 The Order also allows the GMC to appoint persons to visit bodies or persons involved in the provision of postgraduate medical education and training, make provision about information that such persons or bodies must provide and for the GMC to charge fees for carrying out

functions in making approvals. It makes similar provisions in connection with the General Practitioner and Specialist Registers in relation to powers to regulate their form and keeping, as well as the charging of fees for applying for entry into, removal from, and proof of entry in those registers.

4.5 In addition to the legislative provisions contained both in the Order and the Order of Council, it is necessary to put in place a suite of rules and regulations covering operational matters such as application procedures, evidential requirements, notification of decisions, fees and arrangements for appeals. The Order amends the 1983 Act to take the necessary powers to enable the GMC to make those rules and regulations which will have to be enacted by statutory instrument, thus ensuring that all of those processes and procedures will be fair, open and transparent.

4.6 The GMC and PMETB are working together to develop the required rules and regulations with their partners over the coming months. To a large extent the rules and regulations are likely, initially, to mirror those in the 2003 Order which were previously used by PMETB for the same purposes, albeit that there will need to be some changes to provide consistency with the merger

5. Territorial Extent and Application

5.1 The Order extends to all of the United Kingdom.

6. European Convention on Human Rights

6.1 The Parliamentary Under-Secretary of State for Health Services has made the following statement regarding Human Rights:

"In my view the provisions of the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010 are compatible with the Convention rights"

7. Policy background

7.1 The proposal for change resulted from recommendations made in the report of the Tooke inquiry. This was an independent inquiry commissioned by the Secretary of State following the introduction of MMC, to investigate the extent to which MMC had engaged the medical profession, and to make recommendations to ensure that it had the support of the profession in the future. The report of the inquiry recommended a series of far-reaching reforms to the structure of medical education and training in the UK. The inquiry also considered the structures in place for overseeing postgraduate medical education and training.

7.2 The report of the Tooke inquiry noted that the system for overseeing postgraduate medical education and training involved two bodies - the GMC and the PMETB – which had overlapping functions. It recommended that the PMETB should be merged into the GMC to form a single body with responsibility for setting and maintaining standards across the continuum of medical education. The Secretary of State subsequently accepted the recommendation and made a commitment to merge the PMETB and the GMC by April 2010.

7.3 Setting and maintaining standards in medical education and training is necessary to ensure that the doctors of the future are competent in their judgment, up to date in their knowledge and fit for purpose within the context of the wider health system. The underlying purpose is to protect, promote and maintain the health and safety of the public. The report of the Tooke inquiry demonstrated dissatisfaction with the current, fragmented system. There is a lack of fusion between undergraduate and early postgraduate education and a lack of continuity between the process for setting and monitoring standards for training and for continuous professional development, as well as no clear link between registration, certification and revalidation. The existence of two separate bodies permits the development of different cultural approaches and

philosophies, as well as the potential to lead to diseconomies in terms of both finance and expertise.

7.4 Realising the full benefits of the merger will take time. In line with the recommendation that integration should take place as quickly as possible, it makes sense to integrate all of the functions within the GMC in advance of a more comprehensive review to gain the advantages already identified. This will also enable the GMC to take an overview of the whole system and it will then be better placed to identify and to implement any changes required. Work on this is already underway. The GMC and the PMETB have launched a comprehensive review of the regulation of medical education and training led by Lord Patel, Chairman of the National Patient Safety Agency. This review will involve extensive consultation with stakeholders and is expected to report in early 2010. It is likely that, as a result of the review, there will be a need for further legislation that will build on the results of this Order.

7.5 As to the new section 34F(3) regarding automatic re-inclusion on the GP Register, the GMC intends to ask all doctors removing themselves from the register if they would be willing to be automatically re-registered as doctors in an emergency. Currently, however, there is no provision to allow for automatic re-inclusion. This provision would only apply to those doctors whose name had previously been included on the GP Register, and removed through retirement, and not for any reason connected with the conduct of the practitioner. Registration in the GP Register will only be made once they are temporarily registered as doctors under section 18A of the 1983 Act, and will only be for the duration of the emergency.

8. Consultation outcome

8.1 In line with the code of practice for consultations laid down by the Act 1999, the Department of Health carried out formal public consultation. The consultation took place over a 12-week period between 4 June and 28 August 2009. The consultation paper "The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2010 and The Postgraduate Medical Education and Training Order of Council 2010 – A Paper for Consultation was published on the Department of Health website, as well as the websites of the GMC and the PMETB and is available to view at:
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_108327
The Department of Health wrote to the Medical Royal Colleges, devolved administrations and other interested professional bodies, patient groups and professionals to inform them of the consultation exercise and to invite them to participate.

8.2 In total, thirty-five responses were received, representing a mix of bodies/organisations and individual professionals, including major stakeholders in the field of medical education and training. All were reviewed as part of the consultation.

8.3 All bar one of the responses were positive. There was some concern about merging the two bodies rather than waiting for the outcome of the Patel Review. However, this was counterbalanced by very strong views that it makes sense to merge the two bodies in advance, as interim key benefits can be quickly realised, such as having a single contact point, the opportunity to share best practices and to achieve improvements through an integrated approach to education and training and access to pooled resources. Furthermore, early merger will minimise the period of uncertainty for those involved in medical education and training as well as for the PMETB staff

8.4 Several respondents sought reassurance that the GMC should still be required to consult widely on all future changes. In principle, although the GMC have no legal requirement to consult on subordinate legislation, new structures and some regulatory changes, they have always done so in the past before introducing significant changes, and the Government has every expectation that it will continue to do so in the future.

8.5 A range of issues arose subsequent to consultation. These are set out in 'Post-consultation amendments to the section 60 order at page 12 of the Consultation report. In particular, the amendment regarding emergency registration detailed at paragraph 7.5 above.

9. Guidance

9.1 This section 60 order is the overarching statutory framework which abolishes the PMETB and transfer their role to the GMC. The GMC and the PMETB will inform their stakeholders of this change. Further statutory instruments will cover operational matters, and the GMC will issue guidance on these as appropriate.

10. Impact

10.1 The Impact Assessment attached confirms that the merger of PMETB into GMC is the preferred option for achieving greater continuity and cohesion of medical regulation, improved outcomes for medical regulation and education and thus improved patient care.

11. Regulating Small Business

11.1 The Order does not affect small businesses

12. Monitoring and review

12.1 When fully implemented, the recommendation of the independent inquiry to merge the PMETB with the GMC and provide a single regulatory authority will result in economies of scale, a common approach to medical education and training, linkage of accreditation with registration and the sharing of quality enhancement expertise.

13. Contact

13.1 Tina Townsend-Greaves at the Department of Health Tel: 0113 254 6901 or e-mail: Tina.Townsend-Greaves@dh.gsi.gov.uk can answer any queries regarding the instrument.

STATUTORY INSTRUMENTS

2010 No. 0000

HEALTH CARE AND ASSOCIATED PROFESSIONS

DOCTORS

The Postgraduate Medical Education and Training Order of Council 2010

Made - - - -	***
Laid before Parliament	***
Coming into force - -	*1st April 2010*

Their Lordships make the following Order in exercise of the powers conferred by sections 34C(2)(c), 34D(2)(c) and (3), 34F(1)(b), 34G(1) and 34K(1)(c) of the Medical Act 1983(**1**).

Citation and commencement

1. This Order may be cited the Postgraduate Medical Education and Training Order of Council 2010 and shall come into force on 1st April 2010.

Interpretation

2. In this Order—

"the Act" means the Medical Act 1983;

"previous legislation" means—

(a) the European Specialist Medical Qualifications Order 1995(**2**); and

(b) the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003(**3**);

Persons eligible to be registered in, and liable to removal from, the General Practitioner Register

3.—a) Persons are eligible to be registered in the General Practitioner Register for the purpose of section 34C(2)(c) of the Act if they are—

(a) eligible general practitioners as specified in article 4;

(b) eligible general systems general practitioners as specified in article 5; or

(c) persons who are—

(i) registered in the list of visiting medical practitioners from relevant European States mentioned in section 30(1)(d) of the Act; and

(ii) providing services in the United Kingdom as a general practitioner on a temporary and occasional basis, in exercise of entitlement under Schedule 2A to the Act.

(2) If a person whose name is included in the General Practitioner Register by virtue of paragraph (1)(b) ceases to satisfy either of the conditions specified, the Registrar may remove that person's name from that register.

(**1**) 1983 c.54. Sections 34C, 34E, 34H, 34I and 34M are inserted by S.I.2010/ .
(**2**) S.I.1995/3208. This instrument is revoked by S.I.2003/1250.
(**3**) S.I.2003/1250. This instrument is revoked, so far as is material, by S.I.2010/ .

General practitioners eligible for entry in the General Practitioner Register

4.—b) Persons are eligible general practitioners for the purposes of article 3(1)(a) if they are exempt persons and hold any of the following issued in a relevant European State other than the United Kingdom—

(a) a qualification in general practice listed in Annex V, point 5.1.4 of the Directive, together with the corresponding professional title;

(b) a certificate of acquired rights; or

(c) a qualification in general practice which is not listed in Annex V, point 5.1.4 of the Directive, if that qualification—

(i) is accompanied by a certificate of a competent authority of the relevant European State in which the qualification was obtained to the effect that the qualification is evidence of training which satisfies the requirements of article 28 of the Directive, and

(ii) is treated by that State as if it were a qualification listed in relation to that State in Annex V, point 5.1.4 of the Directive.

(2) Persons are also eligible general practitioners for the purposes of article 3(1)(a) if they hold—

(a) a certificate of prescribed experience; or

(b) a certificate of equivalent experience,

which was issued under previous legislation, either by the Postgraduate Medical Education and Training Board or by the Joint Committee on Postgraduate Training for General Practice.

(3) Persons are also eligible general practitioners for the purposes of article 3(1)(a) if they were 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 National Health Service (Vocational Training for General Medical Practice) Regulations 1997(**4**)(exemptions);

(b) the National Health Service (Vocational Training for General Medical Practice) (Scotland) Regulations 1998(**5**) (exemptions); or

(c) the Medical Practitioners (Vocational Training) Regulations (Northern Ireland) 1998(**6**)(exemptions).

(4) Subject to paragraph (5), persons are also eligible general practitioners for the purposes of article 3(1)(a) if they do not fall within paragraph (1) , (2) or (3) but have—

(a) undertaken training in general practice; or

(b) been awarded qualifications in general practice,

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

(5) If a person falling within paragraph (4)(a) or (b) is an exempt person and holds a qualification in general practice which—

(a) was granted otherwise than in a relevant European State, and

(b) has not previously been accepted by a relevant European State as qualifying that person to practise as a general practitioner in that State,

that person is not an eligible general practitioner pursuant to paragraph (4) unless the Registrar is satisfied that the qualification in general practice is evidence of training that meets, or under article 22(a) of the Directive is to be treated as meeting, the requirements of article 28 of the Directive.

(6) If a person falling within paragraph (4)(a) or (b)—

(a) is an exempt person and holds a qualification in general practice which—

(i) was granted otherwise than in a relevant European State, but

(ii) has been accepted by a relevant European State, other than the United Kingdom, as qualifying that person to practise as a general practitioner in that State; or

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

the Registrar shall take account of that acceptance or of that experience or knowledge, when determining the adequacy of the training or qualifications under paragraph (5).

