

30 November 2006

Jan Quirke  
Board Secretary  
PMETB  
7th Floor  
Hercules House  
Hercules Road  
London SE1 7DU

Dear Ms Quirke

#### **PMETB Fees Consultation: October 2006**

The Association of Surgeons in Training (ASiT) are grateful for the opportunity to respond to the consultation on fees charged by PMETB from 1<sup>st</sup> April 2007 to 31<sup>st</sup> March 2008. The issue of PMETB funding is of great importance to our members and a great deal of discussion and concern resulted from the PMETB Fees Consultation: December 2005.

We are concerned that some of the issues raised in the first consultation remain unresolved. We are troubled, for instance, that the principle of *financial self-sufficiency as critical to achieving independence* was felt to be met with 'broad approval'. Of the consultation responses in the public domain, this was not our impression at all – significant concern has been voiced by many.

The most important points we wish to make in this response are:

1. We continue to object to further increases in certification fees when many unresolved issues persist and the PMETB budget remains vague.
2. The funding of quality assurance (QA) must not represent a further charge on trainees. Payments received by PMETB for QA must not originate from budgets that currently fund training activities.
3. Central funding of PMETB from the DOH must continue indefinitely. We do not believe there is a sufficient margin in the 'QA market' to meet the budgetary requirements of PMETB. If the current budget plan fails to generate sufficient income, trainees *must not* be made to pick up the shortfall.

Please find our full response attached.

Yours sincerely

Ewen Harrison  
ASiT VP

**Question 1: We would welcome any comment which respondents might have on the proposed approach towards certification fees, particularly if it provides further thinking on the options open to us.**

1. Whilst we wish to avoid a re-hash of our response to the December 2005 consultation, we believe that a number of issues remain unresolved.
2. We continue to object to further increases in certification fees when many unresolved issues persist and the PMETB budget remains vague.
3. The question of whether *financial* independence from central government is a precondition of *political* independence is of great importance and remains in doubt. We maintain our stated position that financial self-sufficiency is not required for PMETB to fulfil its statutory duties. No statement from PMETB or the Departments of Health has addressed this issue satisfactorily. No evidence has been presented of other agencies with similar terms-of-reference that have failed in their statutory duty as a direct result of government grant-in-aid. On the contrary, many agencies exist and successfully function independently from government while being maintained, fully or in part, by government funding. The independence of PMETB is preserved by the very legislation by which it was established. This issue is of fundamental importance and further discussion on the funding of PMETB is difficult when it remains unresolved. It is imperative that PMETB and/or the Departments of Health justify this principle *in full*. No increase in fees must occur until it is suitably resolved.
4. The predicted PMETB budget remains extremely vague and this is of grave concern to our members. Trainees believe they are on a slippery slope to an even greater and more disproportionate fee.
5. PMETB has stated that all Department of Health (DOH) funding will be withdrawn by 2009/10. If current proposals are met, then 50% of PMETB resources will be self-generated. The shortfall (50%) will be met by charging for other PMETB activity, which will be predominantly quality assurance work (QA). Are we to believe that there is such a large profit margin in QA work to meet this funding shortfall? Will PMETB use its monopoly, in effect, to over-charge organisations for QA work in order to meet its other budget requirements? We are concerned that the deficit will not be met by these measures and that trainees will be subjected to further inequitable increases in fees.
6. A number of other issues remain including the 'value for money' of PMETB to trainees and the short time frame in which these changes have been forced upon us.
7. ASiT continue to accept the legitimacy of the assertion that trainees should contribute a share of the cost of their training. However, this must be proportional and be matched by significant contributions from other stakeholders. We are in the process of exploring the idea of trainees paying one annual fee to one body for training. This would represent the entire contribution of that trainee to their training costs for that year. This holds the possibility of including a contribution to the running of bodies such as PMETB, the Joint Committee for Surgical Training (JCST) and the surgical Royal Colleges, as well as including the costs of certain mandatory courses and exams. The level of cooperation required from interested parties would be significant and it would be naive not to think that this would be difficult to establish. However, it would have many benefits to trainees including providing the stability we all desire, as well as providing a predictable income to these organisations. It may improve efficiency in PME by avoiding duplication of services, and therefore costs, by the different organisations that exist. We are at an early stage of development of these proposals, but we would appreciate any input from PMETB in the potential of such a system.

