

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

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The Secretary of State's introduction



The final report from Professor Sir John Tooke's independent inquiry into Modernising Medical Careers (MMC) was published in January 2008. I am very grateful to Sir John and the Panel for their careful and balanced analysis and diagnosis of the issues.

In arriving at his conclusions and recommendations, Sir John has set the standard for collaborative working with the medical profession and other key stakeholders. We all have a shared interest in ensuring that the highest standards of postgraduate medical education are achieved for the future.

The concerns early last year around the implementation of MMC demonstrated both the importance and the complexity of medical training. Sir John has acknowledged that the development of MMC was an honest attempt to assure the fundamental abilities of the next generation of doctors. He also articulated the firmly held conviction of the Panel that postgraduate medical education should aspire to excellence.

Aspiring to Excellence marks a significant step in moving forward. It is the start of a process – one of building capability and confidence in the mechanisms we use for training our doctors for the future. We need to bring the same effort and attention to developing and nurturing our future clinicians as we give to improving access to and the quality of the services patients receive. These are different sides of the same coin. We also need to enable our doctors both to meet their aspirations to be excellent in their field and to that bring this excellence to bear in their daily practice.

I have taken particular note of an important thread running through the findings and recommendations. That is the need for policy development and implementation to be evidence-based, and for change to be implemented only after careful testing and following co-production with professional and other key stakeholders.

Many of the report's recommendations are far-reaching in their implications for the Department of Health (DH) and for the NHS. They require further development and implementation and this will take time, particularly if we are to meet Sir John's own tests that policy and its further implementation is evidence-based, carefully tested and taken forward with key stakeholders. I am keen that we move forward in the spirit in which the Panel intended.

In responding to the recommendations, I want to mark the importance we attach to ensuring that the training of our doctors, and indeed all health professionals, is in keeping with Sir John's aspirations to excellence. The value we attach to how we train our doctors is a touchstone of our aspirations for the NHS and services for patients as a whole. For that

reason we are committed to getting it right, so that our future doctors are well prepared – not just for their clinical roles, but to play a full part in the wider role of shaping services to best meet patients' needs.

Our NHS, our future: NHS next stage review – interim report identified workforce planning and education as areas that needed strengthening. The workforce planning, education and training element of the review is a comprehensive and wide-ranging suite of projects that cover future clinical roles, workforce planning, education commissioning and funding and education structure and professional regulation.

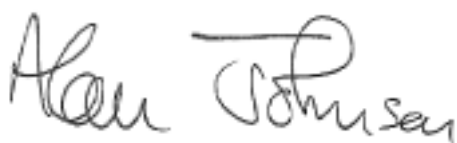
Inevitably there is overlap in the significant recommendations from the Inquiry and the next stage review workstreams. This is reassuring in that it confirms that we are addressing the right issues. But it is also helpful that we have set up machinery that will help us to address the big questions, for example around the central role of the doctor. The next stage review work is due to report by the end of June.

In responding to the Inquiry's recommendations, I also need to acknowledge the progress made since events in early 2007 prompted my predecessor, Patricia Hewitt, to establish Sir John Tooke's Inquiry.

Through the complex and crucial work of the review group led by Professor Neil Douglas, undertaken in extremely difficult circumstances, 2007 specialty training recruitment proceeded to fill 95 per cent of the available training places. Throughout the latter half of 2007, DH worked closely and carefully with the medical profession and the NHS to ensure that the recruitment process was as fair and transparent as possible, and that, ultimately, the NHS was able to recruit the junior doctors its services needed.

Through the MMC England Programme Board, we have worked with the Royal Colleges, the British Medical Association (BMA) and representatives from the NHS to draw up plans for 2008 recruitment and a more flexible training structure. Shared working has begun for 2009 and beyond.

We have made tangible progress; for example, we are changing the immigration rules and that will help us better manage who can apply for junior doctor posts in the future. I remain conscious of the scale of the challenge – not only for 2008 where the competition ratio for posts remains challenging, but also as we move into the more fundamental reforms that lead from the Inquiry's recommendations. I am committed to ensuring that the way we train our doctors in the future aspires to excellence so that patients can expect the very best in care.



Alan Johnson

Section 1: Context

This is the response of the Department of Health (DH) for England to the recommendations of the Independent Inquiry into Modernising Medical Careers (MMC).

Background

The Independent Inquiry into MMC was established by Patricia Hewitt, the Secretary of State for Health, in April 2007. The Inquiry was asked to examine the framework and processes underlying MMC and make recommendations to inform any improvements for 2008 and beyond.

The Inquiry published an interim report in October 2007. It consulted widely on the proposals and published its final report in January 2008. The Inquiry reported support for the recommendations through the consultation.

Responding to the recommendations

In making its response, DH has considered how best to move forward on the recommendations. Many recommendations are met with a direct response; others are substantial and require further work to develop them ahead of implementation. In doing this, DH is mindful of the Inquiry's recommendations around developing sound policy, building on evidence and engagement and the need to test out proposals before rolling them out more generally.