(7) In paragraph (1)(b), "certificate of acquired rights" means a certificate issued under article 30(1) of the Directive to the effect that its holder has an acquired right to practice as a general practitioner under the national security scheme of

(**4**) S.I.1997/2817; relevant amendments made by S.I.1998/669. Those Regulations are revoked by S.I.2003/1250.
(**5**) S.I.1998/5; relevant amendments made by S.I.1998/669 and 2000/23. Those Regulations are revoked by S.I.2003/1250.
(**6**) S.R. 1998 No.13. Those Regulations are revoked by S.I.2003/1250.

the issuing State without the evidence of formal qualifications of a general practitioner referred to in Annex V, point 5.1.4 of the Directive.

General systems general practitioners eligible for entry in the General Practitioner Register

5. A person—

(a) whose case falls within regulation 3(9)(e) of the General Systems Regulations;

(b) to whom regulations 20 to 26 of those Regulations apply by reason of the operation of regulation 3(4) of those Regulations; and

(c) who has a right to practise as a general practitioner in the United Kingdom by virtue of Part 3 of those Regulations (having, in particular, successfully completed any adaptation period that he may be required to complete pursuant to that Part of those Regulations),

is an eligible general systems general practitioner for the purposes of article 3(1)(b).

Persons with acquired rights

6.—c) For the purposes of section 34G(1) of the Act, a person has an acquired right to practise as a general practitioner in the United Kingdom if they fall within one of the categories of persons set out in paragraph (2).

(1) Persons have such an acquired right if—

(a) on 31st December 1994, their name was included in a medical list kept by a FHSA or in any corresponding list kept by a Health Board in Scotland or by the Northern Ireland Central Services Agency for the Health and Social Services in Northern Ireland;

(b) on 31st December 1994, they were suitably experienced within the meaning of section 31 of the National Health Service Act 1977(**7**) (requirement of suitable experience), section 21 of the National Health Service (Scotland) Act 1978 (**8**)(requirement of suitable experience), or Article 8 of the Health and Personal Social Services (Northern Ireland) Order 1978(**9**) (requirement of suitable experience) other than by virtue of—

(i) regulation 8(1)(e) of the 1979 Regulations, regulation 8(1)(e) of the 1980 Regulations or regulation 7(1)(d) of the 1979 Northern Ireland Regulations (exemption for applications to be a restricted services principal); or

(ii) regulation 8(1)(h) of the 1979 Regulations, regulations 8(1)(h) of the 1980 Regulations or regulation 7(1)(g) of the 1979 Northern Ireland Regulations (exemption for doctors who are EC nationals).

even if on that date they had yet to obtain a certificate of prescribed experience or a certificate of equivalent experience under any of those Regulations;

(c) on 31st December 1994, they were established in the United Kingdom by virtue of a qualification in medicine awarded in a relevant European State other than the United Kingdom which had in his case to be recognised in the United Kingdom by virtue of the Directive as entitling them to be registered under section 3(1)(b) of the Act as a fully registered person; or

(d) subject to paragraph (3), on at least 10 days in the period of 4 years ending with 31st December 1994, or on at least 40 days in the period of 10 years ending with that date, they had—

(i) been engaged as a deputy by, or provided as a deputy to, a doctor whose name was included in the medical list of a FHSA or in any corresponding list kept by a Health Board in Scotland or by the Northern Ireland Central Services Agency for the Health and Social Services in Northern Ireland; or

(ii) been employed as an assistant (other than as a trainee general practitioner) by such a doctor.

(2) For the purposes of paragraph (2)(d), engagement or provision as a deputy for a period of less than 24 hours beginning before but ending after midnight counts as engagement or provision on the second day only.

(3) In this article—

"the 1979 Regulations" means the National Health Service (Vocational Training) Regulations 1979(**10**);

"the 1979 Northern Ireland Regulations" means the Medical Practitioners (Vocational Training) Regulations (Northern Ireland) 1979(**11**);

"the 1980 Regulations" means the National Health Service (Vocational Training) (Scotland) Regulations 1980(**12**);

"the 1992 Regulations" means the National Health Service (General Medical Services) Regulations 1992(**13**);

(**7**) 1977 c.49.
(**8**) 1978 c.29.
(**9**) S.I.1978 No.1907 (N.I.26).
(**10**) S.I.1979/1644; relevant amendments were made by S.I.1980/1900/1981/1790, 1984/215, 1985/1353, 1986/1642 and 1991/406.
(**11**) S.R.1979 No.460; relevant amendments were made by S.R.1986 No.69 and 1986 No.309.
(**12**) S.I.1980/30; relevant amendments were made by S.I.1986/1657 and 1991/576.
(**13**) S.I.1992/635.

"FHSA" means a Family Health Services Authority;

"medical list" means the same as in the National Health Service (General Medical and Pharmaceutical Services) (Scotland) Regulations 1974(**14**), the 1992 Regulations or the General Medical Services Regulations (Northern Ireland) 1997(**15**), as the case may be; and

(4) References to legislation in paragraph (4) are to that legislation as in force on 31st December 1994.

Persons eligible to be registered in, and liable to removal from, the Specialist Register

7.—d) Persons are eligible to be registered in the Specialist Register for the purpose of section 34D(2)(c) of the Act if they are—

(a) eligible specialists as specified in article 8;

(b) eligible general systems specialists as specified in article 9; or

(c) persons—

(i) who are registered in the list of visiting medical practitioners from relevant European States mentioned in section 30(1)(d) of the Act; and

(ii) who are providing services in the United Kingdom as a specialist on a temporary and occasional basis, in exercise of entitlement under Schedule 2A to the Act.

(2) If a person whose name is included in the Specialist Register by virtue of paragraph (1)(b) ceases to satisfy either of the conditions specified, the Registrar may remove that person's name from that register.

Specialists eligible for entry in the Specialist Register

8.—e) Persons are eligible specialists for the purposes of article 7(1)(a) if they are exempt persons and hold a recognised specialist qualification as specified in article 10.

(1) Subject to paragraph (4), a person ("S") is an eligible specialist for the purposes of article 7(1)(a) if S—

(a) does not fall within sub-paragraph (1); but

(b) has—

(i) undertaken specialist training; or

(ii) been awarded specialist qualifications,

in a recognised specialty and satisfies the Registrar that that specialist training is, or those qualifications are, or both when considered together are, equivalent to a CCT in the specialty in question.

(2) Subject to paragraph (4), a person ("T") is an eligible specialist for the purposes of article 7(1)(a) if T—

(a) has—

(i) undertaken specialist training; or

(ii) been awarded specialist qualifications,

outside the United Kingdom in a medical specialty which is not a recognised specialty; or

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

and the Registrar is satisfied that these give S a level of knowledge and skill consistent with practise as a consultant in any of the UK health services.

(3) If S or, as the case may be, T, is an exempt person and holds a specialist qualification which—

(a) was granted otherwise than in a relevant European State, and

(b) has not previously been accepted by a relevant European State as qualifying the exempt person to practise as a specialist in that State,

S or, as the case may be, T, is not an eligible specialist pursuant to paragraph (2) or (3) unless the Registrar is satisfied that the specialist qualification is evidence of training that meets, or under article 22(a) of the Directive is to be treated as meeting, the requirements of article 25 of the Directive.

(4) If S or, as the case may be, T—

(a) is an exempt person who holds a specialist qualification which—

(i) was granted otherwise than in a relevant European State; but

(ii) has been accepted by a relevant European State, other than the United Kingdom, as qualifying him to practise as a specialist in that State; or

(**14**) S.I.1974/506; relevant amendments were made by S.I.1978/1762, 1985/1625 and 1980/1990.
(**15**) S.R.1997/380.

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

the Registrar shall take account of that acceptance or of that experience or knowledge, when determining the adequacy of the education or training under paragraph (2) or (3).

(5) A person is also an eligible specialist for the purposes of article 7(1)(a) if that person—

(a) was included in the specialist register maintained by the General Council under previous legislation;

(b) was determined to be an eligible specialist under, or by virtue of, previous legislation; or

(c) holds a Certificate of Completion of Specialist Training awarded under, or by virtue of, previous legislation.

(6) In paragraphs (2) and (3), "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.

General systems specialists eligible for entry in the Specialist Register

9. An exempt person—

(a) whose case falls within regulation 3(9)(a), (c) or (e) of the General Systems Regulations;

(b) to whom regulations 20 to 26 of those Regulations apply by reason of the operation of regulation 3(4) of those Regulations, and

(c) who has a right to practise as a specialist in the United Kingdom by virtue of Part 3 of those Regulations (having, in particular, successfully completed any adaptation period that he may be required to complete pursuant to that Part of those Regulations),

is an eligible general systems specialist for the purposes of article 7(1)(b).

Recognised specialist qualifications granted outside the United Kingdom

10.—f) The following are, for the purpose of article 8(1), recognised specialist qualifications granted outside the United Kingdom—

(a) a specialist qualification listed in Annex V, point 5.1.2 of the Directive which was awarded—

(i) in a relevant European State other than the United Kingdom;

(ii) on or after the reference date and is not evidence of training commenced by the holder before that date; and

(iii) in a recognised specialty;

(b) a specialist qualification listed in Annex V, point 5.1.2 of the Directive—

(i) which was awarded in a relevant European State other than the United Kingdom;

(ii) which was awarded following training commenced by the holder before the reference date;

(iii) which was awarded in a recognised specialty; and

(iv) where the holder of the qualification satisfies the Registrar (by means of a certificate of a competent authority of the relevant European State in which it was awarded or otherwise) that it accords with the standards laid down by article 25 of the Directive;

(c) a specialist qualification which—

(i) was awarded in a relevant European State other than the United Kingdom;

(ii) was awarded in a recognised specialty;

(iii) does not satisfy all the minimum training requirements laid down by article 25 of the Directive;

(iv) was awarded following training commenced by the holder before the reference date; and

(v) is accompanied by a certificate of a competent authority of any relevant European State that the holder has effectively and lawfully been engaged in the practice of his specialty in that State for at least three consecutive years during the five years preceding the date of the certificate;

(d) a specialist qualification in a recognised specialty which—

(i) has been obtained at any time in a relevant European State other than the United Kingdom;

(ii) does not correspond to the titles listed in Annex V, point 5.1.2 and 5.1.3 of the Directive; and

(iii) is accompanied by a certificate of a competent authority of that State to the effect that the qualification is evidence of training which satisfies the requirements of article 25 of the Directive and is treated by that

State as if it were a qualification listed in respect of the relevant specialty in relation to that State in Annex V, points 5.1.2 and 5.1.3 of the Directive;

(e) a specialist qualification which—

(i) was awarded in Spain to doctors who completed their specialist training before 1st January 1995, even if that training does not satisfy the requirements of article 25 of the Directive;