**Question 2: Do you agree with these principles for QA charging – which should inform both the approach towards identifying total costs, and the method(s) used to recover them?**

*Principle 1: A distribution of quality assurance costs in line with the beneficiary pays principle accepting that, quite properly some should be met by trainees, some by Article 11 and 14 applicants and some by the service/ Departments of Health on the basis that all benefit from the provision of quality assured training.*

8. We agree with the principle with the following caveat. The principle of *beneficiary pays* asserts that those who benefit from an action, pay for part of the action in direct proportion to the benefit they receive. The distribution of contributions from each group, therefore, is not equal, but proportional to the benefit each group derive from the action. We strongly believe that the priority of quality assurance in PME is to protect the public. It is rational, therefore, that the public receives greatest benefit from this area of PMETB activity. It follows that the public, in the form of the government and NHS, should pay the greatest proportion of these costs.

*Principle 2: Monies received for quality assurance should not be used to cross subsidise, or fund, activities which should properly be regarded as local Quality Management or Quality Control arrangements.*

9. The distinction between quality assurance, quality management and quality control remains poorly defined. If quality management is the action that training bodies (e.g. Deaneries, Colleges or training providers) are expected to take following PMETB recommendations, then it is reasonable for these bodies to meet these costs. This pre-supposes that clear guidelines exist on the responsibilities of each body prior to PMETB assessment. You state that quality control in this context relates to the quality of training by training providers. This may be viewed as the sum of quality assurance and management, and so the costs should be met by both training bodies and PMETB.

*Principle 3: Simplicity and transparency to those who pay.*

10. We agree fully with this principle.

*Principle 4: Reliable income streams to achieve security of payment.*

11. It is clearly important to have a predictable and reliable income. However, we do not think this should be a guiding principle, as the decision on who should pay should not be determined on a preconceived notion of the ability to recover payment from one group versus another. If this was the case, trainees may be treated unfairly as the leverage available to extract payment from a trainee is likely to be greater than that available to ensure payment from another source, i.e. a trainee may be effectively prevented from working as a consultant if they do not pay. Robust systems must be put in place to ensure the consistent collection of payments from all sources.

*Principle 5: Minimise costs of collection/administration for both PMETB and the payer.*

12. We support this principle, but would hope that administrative efficiency is exercised by PMETB in all activities, not just the collection of payments.

**Question 3: Do you have any views on these methods of calculating the overall fee to be levied for ongoing QA work?**

13. We are surprised that over a year into the existence of PMETB, the thinking on this issue seems to be at such an early stage. The calculation of an overall fee is entirely dependent on who is being charged. Clearly, a balance must be struck between the administrative ease of calculating payments (cost-effectiveness) and fairness to the bodies being charged. A guiding principle should be that the larger the organisation being levied, the more cost-effective the exercise with the preservation of equity. For instance, charging the NHS at a national level makes for easy calculations and equity for all. As the size of the body being charged decreases, the difficulty in calculating a fair charge becomes greater. Thus, charging small bodies will cost more and be less fair (see 16 – 20 on who should pay).
14. If small bodies are to be charged, e.g. deaneries, a surrogate must be found that accurately reflects training costs to that body, e.g. total trainee days for a given period. This is likely to be costly to calculate.
15. Costs to smaller bodies should only reflect the numbers of trainees that body is responsible for and should not reflect PMETB costs in quality assuring that body.

**Question 4: Should we look for a fees structure which rewards good performance and penalises poor performance? If so how do you think we measure this? And how might a charge be adjusted?**

16. This question is superficially attractive but the principle is flawed. We are strongly of the view that fees should not be used by PMETB to improve performance. A significant concern is that trainees in failing deaneries would be further penalised through the budget cuts that would result from punitive PMETB fees. Rewarding well-managed deaneries will always be at the detriment of those not doing so well. Market forces may improve deanery performance in the long term (and this is a big 'may'), but they will undoubtedly hurt many trainees in achieving this aim. Other mechanisms of improving deanery performance must be used. We believe that the QA process in itself should be robust enough to effectively penalise poorly performing Deaneries, without financial implications for the Deanery and its trainees. We believe the de-recognition of training posts in poorly performing deaneries is the strongest method of ensuring corrective action is taken.