(ii) was awarded in a recognised specialty; and

(iii) is accompanied by a certificate issued by a competent authority in Spain attesting that the person concerned has passed the examination in specific professional competence held in accordance with article 27(2) of the Directive with a view to ascertaining that the person concerned possesses a level of knowledge and skill comparable to that of doctors who possess a specialist qualification listed in respect of the relevant specialty in relation to Spain in Annex V, points 5.1.2 and 5. 1.3 of the Directive;

(f) a specialist qualification in a recognised specialty—

(i) which is evidence of training which does not accord with the standards laid down by article 25 of the Directive, undertaken on the territory of the former German Democratic Republic and begun before 3rd April 1992;

(ii) where the holder of the qualification satisfies the Registrar (by means of a certificate of a competent authority in Germany or otherwise) that he is entitled by virtue of that qualification to practise his specialty throughout the territory of Germany on the same conditions as the holder of a qualification awarded in Germany and listed in Annex V, point 5.1.2 of the Directive,

(iii) where evidence of the qualification is accompanied by a certificate of a competent authority in Germany that the holder has effectively and lawfully been engaged in the practice of his specialty in Germany for at least three consecutive years during the five years preceding the date of the certificate; and

(g) a specialist qualification which—

(i) was awarded by, or which relates to training started in, the territory specified in column (a) of the table below before the date specified in the corresponding entry in column (b) of that table;

(ii) is accompanied by an attestation by a competent authority of the relevant European State specified in the corresponding entry in column (c) in that table to the effect that that qualification has, on its territory, the same legal validity as regards access to and practice of specialised medicine as a qualification awarded in that specialty in that State and listed in Annex V, point 5.1.2 of the Directive in respect of that State, and

(iii) is accompanied by a certificate from that authority that the holder has effectively and lawfully been engaged in the activity in question in that State for at least three consecutive years during the five years prior to the date of issue of that certificate.

Column (a)	*Column (b)*	*Column (c)*
Former Czechoslovakia	1st January 1993	Czech Republic
Former Czechoslovakia	1st January 1993	Slovakia
Former Soviet Union	20th August 1991	Estonia
Former Soviet Union	21st August 1991	Latvia
Former Soviet Union	11th March 1990	Lithuania
Former Yugoslavia	25th June 1991	Slovenia

(2) In paragraph (1) "the reference date", in relation to a relevant European State, means the date specified in relation to that State in the column entitled "Reference date" in Annex V, point 5.1.2 of the Directive.

Recognised specialities within the United Kingdom

11.—g) The specialties specified in the Schedule are those which are recognised within the United Kingdom for the purposes of the Act.

(1) Part 1 of the Schedule specifies both the specialties with a minimum training period and the minimum training period relevant to those specialties.

(2) Part 2 of the Schedule specifies the specialties with no minimum training period.

(3) Nothing in the Schedule shall prevent the award of a Certificate of Completion of Training in medical microbiology and virology to a person who was undergoing the education and training necessary to obtain such an award on 28th August 2009.

`Name
Clerk of the Privy Council

SCHEDULE

Article 11

Recognised specialties within the United Kingdom

PART 1

Recognised specialties within the United Kingdom with minimum training periods

Five years
Emergency medicine (*also known as accident and emergency medicine*)
General (internal) medicine* (*formerly known as general medicine*)
General surgery*
Neurosurgery* (*also known as neurological surgery*)
Trauma and orthopaedic surgery* (*also known as orthopaedics, and formerly known as orthopaedic surgery*)
Paediatric surgery
Plastic surgery*
Cardio-thoracic surgery (*also known as thoracic surgery*)
Urology*

Four years
Cardiology (*formerly known as cardio-vascular disease*)
Chemical pathology (*also known as biological chemistry and as clinical biochemistry*)
Child and adolescent psychiatry (*also known as child psychiatry*)
Clinical neurophysiology
Clinical pharmacology and therapeutics (*also known as pharmacology*)
Infectious diseases (*also known as communicable diseases*)
Public health medicine (*also known as community medicine*)
Dermatology
Clinical radiology* [*also known as diagnostic radiology and formerly known as radiology*)
Gastro-enterology
Geriatric medicine (*formerly known as geriatrics*)
Immunology (*also known as immunopathology*)
Medical microbiology (*also known as microbiology and bacteriology)*
Medical virology

Neurology*
Nuclear medicine
Obstetrics and gynaecology*
Occupational medicine
Oral and maxillo-facial surgery (*also known as dental, oral and maxillo-facial surgery (basic medical and dental training)*
Paediatrics*
General psychiatry* (*also known as psychiatry, as general adult psychiatry, and as mental illness*)
Clinical oncology (*also known as radiotherapy*)
Renal medicine (*also known as renal disease, and formerly known as nephrology)*
Respiratory medicine* (*also known as thoracic medicine*)
Rheumatology
Tropical medicine
Genito-urinary medicine (*also known as venereology*)

Three years
Anaesthetics*
Endocrinology and diabetes mellitus (*also known as endocrinology*)
Haematology (*also known as general haematology*)
Ophthalmology*
Otolaryngology* (*also known as otorhinolaryngology, and as ENT surgery*)

[Note: The specialties marked * above are those listed in Annex V, point 5.1.3 of the Directive which are common to all relevant European States. The remaining specialties are those in which the United Kingdom awards a qualification but which are peculiar to two or more relevant European States.]

PART 2

Recognised specialties with no minimum training period

Acute internal medicine
Allergy
Audiological medicine
Clinical genetics
Community sexual health and reproduction
Forensic psychiatry
Intensive care medicine
Medical oncology
Medical ophthalmology
Psychiatry of learning disability
Old age psychiatry
Paediatric cardiology
Palliative medicine
Pharmaceutical medicine
Psychotherapy
Rehabilitation medicine
Sport and exercise medicine.

EXPLANATORY NOTE

(This note is not part of the Order)

This Order sets out the categories of registered medical practitioners, other than those who have been awarded a certificate of completion of training, who are eligible for entry in the General Practitioner Register and the Specialist Register kept by the General Medical Council. The eligibility criteria are largely based on the content of Directive 2005/36/EC(**16**) concerning the recognition of professional qualifications.

Article 3(1) prescribes that the categories of registered medical practitioners are eligible for entry into the General Practitioner Register are both those set out in articles 4 and 5 and those who are on the list of visiting medical practitioners from the EU and are practising in this country as a general practitioner (article 3(1)(b)) on a temporary and occasional basis. Article 3(2) provides that people within article 3(1)(b) may be removed from that register if they cease to be such a person. Article 4 relates to exempt persons who are eligible general practitioners and article 5 relates to exempt persons who are eligible general systems general practitioners.

Article 6 prescribes which registered medical practitioners who have acquired rights to practice as general practitioners in the United Kingdom, are eligible for entry in the General Practitioner Register.

Article 7(1) prescribes that the categories of registered medical practitioners are eligible for entry into the Specialist Register are both those set out in articles 8 and 9 and those who are on the list of visiting medical practitioners from the EU and are practising in this country as specialists on a temporary and occasional basis (article 7(1)(b)). Article 7(2)

(**16**) OJ No.L255, 30.09.2005, p.22 as amended by Council Directive 2006/100/EC of 20th November 2006, OJ L363 of 20.12.2006, p.141.

provides that people within article 7(1)(b) may be removed from that register if they cease to be such a person. Article 8 relates to exempt persons who are eligible specialists and article 9 relates to exempt persons who are eligible general systems specialists.

Article 10 prescribes the qualifications granted outside the United Kingdom which must be recognised when determining whether or not a registered medical practitioner is eligible for entry on to the Specialist Register. Article 11 and the Schedule prescribe the medical specialties which the UK recognises and the minimum training period for those specialties where applicable.

Summary: Intervention & Options

Department /Agency:	Title:	
Department of Health	**Impact Assessment of the merger of PMETB and GMC (Public Spending IA)**	
Stage: Final Proposal Stage	**Version:** 1.1 Final Draft	**Date: 30 October 2009**
Related Publications: The Secretary of State for Health's response to Aspiring to Excellence: Final report of the Independent Inquiry into Modernising Medical Careers		

Available to view or download at:

http://www.dh.gov.uk/en/Publicationsandstatistics/DH_083203

Contact for enquiries: Mike Clement **Telephone:** 020 7972 3722

What is the problem under consideration? Why is government intervention necessary?

Medical regulation is split between two bodies, PMETB and GMC. This leads to discontinuity of oversight of medical education and may impede improvements to medical education and the DH objective of better patient care for all. The Independent Inquiry into Modernising Medical Careers (MMC), defined a single regulatory authority that would improve the quality of medical regulation. Government intervention is necessary, as PMETB is a DH sponsored public body and amendment to primary legislation is required.

What are the policy objectives and the intended effects?

The policy aim is to improve medical regulation and training and thus improve patient care. The policy objective is to establish an improved single regulatory authority, as recommended in the Independent Inquiry into MMC, that will facilitate a common approach to medical regulation, flexible training, and wider pool and sharing of quality enhancement expertise. The intended effects are; greater continuity and cohesion of medical regulation and education across all career stages, improved outcomes for medical regulation and education, and thus improved medical practice and patient care.

What policy options have been considered? Please justify any preferred option.

Option 1 – Do nothing. This fails to meet the above policy objectives.

Option 2 (recommended) – Merge PMETB into GMC. This is the recommended option as it will meet all the above policy objectives.

(Note: two other options were considered at the consultation stage, however following the qualitative assessment and the consultation responses only Options 1 and 2 remain viable. Further details of this are given in the consultation document and attached evidence summary)

When will the policy be reviewed to establish the actual costs and benefits and the achievement of the desired effects? April 2013

Ministerial Sign-off For final proposal/implementation Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:

Ann Keen .....Date: ***6th November 2009***

Summary: Analysis & Evidence

Policy Option: 2	Description: Assimilate PMETB into the GMC (Public Spending IA)

COSTS (EXCHEQUER IMPACTS)

ANNUAL COSTS	
One-off (Transition)	**Yrs**
£ 6,800,000	4
Average Annual Cost (excluding one-off)	
£ -1,425,000	

Description and scale of **key monetised EXCHEQUER IMPACTS** by 'main affected groups' One off costs include all transition/merger costs incurred by DH and PMETB inc DH gap funding for PMETB excess in 2010/1-2012/3. There is an annual cost saving to DH as DH funding of PMETB functions ceases from 2010/11. The figure used is DH funding as at 31/03/09 taken from PMETB annual accounts report.

Total Cost (PV) **£ 175,000**

Other **key non-monetised EXCHEQUER IMPACTS** by 'main affected groups' ***PMETB, NHS, and patients*:** disruption to medical regulation and education during the transition period, achieves the benefits of improved medical regulation and education and thus patient care through creation of an improved single regulatory authority.

BENEFITS (NON-EXCHEQUER IMPACTS)

ANNUAL BENEFITS	
One-off	**Yrs**
£ 1,250,000	4
Average Annual Benefit (excluding one-off)	
£ -1,175,000	

Description and scale of **key monetised NON-EXCHEQUER IMPACTS** by 'main affected groups' One off impacts to GMC include relocation of a function to Manchester, opportunity costs of GMC staff time spent on merger activities and DH gap funding for PMETB excess. Average annual benefit to GMC includes costs of funding PMETB functions, and cost savings from integration when GMC take over from DH in 2010 post merger.

Total Benefit (PV) **£ -3,625,000**

Other **key non-monetised NON-EXCHEQUER impacts** by 'main affected groups'. ***GMC:*** disruption to medical regulation and education during transition period, narrow extension of GMC's remit, utilisation of GMC's greater resources, utilisation of GMC's strong reputation, support from the medical profession.

Key Assumptions/Sensitivities/Risks :Figures are best estimates (including optimism bias) rounded to the nearest £25,000 to allow for some uncertainty. Implementation timetable and costs dependant on enabling legislation. Risks=loss of staff, inability to maintain business continuity, inability to realise cost savings, behaving as separate bodies post merger thus not fully realising the full range of benefits.

Price Base Year 2009	Time Period Years 6	**Net Benefit Range** (NPV) **£ not available**	**NET BENEFIT** (NPV Best estimate) **£ -3,800,000*(exc op costs)**

What is the geographic coverage of the policy/option?			United Kingdom	
On what date will the policy be implemented?			April 2010	
Which organisation(s) will enforce the policy?			GMC	
What is the total annual cost of enforcement for these organisations?			£ N/A	
Does enforcement comply with Hampton principles?			Yes	
Will implementation go beyond minimum EU requirements?			Yes	
What is the value of the proposed offsetting measure per year?			£ N/A	
What is the value of changes in greenhouse gas emissions?			£ N/A	
Will the proposal have a significant impact on competition?			No	
Annual cost (£-£) per organisation (excluding one-off)	Micro	Small	Medium	Large
Are any of these organisations exempt?	No	No	N/A	N/A

Impact on Admin Burdens Baseline (2005 Prices) (Increase - Decrease)

Increase of £ Decrease of £ **Net Impact** £

Key: **Annual costs and benefits: Constant Prices** **(Net) Present Value**

Improving the quality of medical regulation – assessment of options

1. Introduction

1.1 Medical education regulation ensures proper standards in the medical training. Its purpose is to protect, promote and maintain the health and safety of the public. An important component of ensuring proper standards is ensuring adequate training. An Independent Inquiry into Modernising Medical Careers (MMC), led by Sir John Tooke, consulted 4630 doctors and made recommendations on improving medical education. The Inquiry revealed significant problems with the current regulatory framework for medical education and training:

1.2 The two regulatory bodies currently involved in regulation of these stages:

1.3 The General Medical Council (GMC)

The GMC is an independent regulator with four main functions:

a. Controlling entry to the medical register and ensuring that licensed doctors are up to date and fit to practise
b. Fostering good medical practice
c. Promoting high standards of medical education
d. Dealing with doctors whose fitness to practise is in doubt

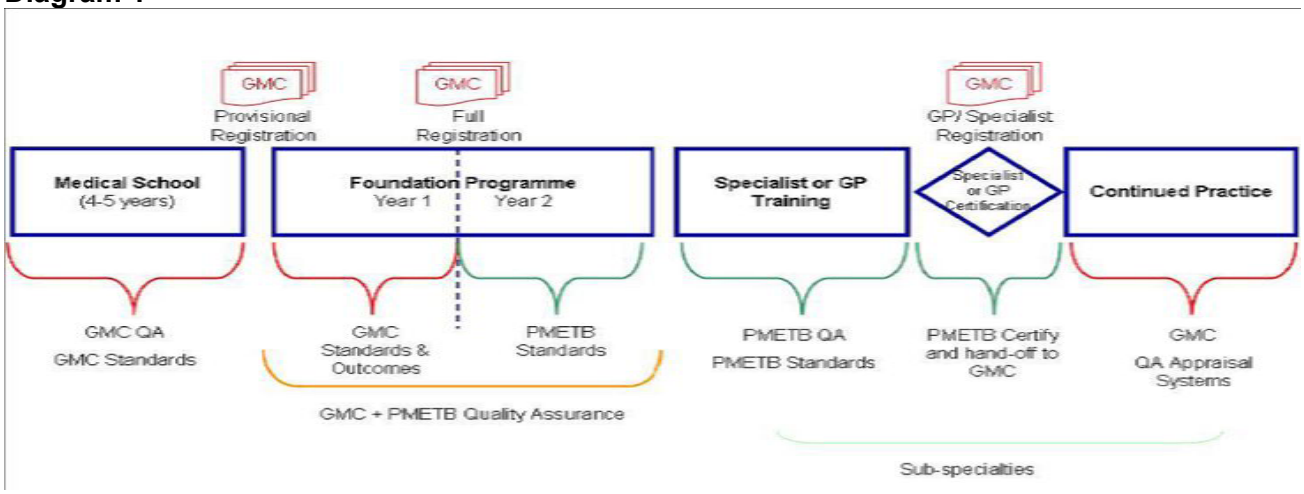
1.4 The Postgraduate Medical Education and Training Board (PMETB)

PMETB is a regulator sponsored by the Department of Health with four main functions:

a. Establishing standards of, and requirements relating to, postgraduate medical education
b. Securing the maintenance of these standards and requirements
c. Developing and promoting postgraduate medical education and training
d. Certifying doctors for application to the specialist register or general practice register, and for application for their certificate of completion of training, to the GMC

1.5 Diagram 1 shows the current responsibilities of GMC and PMETB for regulating the stages of the medical training continuum:

Diagram 1



1.6 Timeline of medical regulator changes: how the current situation developed

1858 GMC established under the Medical Act 1858: GMC subsequently regulated undergraduate education; Royal Colleges and Faculties informally regulated all further education and training.

1975 The Report of the Inquiry into the Regulation of the Medical Profession ('The Merrison Report' recommended that the GMC should also regulate postgraduate medical education and training. The GMC was given responsibility for regulating specialist training for EU minimum standards.

1978 The Medical Act 1978 gave GMC continued responsibility for undergraduate education in addition to the general function of 'promoting high standards of medical education and co-ordinating all stages of medical education'.

1979 The Joint Committee for Postgraduate Training in General Practice (JCPTGP) was established to regulate GP training.

1993 The Calman Report recommended that a UK Certificate of Completion of Specialist Training (CCST) be introduced. The Specialist Training Authority (STA) of the Medical Royal Colleges was established to regulate specialist training and to award CCSTs; the JCPTGP remained responsible for GP training.

2001 High profile inquiries raised concerns about medical self-regulation; the Bristol Inquiry (2001) recommended that postgraduate medical education should be regulated by the GMC.

2003 The government created The Postgraduate Medical Education and Training Board (PMETB) to replace the STA and JCPTGP .

2005 PMETB replaced the JCPTGP and STA as regulator of postgraduate medical education.

2008 The Independent Inquiry into Modernising Medical Careers ('The Tooke Report') recommended assimilation of PMETB into GMC.

1.7 More detail is available on the historical context of medical regulators at Annex C.

2. Features of an "ideal" regulatory authority.

2.1 The Independent Inquiry in to Modernising Medical Careers set out the features of an ideal regulatory authority:

It is clear from the evidence received that the profession perceives the need for a regulatory authority that is external to government, has strong lay representation and works in close partnership with the profession, drawing fully on relevant specialist expertise. In the view of the Inquiry, the ideal Regulatory Authority would also facilitate flexible training and ideally embrace the essential continuum of medical education from undergraduate studies through to revalidation and continuing professional development.

2.2 In view of the principle that regulation and service provision (through the NHS) should be kept entirely separate, the Inquiry specifically recommended that the regulator should be independent of the NHS, the monopoly employer.

Table 1: The extent to which the current medical regulatory authorities meet the features of an ideal regulatory authority – the policy objectives

Features of an ideal regulatory authority	GMC	PMETB
Single regulatory authority	No	No
External to government and NHS	Yes	No

Strong lay representation	Yes	Yes
Works in close partnership with the profession	Yes	Partial
Facilitate flexible training	No	No
Embrace continuum of medical education	No	No
Meets all features	**No**	**No**

3. Options

Option 1: Do nothing: continue with the existing two medical regulatory bodies

Option 2: Merge PMETB into GMC (recommended option)

Option 3: Merge GMC into PMETB

Option 4: Create a new single medical regulatory body

3.1 There were four options originally short-listed and considered at the consultation stage. All four options were assessed qualitatively and subject to consultation. From the results of the consultation and the qualitative assessment it was clear that Option 2 was the only viable alternative option to the “do nothing” that would fully meet the policy objectives. As a result, only Option 2 has been subject to a quantitative assessment, where economic costs and benefits marginal to the “do nothing” have been quantified where possible.

3.2 The qualitative assessment of all four options is shown in section 4.

3.3 The consultation response is shown in section 5

3.4 The quantitative assessment of Option 2, marginal to the “do nothing” Option 1, is shown in section 6.

3.5 The conclusion and final recommendation is detailed in section 7.

4. Qualitative Assessment of the Options

Summary

Table 2: The extent to which each policy option meets the features of an ideal regulatory authority – thus can achieve the policy objectives and improve medical regulation and education, and thus improve patient care.

Features of an ideal regulatory authority	Option 1	Option 2	Option 3	Option 4
Single regulatory authority	No	Yes	Yes	Yes
External to government and NHS	No	Yes	No	Yes
Strong lay representation	Yes	Yes	Yes	Yes
Works in close partnership with the profession	Partial	Yes	Yes	Yes
Facilitate flexible training	No	Yes	Yes	Yes
Embrace continuum of medical education	No	Yes	Yes	Yes
Meets all features	**No**	**Yes**	**No**	**Yes**

Table 3: Summary of benefits of Options 1 – 4

Benefits	Option 1	Option 2	Option 3	Option 4
Overall Policy Benefits				
Meets criteria of 'ideal regulatory authority' thus can achieve the policy objectives and therefore improve medical regulation and education and thus improve patient care.	No	Yes	No	Yes
Merger Benefits				
No change/narrow extension of remit	Yes	Yes	No	No
Current expertise in medical regulation	Yes	Yes	Yes	No
Strong reputation for medical regulation	Partial	Yes	Partial	No
Strong reputation for education quality enhancement	Partial	Yes	Partial	No
Greater resources than the other body	Not applicable	Yes	No	Not applicable
Cohesive IT strategy	Partial	Yes	No	No
Option favoured by the medical profession	No	Yes	No	No
Could bring about swift and efficient changes to postgraduate education	No	Yes	Yes	No

Table 4: Summary of risks of Options 1 – 4

Risks	Option 1	Option 2	Option 3	Option 4
Staff loss	Low	Medium	High	High
Inability to maintain business continuity	Low	Medium	Medium	High
Failure to deliver a 'single continuum' of medical education	High	Low	Low	Unknown
Functioning and behaving as separate bodies after assimilation	Not applicable	Medium	High	Not applicable
Reputational damage to government by failing to deliver promptly	Not applicable	Low	High	High
Unknown body	Low	Low	Low	High

4.1 Option 1: Do nothing: continue with the existing two medical regulatory bodies

4.1.1 After extensive consultation, the Independent Inquiry into Modernising Medical Careers concluded:

'Despite most authorities acknowledging that medical education should be seamless from undergraduate days through to continuing professional development the regulation of medical education is divided between two bodies: the GMC is responsible for undergraduate education, FY1, CPD and revalidation, whilst PMETB is responsible for Postgraduate Training post FY1, apart from FY2 which is theoretically unregulated but in practice shared between the GMC and PMETB. Such a duplicated regulatory structure creates diseconomies, fails clearly to link registration, certification and revalidation in the same body, permits the development of different cultural approaches and promotes the separateness of the trainee mentality. One body is therefore preferable.'