**Question 5: Do you have any views on who we should charge for ongoing QA work: Deanery, individual provider or NHS/departments of health?**

17. You state:

If the starting point (in line with our fees principles) is that trainees should make a contribution but not meet all the costs, there are a number of options on who should pay.

Firstly, the starting point is not that trainees should contribute with further options on who should pay – the starting point is that all beneficiaries should contribute.

18. Two separate issues exist. The first is who ought to be charged for QA work. The second is whether that charge should be used to alter the behaviour of the body being charged, i.e. reward and penalise based on performance. As we have stated above, we strongly believe that using fees as incentives in this manner will have a detrimental effect on trainees in failing organisations.

19. Leading on from this point, whether PMETB is funded from the DOH, the NHS or the Deaneries, the ultimate origin of the funding is the same – the taxpayer. Therefore, the taxpayer's money should be used in the most efficient manner – directly from government. It makes no sense to us for government to spend money calculating payments to Deaneries and for PMETB to spend more money calculating payments from Deaneries. Are we naive to think this is a complete waste of money?
20. What cannot occur is for trainees to be charged indirectly. We are greatly concerned that charging Deaneries represents effectively a second charge on trainees. Deanery budgets are already under a great deal of pressure and this is affecting training budgets e.g. study leave allocations. Extremely robust mechanisms must exist to ensure that Deaneries are adequately compensated for payments made to PMETB and that trainees do not suffer as a result. This, particularly in the light of the Minister for Health's recent statements regarding training budgets, seems unlikely to happen. Deanery charging cannot be a further tax on trainees.
21. We agree that charging local NHS bodies based on trainee numbers may act as a disincentive to train. It is essential, therefore, that the NHS recognises the importance of training and is levied at a national level.

***Question 6: Do you think we should consider an annual fee to deaneries? If so should this contribute to ongoing QA costs and one off pieces of QA work, or just the former? How do you think it could be calculated fairly? And how could we ensure payment, given that any non payment would increase costs for others?***

22. As stated above, we are gravely concerned that Deanery charging represents a surrogate for charging trainees.

***Question 7: Would you support a review stage, which may obviate the need for a formal appeal, with a relevant charge attached?***

23. Without detailed knowledge of the PMETB appeals process, it seems odd to have included this question in the consultation. It should be a matter for PMETB to establish the most cost-effective and fair mechanism by which to conduct reviews. Clearly, if an appeals mechanism involving a new panel can resolve the issue more efficiently and to everyone's satisfaction, then it is to be supported. One has to wonder though, what new information the new committee has access to by which the decision of the original committee can be overturned, if a formal appeal process is avoided?

***Question 8: Should PMETB meet all the direct costs of visits (expenses etc), some of which are currently met by Deaneries, and reflect such costs in its approach to charging?***

24. As a point of principle, costs directly linked to QA should be met by PMETB. The panel performing assessment visits should be independent of the Deanery and working under the direct control of PMETB. Therefore, this cost should be directly funded by PMETB. We accept that these costs will have to be reflected in charging.

***Question 9: Should PMETB move to remuneration of all visitors (and QA panel members), even though, under the consultant contract, Doctors should be released for this work – bearing in mind that such costs would have to be reflected in charges?***

25. The role of doctors within new consultant contract is under scrutiny by NHS trusts. It is imperative that to achieve the highest quality of inspections, the best qualified

individuals are released from duties within their trust to perform the inspection visit. Whether this should involve remuneration of the individual or the NHS trust is debatable. Under the GMC's Duties of a Doctor the role of the medical expert is highlighted. It is entirely reasonable that as a matter of professional regulation, individuals should be funded by the DOH to carry out these duties as they have benefits for the entire health service (recognising the service and training go hand-in-hand).

**Question 10: Do you have any further suggestions on how we might recover costs?**

26. As outlined above, the principle of *beneficiary pays* is central to the method of recovery of costs. We believe strongly that PMETB must begin urgent negotiations with the DOH in order to ensure the shortfalls in funding, *that will occur*, are compensated for centrally. We do not believe that this would compromise the ability of PMETB to be politically independent as the DOH would be regarded as a beneficiary of the actions of PMETB.