4.1.2 In Option 1, almost none of the features of an 'ideal regulatory authority' are met and the current problems, as outlined in the Inquiry (above) would continue.

Table 5: Brief explanation for scores for Option 1

Features of an ideal regulatory authority	
Single regulatory authority	No: GMC and PMETB will maintain separate functions.
External to government and NHS	No: PMETB is sponsored by the Department of Health
Strong lay representation	Yes: Both boards include lay representatives
Works in close partnership with the profession	Partial: GMC does work in close partnership with the profession. However PMETB has been negatively perceived as taking authority from the Royal Colleges, and failing to establish a collaborative relationship
Facilitate flexible training	No: Regulation is discontinuous with two bodies
Embrace continuum of medical education	No: Regulation is discontinuous with two bodies
Benefits	
Meets criteria of 'ideal regulatory authority'	No: see above
No change/narrow extension of remit	Yes: there would be no change in remit
Current expertise in medical regulation	Yes: Both bodies have significant expertise
Strong reputation for medical regulation	Partial: GMC has been established since 1858 and has a strong reputation. PMETB however was established in 2005 and does not yet have the same level of reputation.
Strong reputation for education quality enhancement	Partial: GMC has been established since 1858 and has a strong reputation. PMETB however was established in 2005 and does not yet have the same level of reputation.
Greater resources than the other body	Not applicable: there would be no change
Cohesive IT strategy	Partial: PMETB's IT system is in urgent need of development; GMC has established a cohesive IT strategy with reliable, secure IT hardware and software, and support staff.
Option favoured by the medical profession	No: At least 82% of doctors favour a different option
Could bring about swift and efficient changes to postgraduate education	No: The discontinuity across the continuum of medical education inhibits these changes from being made.
Risks	
Staff loss	Low: As there will be no change from the current situation, it is felt the loss of staff will be unchanged.
Inability to maintain business continuity	Low: The situation will continue as before.
Failure to deliver a 'single continuum' of medical education	High: The two bodies will continue to regulate different stages of medical education.

Functioning and behaving as separate bodies after assimilation	High: they will continue to be separate bodies.
Reputational damage to government by failing to deliver promptly	Not applicable: the current situation would be unchanged.
Unknown body	Low: GMC and PMETB are both known bodies.

4.1.3 Costs of Option 1

4.1.4 Option 1 represents no change to current cost.

4.2 Option 2: Merge PMETB into GMC (Recommended Option)

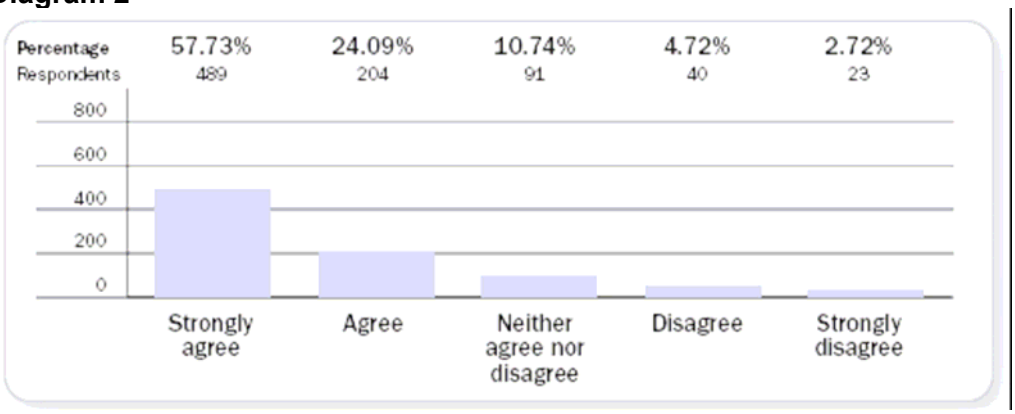
4.2.1 Following the e-consultation of 4630 medical professionals, and analysis of the situation, the Independent Inquiry into Modernising Careers recommended assimilation of PMETB into GMC in its interim report of October 2007:

PMETB should be assimilated in a regulatory structure within GMC that oversees the continuum of undergraduate and postgraduate medical education and training, continuing professional development, quality assurance and enhancement. The greater resources of the GMC would ensure that the improvements that are needed in postgraduate medical education will be achieved more swiftly and efficiently. To this end the assimilation should occur as quickly as possible.

Recommendation 30

4.2.2 A further round of e-consultation of medical professionals on the findings of the interim report revealed that this recommendation was strongly supported, with 82% of respondents agreeing or strongly agreeing with the recommendation (Diagram 2). Consequently, recommendation 30 was carried forward unchanged to the final report of the inquiry.

Diagram 2



4.2.3 The Inquiry further states:

> *Co-location of such regulatory functions in a single regulatory body is perceived as offering the potential for shared expertise and philosophy as well as value for money derived from economies of scale. The ideal regulatory authority would also report direct to Parliament rather than through the Department of Health, given the fact that approximately 25% of UK doctors do not work for the NHS and thus the authority should be independent of the monopoly employer. The financial burden of regulation falls heavily on the trainee under PMETB and many feel it more appropriate that such costs should be borne by the profession as a whole.*

Table 6: Brief explanation for scores for Option 2

Features of an ideal regulatory authority	
Single regulatory authority	Yes: PMETB would be merged into GMC to create a single body
External to government and NHS	Yes: GMC is currently independent.

Strong lay representation	Yes: 50% of GMC's board are lay representatives.
Works in close partnership with the profession	Yes: GMC has strong links with the profession.
Facilitate flexible training	Yes: GMC has the necessary resources and expertise, and this would be facilitated by having a single regulator across the continuum of medical education.
Embrace continuum of medical education	Assimilating the intermediate component of medical education would embrace the continuum of medical education from undergraduate studies through to revalidation and continuing professional development, promoting seamlessness and cohesion of medical education and training, and facilitating links between accreditation, registration, certification and revalidation
Benefits	
Meets criteria of 'ideal regulatory authority'	Yes: See above.
No change/narrow extension of remit	Yes: The GMC already regulates two of the three components of medical education effectively and efficiently; while this is a significant extension of GMC's remit, it is in a functional area in which GMC already has a strong track record.
Current expertise in medical regulation	Yes: The GMC has expertise in medical regulation
Strong reputation for medical regulation	Yes: The GMC has a strong reputation in medical regulation
Strong reputation for education quality enhancement	Yes: The GMC has a strong reputation for quality enhancement of undergraduate education that could be utilised for developing postgraduate education.
Greater resources than the other body	Yes: The net operating cost of PMETB in 2007/08 was £1,171,269; the net operating cost of GMC in 2007: £73,642,000.
Cohesive IT strategy	Yes: GMC has established a cohesive IT strategy with reliable, secure IT hardware and software, and support staff.
Option favoured by the medical profession	Yes: 82% of the medical profession favour Option 2
Could bring about swift and efficient changes to postgraduate education	The greater resources of the GMC would ensure that the improvements needed in postgraduate medical education would be achieved swiftly and efficiently while harnessing the expertise of PMETB.
Risks	
Staff loss	Low: There is a risk that there will be staff lost during the transition period; there is no plan for redundancies, and due to its greater scale, the GMC is able to commit to providing comparable jobs after the merger.
Inability to maintain business continuity	Low: There may be some disruption during the transition period, particularly for PMETB where

	there is a greater degree of uncertainty among staff, but GMC's greater scale allows for application of project planning and management resources
Failure to deliver a 'single continuum' of medical education	Low: This option would deliver the single continuum of medical education.
Functioning and behaving as separate bodies after assimilation	Low: Co-location will enable functional integration.
Reputational damage to government by failing to deliver promptly	Medium: This option is likely to be achieved in the stated timescale.
Unknown body	Low: Both bodies are known and proven.

4.2.4 Costs of Option 2

4.2.5 Costs (and cost savings) of option 2 have been quantified and the analysis is contained in Section 6.

4.3 Option 3: Merge GMC into PMETB

Table 7: Brief explanation for scores for Option 3

Features of an ideal regulatory authority	
Single regulatory authority	Yes: GMC would be merged into PMETB to create a single body, but there would continue to be separate regulators for other aspects of professional regulation.
External to government and NHS	No: PMETB is sponsored by the Department of Health.
Strong lay representation	Yes: PMETB's board includes lay representatives
Works in close partnership with the profession	Partial: PMETB has been negatively perceived as taking authority from the Royal Colleges, and failing to establish a collaborative relationship.
Facilitate flexible training	Yes: the creation of a continuum of medical education would facilitate this.
Embrace continuum of medical education	Yes: Assimilating the initial and final components of medical education would embrace the continuum of medical education from undergraduate studies through to revalidation and continuing professional development, promoting seamlessness and cohesion of medical education and training, and facilitating links between accreditation, registration, certification and revalidation
Benefits	
Meets criteria of 'ideal regulatory authority'	No: See above
No change/narrow extension of remit	No: PMETB currently regulates only one of the three stages of medical education, thus this option would require a wide extension of remit.
Current expertise in medical regulation	Yes: PMETB has expertise in medical regulation though it has been established for a much shorter period than GMC.
Strong reputation for medical regulation	Partial: PMETB only started operating in 2005.
Strong reputation for education quality enhancement	Partial: PMETB only started operating in 2005.
Greater resources than the other body	No: The net operating cost of PMETB in 2007/08 was £1,171,269; the net operating cost of GMC in 2007: £73,642,000.
Cohesive IT strategy	No: PMETB's IT system is in urgent need of development

Option favoured by the medical profession	No: At least 82% of the medical profession do not favour this option – no assumption could be made about their willingness to continue an approach which had virtually no support.
Could bring about swift and efficient changes to postgraduate education	Yes: The combined resources of the GMC and PMETB would ensure that the improvements needed in postgraduate medical education would be achieved swiftly and efficiently while harnessing the expertise of GMC.

Risks	
Staff loss	High: There is a risk that there will be staff lost during the transition period; there is no plan for redundancies.
Inability to maintain business continuity	Medium: There may be some disruption during the transition period.
Failure to deliver a 'single continuum' of medical education	Low: This option would deliver the single continuum of medical education.
Functioning and behaving as separate bodies after assimilation	High: They may continue to function as a separate bodies; this risk could be reduced by GMC relocating to the PMETB's building; this is not viable due to a lack of accommodation space.
Reputational damage to government by failing to deliver promptly	High: Assimilating a larger body into a smaller body will lead to greater cost and disruption, and may lead to delays.
Unknown body	Low: GMC and PMETB are known regulators.

4.3.1 Costs of Option 3

4.3.2 GMC is a much larger body than PMETB. It is significantly more expensive, disruptive and unnecessarily risky for a larger body, in this case the GMC, to merge into a smaller body, PMETB. As a result, this option would lead to greater cost, for less benefit.

4.3.3 Cost drivers of any merger include:

- Synchronising IT systems: e.g. email accounts
- Synchronising HR e.g. pay scales, pensions
- Synchronising Organisation values/rules
- Physical relocation costs
- Costs of managing the merger

4.3.4 The above bullet points indicate just some or the costs drivers of any merger. The larger the number of people that are required to move organisation, as result of a merger, the higher the costs. It is therefore not possible that option 3 would be cheaper than option 2 (PMETB to merge into GMC) due to the relative size of the organisations.

4.3.5 It can be seen from the qualitative assessments that this long-list option would fail to meet all of the policy objectives, and would incur a greater cost. It is therefore not viable and has not been short-listed.

4.3.6 As a result, the large amounts of time and resources required to fully quantify the costs of this option have not been committed

4.4 Option 4: Create a new single medical regulatory body

Table 8: Brief explanation for scores for Option 4

Features of an ideal regulatory authority	
Single regulatory authority	Yes: a new body could be designed to meet the features of an ideal regulatory authority
External to government and NHS	Yes: a new body could be designed to meet the features of an ideal regulatory authority
Strong lay representation	Yes: a new body could be designed to meet the features of an ideal regulatory authority
Works in close partnership with the profession	Yes: a new body could be designed to meet the features of an ideal regulatory authority
Facilitate flexible training	Yes: a new body could be designed to meet the features of an ideal regulatory authority
Embrace continuum of medical education	Yes: a new body could be designed to meet the features of an ideal regulatory authority
Benefits	
Meets criteria of 'ideal regulatory authority'	Yes: a new body could be designed to meet the features of an ideal regulatory authority
No change/narrow extension of remit	No: The body would be created and therefore would have no previous remit: this option would represent a massive new remit.
Current expertise in medical regulation	No: This new body would have no previous expertise in medical regulation (though would likely draw on expertise from the current regulators)
Strong reputation for medical regulation	No: This new body would have no previous reputation.
Strong reputation for education quality enhancement	No: This would be a new body with no previous expertise in education or quality enhancement (though would likely draw on expertise from the current regulators)
Greater resources than the other body	Unclear: Creating a new body would create very high costs.
Cohesive IT strategy	No: A new body would need to develop a new IT strategy.
Option favoured by the medical profession	No: At least 82% of doctors disfavour this option.
Could bring about swift and efficient changes to postgraduate education	No: This body would have no previous experience of medical education (though would likely draw on expertise from the current regulators).
Risks	
Staff loss	High: The GMC and PMETB would both cease to exist, causing major disruption and unemployment, with massive potential loss of skills.
Inability to maintain business continuity	High: The period of transfer of duties would lead to massive disruption.
Failure to deliver a 'single continuum' of medical education	Low: a new body could be designed to deliver a single continuum.
Functioning and behaving as separate bodies after assimilation	Medium: in theory this would be a new body with no assimilation; in practice, many of its employees would likely come from GMC and PMETB and may behave accordingly.
Reputational damage to government by failing to deliver promptly	High: Creating a new body, and dissolving the current two bodies, would be expensive, disruptive, and would take time.
Unknown body	High: This new body would have no reputation and would have to build confidence in its ability to deliver its responsibilities.

4.4.1 Costs of Option 4

4.4.2 Creating a new body is substantially more expensive than assimilating one body into another, and would cause maximum disruption and take maximum time to create.

4.4.3 Cost drivers of a new organisation include:

- Designing and building sufficient IT systems: e.g. email accounts
- Developing and implementing HR policies e.g. pay scales, pensions
- Developing and implementing organisation values/rules
- Accommodation costs e.g. finding suitable accommodation
- Costs of managing the establishment of a new organisation
- Branding costs e.g. logo, website, stationary
- Promotional/publicity costs e.g. ensuring stakeholders are aware of the new organisation and its functions.

4.4.4 The above bullet points indicate just some of the cost drivers of establishing a new single organisation (option 4). Not all of these costs apply to option 2, and those that do would be on a smaller scale as they affect a smaller number of people and/or would build on what is already in place. It is therefore not possible that option 4 would be cheaper than option 2 (PMETB to merge into GMC).

4.5.5 This long-listed option of creating a new body might be designed to meet all of the policy objectives, and thus the features of an 'ideal regulatory authority'. However, in view of the fact, that another option (option 2) exists that meets all of the policy objectives, the high expense and extreme disruption render this option not viable, and thus it has not been short-listed. As a result, the large amounts of time and resources required to fully quantify the costs of this option have not been committed.

4.6 Qualitative Assessment Conclusion

4.6.1 It can be seen from the qualitative assessments of costs, benefits and risks that:

- Option 1 (do nothing) is relatively low risk with no change to current costs. However, it delivers few benefits and, fundamentally, fails to meet the policy objectives around improving the current quality of medical regulation. Therefore, this option is not viable.

- Option 2 (merge PMETB into GMC) meets all the policy objectives and should improve medical regulation and education and thus patient care, and delivers a full range of merger related benefits whilst maintaining a medium/low level of risk.

- Option 3 (merge GMC into PMETB) does not meet all of the policy objectives and thus delivers few benefits. It is also shown to be higher risk and higher cost than option 2, and thus not viable.

- Option 4 (new single regulatory body) meets all the policy objectives and should improve medical regulation and education and thus patient care. However, it does not deliver a full range of merger related benefits and has been shown to be relatively high risk and high cost. Therefore, this option is not viable.

4.6.2 From the above it is clear that Option 2 is the only option that meets all of the policy objectives, and thus benefits of improved medical regulation, education, and thus patient care, whilst minimising costs. Option 2 has therefore been subject to a robust economic cost benefit analysis that has quantified, where possible, the marginal impacts of Option 2 over Option1 (do nothing). This analysis is contained with section 6 of this impact assessment.

4.6.3 Option 2 (merge PMETB into GMC) offers to meet all the policy objectives, and related benefits, by delivering the 'ideal regulatory authority' recommended by Tooke, and previously by the Merrison Report and Bristol Inquiry, as an independent regulatory authority embracing the full continuum of medical education and training. Prompt assimilation would enable achievement of the policy objectives and benefits identified from the merge.

5. Public Consultation Response

5.1 Comments were sought on the proposed assimilation of the statutory functions of the Postgraduate Medical Education and Training Board (PMETB) into the General Medical Council (GMC) and 35 responses were received. The options assessment set out above was included in the consultation document.

5.2 There was very strong support (97%) with the proposal for a single regulator. There was also strong support (93%) for merging PMETB into GMC as the preferred method of creating the "ideal" regulatory body. The majority of respondents (86%) supported merging the two bodies as soon as possible although (14%) supported waiting for the outcome of the Patel Review. Most respondents (97%) supported the proposal that the GMC Council should have the flexibility to organise the new functions efficiently and should not be required to replicate the PMETB statutory committee structure.

5.3 There was general agreement that the draft legislation provided a sound framework to achieve the policy objectives. Minor drafting changes are proposed in the light of consultation feedback.

6. Quantitative Assessment of Option 2 marginal to the "do nothing" Option1

6.1 The results of the qualitative assessment and consultation response indicate that, Option 2, merging PMETB into GMC, would be the preferred method of creating an improved single regulatory body as defined by Independent Inquiry into Modernising Medical Careers, and thus the preferred method of improving medical regulation and consequently patient care.
As a result of the above, costly time and resource was not spent on quantifying the economic costs and benefits of Option 3 and Option 4.

6.2 Where possible the marginal economic costs and benefits of Option 2 over Option 1 (do nothing) were quantified by GMC and PMETB in their Full Business Case. These are shown in table 6.1.

The overall benefit of the preferred Option 2 (marginal to the do nothing-Option 1), is that a single improved regulatory authority will be created and this will lead to improved medical regulation and education for all the medical profession at all career stages, and thus improved patient care overall. It would be extremely difficult to formally quantify these impacts. Given this and that the robustly estimated cost of preferred Option 2 is below the formal IA threshold, costly time and resources have not been committed to quantify these.

6.3 It was also necessary to consider the change in funding for the PMETB functions under Option 2 compared to Option 1 (do nothing). Under Option 1, PMETB operating costs are £2,106,524, DH partially funds this at £1,425,000 a year (as at 31st March 2009 taken from PMETB annual accounts) and PMETB cover the excess through alternative sources.

Under Option 2, once the merger is complete (2010/11), the above DH funding of PMETB functions ceases as these functions are subsumed into GMC as the new merged organisation. GMC take over the responsibility of meeting the full operating costs for providing PMETB functions. DH agreed to fund the excess previously covered by PMETB alternative sources, for a transition period of three years post merger, while GMC review their income structure and the savings from integration are fully realised.

This difference between funding sources between the two options is shown in Table 6.2.

6.4 The figures shown in the "Summary: Analysis and Evidence" sheet come from Table 6.3, which reflects the marginal impacts of Option 2 over Option 1 (do nothing) including: the transition costs and benefits, and ongoing annual costs and benefits (as in Table 6.1) and the costs and benefits of changes in funding (as in Table 6.2).

Area				Expected values (£)							Proposed allocation of costs	Notes
				Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	Total		
				2009	2010	2011	2012	2013	2014			
				Project period				Steady state				
COSTS (2009 prices)	Project costs	PMETB merger preparation costs	Salaries	390,000						390,000	DH	Additional staff required to carry out merger related functions
			Business critical staff retention	200,000						200,000	DH	Staff identified and package costs agreed on a case by case basis; item under discussion with DH
			Legal Advice	66,000						66,000	DH	Advice on staff/T&C issues, lease, etc.; item under discussion with DH
			Audit	9,000						9,000	DH	Additional work to ensure systems fit for purpose at time of transfer
			Learning & Development	42,000						42,000	DH	Career advice and training for staff
			Professional advice	90,000						90,000	DH	Cost of preparing systems for transfer of data
			Board & Committee costs	10,500						10,500	DH	Additional Board and Committee meetings
			Travel	5,250						5,250	DH	Additional staff travel to GMC for merger related meetings
			Website	25,000						25,000	DH	Additional technical skills to update and change website
			Opportunity cost of staff time spent in merger preparations	60,900						60,900	PMETB	Assumed five days of each PMETB employee's time; calculation based on £2.9m annual staff costs
			Subtotal	**900,000**	**0**	**0**	**0**	**0**	**0**	**900,000**		
		Colocating PMETB at Regents Place	Lease termination penalty at Hercules House	45,900						45,900	DH	Reflects 3 month notice charge following issue of notice for termination of lease on 1 July 2009
			Dilapidations at Hercules House	120,000						120,000	DH	
			Termination of IS support contract with BDA	140,400						140,400	DH	Reflects minimum 12 month notice charge
			IS services set up	219,135						219,135	DH	
			Fit out of 8000 sq ft of space at Regents Place	474,810						474,810	DH	
			Architects fees for interior design	14,290						14,290	DH	
			Legal fees	7,350						7,350	DH	
			Project management	140,900						140,900	DH	9 months' project management services at £15,650 per month (excl. VAT)
			Move of PMETB staff and assets	18,270						18,270	DH	
			Office furniture	97,800						97,800	DH	75 workstations at £1,300 per unit (excl. VAT)
			Subtotal	**1,290,000**	**0**	**0**	**0**	**0**	**0**	**1,290,000**		

COSTS (2009 prices)	Project costs	Relocating GMC function to Manchester	Fit out costs	441,210					441,210	GMC		
			Move cost	14,595					14,595	GMC		
			AV equipment/furniture	52,200					52,200	GMC		
			Legal fees	4,095					4,095	GMC		
			Agency fees	16,465					16,465	GMC		
			Recruitment and training	27,300					27,300	GMC		
			Opportunity cost of staff time spent on relocation	9,000					9,000	GMC	Assumed ten days of each employee's time; calculation based on share of 4 typical employees in GMC total £25.3m annual staff costs	
			Subtotal	**560,000**	**0**	**0**	**0**	**0**	**0**	**560,000**		
		Organisational integration	Legal advice on aligning terms and conditions	36,000					36,000	DH		
			Actuarial advice on pension schemes	96,000					96,000	DH		
			Pre-merger non-mandatory training for PMETB staff	10,500					10,500	DH		
			Mandatory on-boarding training for PMETB staff	10,500					10,500	DH		
			Administration of pension scheme transfer	31,500					31,500	DH		
			IS integration		1,050,000	1,050,000			2,100,000	DH	Transfer of PMETB operations onto new IS platform; based on detailed estimate by GMC IS team	
			Stakeholder engagement	120,000					120,000	DH		
			Creation of single public face (website/stationery/etc.)	60,000					60,000	DH		
			Opportunity cost of PMETB staff time spent on integration activities	121,800					121,800	PMETB	Assumed ten days of each affected employee's time; calculation based on £2.9m PMETB annual staff costs	
			Opportunity cost of staff time spent on integration activities	239,400					239,400	GMC	Assumed ten days of each affected employee's time; calculation based on £5.7m annual staff costs (total for affected GMC functions)	
			Subtotal	**730,000**	**1,050,000**	**1,050,000**	**0**	**0**	**0**	**2,830,000**		
	Ongoing costs created by project	Organisational integration	Marginal cost of more generous GMC benefits		126,000	126,000	126,000	126,000	126,000	630,000	GMC	£2,000 per employee per year; includes private health insurance, health screening; estimate based on conclusions of Towers Perrin scoping study
			Marginal cost incurred by transfer of PMETB staff onto GMC pay scale		84,000	84,000	84,000	84,000	84,000	420,000	GMC	2% of PMETB budgeted staff costs for 2009-2010 per year; estimate based on conclusions of Towers Perrin scoping study
			Marginal cost of higher employer contribution to pension		115,500	115,500	115,500	115,500	115,500	577,500	GMC	4.5% of PMETB salary bill (which is itself approx. 70% of total staff costs); estimate based on conclusions of Towers Perrin scoping study
			Integration of governance under Council		36,750	36,750	36,750	36,750	36,750	183,750	GMC	Cost to run board of this type based on GMC experience
			Subtotal	**0**	**360,000**	**360,000**	**360,000**	**360,000**	**360,000**	**1,800,000**		

COSTS (2009 prices)	Total costs		Total project costs	3,470,000	1,050,000	1,050,000	0	0	0	5,570,000	
			Total ongoing costs	0	360,000	360,000	360,000	360,000	360,000	1,800,000	
			TOTAL COSTS	3,470,000	1,410,000	1,410,000	360,000	360,000	360,000	7,370,000	
			PV - total project costs	3,470,000	1,010,000	960,000	0	0	0	5,450,000	Present value calculation of costs - discount factor of 3.5%
			PV - total ongoing costs	0	350,000	340,000	320,000	310,000	300,000	1,620,000	Present value calculation of costs - discount factor of 3.5%
			PV - TOTAL COSTS	3,470,000	1,360,000	1,320,000	320,000	310,000	300,000	7,080,000	Present value calculation of costs - discount factor of 3.5%
SAVINGS (2009 prices)		Savings from integration	PMETB Board disbanded		294,250	294,250	294,250	294,250	294,250	1,471,250	GMC	Achievable estimate equal to two thirds of PMETB 2009-2010 budgeted costs for Board and panels
			Non-renewal of temporary/fixed-term employment contracts		25,000	50,000	75,000	100,000	125,000	375,000	GMC	Currently approx. 20% of PMETB headcount; achievable estimate of 25% reduction over 5 years; % baseline derived from 2006-2007 and 2007-2008 figures
			Release of PMETB training and recruitment budget		16,667	33,333	50,000	66,667	83,333	250,000	GMC	3% of budgeted staff costs for 2009-2010 per year; achievable estimate of reduction to zero over 5 years; % baseline derived from 2006-2007 and 2007-2008 figures
			Natural wastage of PMETB headcount		29,167	58,333	87,500	116,667	145,833	437,500	GMC	Achievable estimate of incremental reduction of 5% in PMETB budgeted staff costs for 2009-2010 over 5 years (1% shrinkage per year)
			Operations integration efficiencies (non-HR related)		36,667	73,333	110,000	146,667	183,333	550,000	GMC	Achievable estimate of incremental reduction of 10% from PMETB 2009-2010 budget baseline of £2.2m per year over 5 yrs (2% shrinkage per year)
			Support function and procurement integration efficiencies (non-HR related)		30,000	60,000	90,000	120,000	150,000	450,000	GMC	Achievable estimate of incremental reduction of 10% from PMETB 2009-2010 budget baseline of £1.8m per year over 5 yrs (2% shrinkage per year)
			Difference between accommodation costs at Hercules House and CAC Manchester		28,125	28,125	28,125	28,125	28,125	140,625	GMC	Accommodation is £4.50 per sq ft cheaper in Manchester; assume 8000 sq ft of space
			Subtotal	0	460,000	600,000	730,000	870,000	1,010,000	3,670,000		
	Total savings		TOTAL SAVINGS	0	460,000	600,000	730,000	870,000	1,010,000	3,670,000		
			PV - TOTAL SAVINGS	0	440,000	560,000	660,000	760,000	850,000	3,270,000	Present value calculation of savings - discount factor of 3.5%
NPV			PV - TOTAL COSTS	3,470,000	1,360,000	1,320,000	320,000	310,000	300,000	7,080,000	Present value calculation of costs - discount factor of 3.5%
			PV - TOTAL SAVINGS	0	440,000	560,000	660,000	760,000	850,000	3,270,000	Present value calculation of savings - discount factor of 3.5%
			NPV	-3,470,000	-920,000	-760,000	340,000	450,000	550,000	-3,810,000	i.e. savings minus costs

Changes to PMETB funding post merger marginal to the do nothing option.

This table reflects that GMC take over responsibility for PMETB functions, and thus the funding of these functions, from DH, once the merger is complete in 2010/11.

	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5	
	2009	2010	2011	2012	2013	2014	
	Project period				Steady state		Total Present Costs (£)
PMETB Funding: DH (£)		-1,375,125	-1,325,250	-1,275,375	-1,225,500	-1,175,625	-6,376,875
PMETB Funding: GMC (£)		1,375,125	1,325,250	1,275,375	1,225,500	1,175,625	6,376,875
DH - gap funding of PMETB excess(£)		656,200	632,400	608,600			1,897,200
GMC- gap funding for PMETB excess (£)		-656,200	-632,400	-608,600			-1,897,200
Discount Rates	1.00	0.97	0.93	0.90	0.86	0.83	

DH - gap funding of PMETB overspend (£)		680,000	680,000	680,000				(undiscounted total) 2,040,000

PMETB Financing Received from DH as at 31st March 2009	1,425,000	This figure is taken from PMETB Annual Report and Accounts 2008/09 This figure is from the table entitled "Reconciliation of Net Operating Cost to Financing received from the UK Government" page 55.

http://www.pmetb.org.uk/index.php?id=annualreport

DH currently partially funds PMETB. After full implementation of the merger, GMC will be responsible for funding existing PMETB functions. This is to help ensure the new merged organisation is independent from government.

In the transition towards full implemention DH have agreed to fund GMC the excess of existing PMETB costs against existing DH funding. This transitional funding will last 3 years whilst GMC undergo review of their income structure. SEE DETAILS BELOW.

As at 31/03/09 PMETB operating costs were £2,106,524 of which DH financed £1,425,000 whilst PMETB had responsibility for funding the £681,524 excess from other sources. This cost of providing PMETB functions will be taken over by GMC post merger (marginal cost increases and marginal cost savings of full integration are included in the analysis via table 6.1)
DH has agreed to fund the £680,000 excess for 3 years post merger, to cover the funding gap, until GMC has realised the full savings and reviewed their income structure

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Costs and benefits figures taken from from FBC v3 Economic Case

Cost Heading	(£) 2009	Rounded figures	Detail
Costs (Exchequer Impacts)			
One Off/Transition Costs:	6,810,600	6,800,000	These include all transition costs that are allocated to DH as it is agreed DH will fund the main costs of the merger. Including DH transitionary gap funding to cover PMETB excess operating costs.
Average Annual Costs:	-1,425,000	-1,425,000	There is an ongoing saving to the Exchequer as DH funding of PMETB ceases in Year 1 (2010). This
(both above undiscounted)			figure is DH financing of PMETB as at 31/03/09 from PMETB annual accounts
Total Cost (discounted)	180,925	175,000	This is the present value for total costs over the 2008 year 0 to 2014 year 5.
Benefits (Non-Exchequer Impacts)			
One Off/Transition Benefit	1,240,600	1,250,000	This figure includes the GMC costs of relocating a business function to Manchester, the opportunity costs of
			GMC staff time spent on merger related activity plus the transition gap funding from DH to cover PMETB excess.
Average Annual Benefit	-1,173,333	-1,175,000	This figure includes the ongoing marginal costs and costs savings of organisational integration, as well as the
(both above undiscounted)			, as well as the PMETB funding costs to be incurred by the GMC from Year 1 onwards.
			An average of the savings from year 0-year 5 is taken as the average annual cost savings from integration.
Total Benefit (Discounted)	-3,629,075	-3,625,000	This is the present value of the total benefit from 2009 year 0 to 2014 year 5.
Net Benefit (NPV)	-3,810,000	-3,800,000	This figure is the discounted value of total benefits minus the discounted value of total costs.
including op cost uplift:	-4,063,295	-4,075,000	This figure allows for the opportunity cost of Exchequer Funding. DH costs are uplifted by 2.4
			to reflect the opportunity forgone i.e. the benefits that the NHS could have bought for the same cost.
			As the Exchequer has a cost saving, the uplift reflects the increased value of this saving to the NHS.
			All figures except DH PMETB funding figures include risk estimate evaluations of 0-20%
			depending on each cost item

7. Recommendation: Merge PMETB into GMC

7.1 The options analysis set out in Section 4 above indicate that the merger of PMETB into GMC (Option 2) is the best option to enable us to improve medical regulation by providing greater cohesion of medical regulation and thus to improve medical training and patient care. This option will deliver all the key benefits and has low risks. In financial terms this option will have a one off (economic) cost of £6.8M but offers an ongoing saving to the Exchequer as DH funding of PMETB will cease in 2010.

7.2 From consultation there was general agreement that the draft legislation provided a sound framework to achieve the policy objectives set out. Respondents were particularly supportive of the proposal to place all the responsibility for medical education and training in a single body.

7.3 For these reasons it is recommended that (Option 2) the merger of PMETB into GMC is taken forward as recommended by the Independent Inquiry into Modernising Medical Careers.

Related publications

1. Independent Inquiry into Modernising Medical Careers

   http://www.mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf

2. The Secretary of State for Health's response to Aspiring to Excellence: Final report of the Independent Inquiry into Modernising Medical Careers

   http://www.dh.gov.uk/en/Publicationsandstatistics/DH_083203

3. Merrison Report
   Royal Commission on the National Health Service. (Cmnd. 7615)
   London: HMSO, 1979

4. Calman Report
   Hospital doctors' training for the future: the report of the Working Group on Specialist Medical Training.
   London: Dept. of Health, 1993.

5. The Bristol Inquiry

   www.bristol-inquiry.org.uk

6. The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003

   http://www.opsi.gov.uk/SI/si2003/20031250.htm

Specific Impact Tests: Checklist

Ensure that the results of any tests that impact on the cost-benefit analysis are contained within the main evidence base; other results may be annexed.

Type of testing undertaken	*Results in Evidence Base?*	*Results annexed?*
Competition Assessment	No	No
Small Firms Impact Test	No	No
Legal Aid	No	No
Sustainable Development	No	No
Carbon Assessment	No	No
Other Environment	No	No
Health Impact Assessment	No	Yes
Race Equality	No	Yes
Disability Equality	No	Yes
Gender Equality	No	Yes
Human Rights	No	No
Rural Proofing	No	No

Annexes

Annex A: Summary of Specific Impact Assessments

Health impact assessment

PMETB staff will be subject to GMC terms and conditions following assimilation. We would of course expect improved quality of medical regulation to increase patient safety for all people using healthcare services. The screening questions raised no additional issues.

Equality assessment

Title
Merger of PMETB into the GMC

Negative impact

The proposed policy is not likely to impact negatively on equality in relation to disability, ethnicity, gender, sexual orientation, age, religion or belief.

- Will the policy present any **problems or barriers** to any community or group? NO
- Will any group of people be **excluded** as a result of your policy? NO
- Does the policy have the potential to **worsen** existing discrimination and inequality? NO
- Will the policy have a negative effect on **community relations**? NO

Positive impact

The proposed policy is not likely to impact positively on equality in relation to disability, ethnicity, gender, sexual orientation, age, religion or belief.

Evidence

Effects of merger on equality and diversity
The GMC and PMETB are firmly committed to promoting equality and valuing diversity both in terms of fulfilling statutory legal obligations and in order to meet aspirations in terms of embodying best practice. Both bodies currently have well-established equality and diversity principles. PMETB staff will be subject to GMC's equality policy following the merger.

The GMC promotes equality and values diversity. Its equality scheme was created following wide consultation, including patients, public, doctors, and a wide variety of organisations. The equality scheme gathers information about the effects of its policies and practices on equality and diversity, including the extent to which equality and diversity is promoted to their staff, and taken into account in its services and functions. The guiding principle of the GMC is to place the elimination of unlawful discrimination and the promotion of equality of opportunity at the heart of their policy-making and decision making. The GMC has appointed a Director to 'champion' equality and diversity. Addressing equality and diversity issues will form an integral part as the merger of PMETB and GMC develops.

An independent consultancy report on equality and diversity at the GMC, undertaken in January 2009, included a review of the PMETB approach and revealed that there are several common areas in the PMETB and GMC approach to equality and diversity. In bringing the two organisations together, there is likely to be scope for exchange and learning on equality and diversity. Indeed, equality and diversity is an agreed area of joint work between the GMC and PMETB in the period leading up to the merger.

The GMC's Business Plan for 2009 includes a specific commitment 'to develop further and implement our strategy for valuing diversity and promoting equality in all aspects of our work". This commitment will ensure that equality and diversity sit at the heart of policy development and decision making following the merger.

Staff composition
The GMC Council (comprising 24 members) will continue as the governing body following the merger of PMETB with the GMC. The Board of PMETB will cease its function following the merger.

The GMC Council members were appointed by the Appointments Commission – their term of office is fixed for a four year period and took effect from 1 January 2009. The Appointments Commission monitored the diversity of all applicants and holds information on the gender, age, ethnicity and disability of all Council members. There are 24 council members – 12 are medical members; 12 are lay members.

Of the 12 medical members of Council:
- 8 have declared themselves as White – British, 1 as White – Irish, 1 as Asian, and 2 as Indian
- 5 are male, 7 are female
- 1 has declared a disability
- 1 is aged 20-30, 9 are aged 51-60 and 2 are aged 61-70.

Of the 12 lay members of Council:
- All are white, with 11 declaring themselves as White – British and 1 as White – other
- 9 are male, 3 are female
- 2 have declared a disability
- 1 is aged 41-50, 5 are aged 51-60, 5 are aged 61-70, and 1 is aged 71-80

The GMC monitors the diversity of its workforce (and other areas of its operation, such as the diversity of Fitness to practise panellists). PMETB adopts a similar approach. 62.5% of GMC's total workforce are women. 33% of Directors are women; 33% of Assistant Directors are women; 39% of Head of Section are women. 8% of the workforce work part time, others work from home; the GMC's flexible working policy is open to all.

Staff conditions
Every aspect of Human Resources (HR) in the GMC is intrinsically linked to diversity, and as an organisation the GMC has made a commitment to policies and procedures that are fair, objective, transparent, and free from discrimination. The full suite of HR policies, procedures and advice in place to assist PMETB employees in assimilating into the GMC will take all equality issues into account.

The GMC's maternity and paternity schemes go beyond statutory requirements.

The GMC undertook a pay analysis in March 2006 to address the gender pay gap. This has led to an equal pay audit in order to ensure that equal pay issues are effectively identified and resolved.

The GMC provides a dedicated Information Systems helpdesk and a Facilities Service which provides a service to disabled staff requiring a range of technological and building-related reasonable adjustments. They have undertaken DDA building audits in their London and Manchester offices. The GMC's transitional HR processes will ensure the inclusion of support for PMETB staff being assimilated into the GMC who may require reasonable adjustments to be made to the workplace or to their working arrangements.

Staff training
All staff are required to attend diversity training (level 1); those employees with policy making, planning and key service delivery roles attend a higher level of training (level 2). The GMC staff intranet provides equality e-learning, material about the Equality Scheme, the Committee for Equality and Diversity (CDE), the Equality Impact Assessment procedure, and the results of their Communications Accessibility Audit, in addition to their Valuing Diversity resource guides, developed to provide information and advice on diversity and equal opportunities to healthcare professionals.

Equality impact of merger on doctors

There is not expected to be a disproportionate impact on the equality strands. The two organisations will work closely together on key policy areas to ensure there will be no negative equality impact on registrants.

Fitness to practise
Of doctors subject to completed fitness to practise hearings during January to November 2007, 83.3% were male and 16.7% female. There is also overrepresentation of international medical graduates within fitness to practise procedures. The GMC is undertaking extensive research to seek explanations and address these as appropriate.

The recruitment process for examiners for the fitness to practise panel were 'equality proofed' to avoid discrimination on GMC's behalf by Third Vision Consultancy. Of the 11 Examiners appointed, five are women, three are from ethnic minority groups, and one is registered disabled. The same procedure was taken for recruitment of panellists (66% male, 34% female). All panellists are required to undertake induction and refresher training in equality and diversity.

Monitoring
The GMC collects equality monitoring data from staff on recruitment, with an update at least every two years.

The GMC collects gender, age (via date of birth), and ethnicity from doctors at registration. The GMC recently embarked on an exercise to collect ethnicity data from existing registrants – 164,000 responses were received, which equates to approximately 66% of doctors on the Medical Register. The GMC plans to collect disability data from doctors in 2010.

The GMC is part of a dedicated forum, which meets quarterly, to discuss and share best practice on general diversity issues in the medical profession. The forum includes representatives from the Department of Health, NHS Employers, and the British Medical Association.

Current Equality Policies

GMC's full equality policy is available here: http://www.gmc-uk.org/about/equality_scheme/index.asp

PMETB's full equality policy is available here: http://www.pmetb.org.yk/index.php?id=equality

Screening assessment

Adverse impact is unlikely, but positive impact is also unlikely. A full EqIA is therefore not required.

Annex C: Historical context of medical regulators

Historical Context

The GMC was established under the Medical Act 1858 (1883 amendment) to 'protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.' It provided a regulatory framework for undergraduate medical education and training, after which training and accreditation was managed by the Royal Colleges and Faculties pertaining to individual specialties. The GMC maintained a list of all registered UK doctors.

In 1975, the Report of the Inquiry into the Regulation of the Medical Profession ('the Merrison Report') identified the need for a regulatory framework for postgraduate medical education and training. As the GMC already provided this framework for undergraduate medical education and training, the Merrison Report concluded that the GMC should take on this further role, having 'a regulating function over all stages of medical education' and creating unification of medical training regulation throughout the doctor's career. The report stated that only by 'having one body overseeing all medical education will it be possible to achieve what we believe has become essential: the co-ordination of medical education'.

The Medical Act 1978 gave the GMC responsibility for regulating specialist training for EU minimum standards, with the general function of 'promoting high standards of medical education and co-ordinating all stages of medical education'.

The Joint Committee for Postgraduate Training in General Practice (JCPTGP) was subsequently established for regulating general practice vocational training through the NHS Vocational Training Regulations 1979 Section 30.

In 1993 the Calman Report recommended that legislation be enacted to introduce a UK Certificate of Completion of Specialist Training (CCST) awarded by the GMC following recommendation by the relevant Royal College or Faculty. This ensured consistency with European Commission law. The report also recommended that Royal Colleges and Faculties set standards for medical education. The Specialist Training Authority (STA) of the Medical Royal Colleges was established to regulate specialist training and to award CCSTs; the JCPTGP remained responsible for GP training. The Specialist Register was held by the GMC.

Concerns were raised about medical self-regulation following high-profile inquiries, and in particular, the Bristol Inquiry (2001) recommended that in addition to regulating undergraduate medical education, postgraduate medical education should also be regulated by the GMC.

The government decided instead to create an independent medical standards board to replace the STA as consultation indicated that this body would better reflect the views of patients and NHS than giving responsibility to the GMC. The Postgraduate Medical Education and Training Board (PMETB) was therefore created in September 2003 with the aims of ensuring that training doctors' educational needs were met, employers' needs were met, and patients' needs were met, by establishing, developing and maintaining standards of postgraduate medical education. The consultation that led to the creation of PMETB suggested consideration be given to the merging of these stages to provide a seamless, consistent regulator throughout medical education.

Using this model, regulation of medical education is currently split into three stages with two different regulators: undergraduate education (GMC), specialist training (PMETB), and continuing professional development (GMC).

In 2003, the Government created PMETB as a single regulator that would replace the JCPTGP and the STA. PMETB became the single competent authority for postgraduate medical education and training from 2005.