The final report made two new and additional recommendations. One was around the implications of the European Working Time Directive (EWTD) on training; the other proposed establishing a body described as NHS: Medical Education England (NHS: MEE), which would bring together many training and workforce functions. This recommendation is the single most significant addition to the interim report and, as such, requires very careful consideration before DH responds. It also necessarily has implications for how we respond to a number of other recommendations. Where this is the case it is indicated in the response. Where recommendations are the subject of the continuing next stage review (NSR), this is also indicated.

A number of recommendations are either UK-wide or require the four countries to act in partnership. The individual circumstances in the other UK countries mean that they are working to different timetables for responding and so in some cases it is not possible to present a UK-wide approach.

The response follows the structure of the Inquiry's report.

Section 2: Summary of the response to each recommendation

The following recommendations are agreed or agreed in principle

- 1 The principles underpinning postgraduate medical education and training should be redefined and reasserted.
- 2 Policy development should be evidence-led where such evidence exists and evidence must be sought where it does not.
- 3 DH should consult with the medical profession and the NHS on shifts in government policy which affect postgraduate medical education and training, workforce considerations and service delivery.
- 4 Changes to the structure of postgraduate medical education and training should be consistent with the policy objectives and conform to agreed guiding principles.
- 6 DH should strengthen policy development, implementation and governance. The Chief Medical Officers (CMOs) should be the Senior Responsible Owners (SROs) for medical education.

This recommendation is agreed subject to noting that in England there is a separate SRO. The reporting arrangements are set out in the text.
- 7 The introduction of changes should involve all relevant stakeholders; abide by best principles of project and change management and include trialling; and be subject to rigorous monitoring and evaluation.
- 8 DH should strengthen its links with education, clinical service and research within DH and with NHS providers and other government departments.
- 9 Universities and the strategic health authorities (SHAs) should forge functional links to optimise the health:education sector partnership. SHA chief executives should have the creation of collaborative links between local health and education providers as one of their key annual appraisal targets.
- 10 All four departments of health in the UK and the four CMOs must be involved in any moves to change medical career structures.
- 11 DH should have a coherent model of medical workforce supply. We recommend that overseas students graduating from UK medical schools should be eligible for postgraduate training, as should refugee doctors with the right to remain in the UK.

- 14 The content of higher specialty training and the numbers of positions will be informed by dialogue between the colleges, deaneries, employers and medical workforce advisory machinery.
- 16 DH should make explicit its plans for the optimal use of the skills of the medical graduates it has commissioned. There should be sufficient numbers of core specialty training posts to accommodate doctors who complete foundation year 1 (F1).
- 17 Career aspirations and choices should be informed by accurate data. Medical schools should play a greater role in careers advice.
- 22 A formal review of the compliance with Service Level Agreements (SLAs) between DH and the SHAs relating to commissioning training should be undertaken in 2008/09.
- 27 To incentivise trusts to give education and training sufficient priority they should be integrated into the Healthcare Commission's performance reporting regime.
- 29 Training implications relating to revisions in postgraduate medical education and training need to be reflected in appropriate staff development and job plans. Compliance should form part of the core standards.
- 30 The Postgraduate Medical Education and Training Board (PMETB) should be assimilated in a regulatory structure within the General Medical Council (GMC).
- 32 F1 curriculum and assessment tools should be reviewed.
- 37 Satisfactory completion of assessments of knowledge, skills, attitudes and behaviours will allow eligibility for staff grade positions and higher specialist training.
- 38 Staff grade positions must be destigmatised and contract negotiations rapidly concluded.
- 39 Doctors should be allowed to interrupt their training for one year or longer by agreement to seek alternative experience that enhances their career and contribution to the NHS, having regard to service need.
- 40 Selection into higher specialist training will be informed by the Royal Colleges working in partnership with the regulator.
- 41 Integrated clinical academic training pathways in all specialties, including general practice, should be flexibly interpreted and transfer to and from conventional clinical training pathways facilitated.
- 42 Clinical lecturer posts in England will normally be coincident with higher specialist training.

The following recommendations are agreed in principle and being considered as part of the next stage review

- 5 There needs to be a shared understanding of the roles of all doctors in the contemporary healthcare team that takes due account of public expectations.
- 12 DH should urgently review its medical workforce advisory machinery.
- 13 DH should work with the GMC to create robust databases that hold information on the registered/certificated status of all doctors practising in the UK.
- 15 Explicit policies should be developed and implemented to manage the transitional 'bulge'.
- 19 There should be opportunities for training in medical management during postgraduate training years.
- 20 Doctors in training should be better represented in the management structures of trusts.
- 23 Funding flows for postgraduate medical education and training should accurately reflect training requirements and the contributions of service and academia.
- 24 The Medical Postgraduate Deanery function in England should be formally reviewed.
- 25 Postgraduate Medical Deans should have strong accountability links to medical schools.
- 43 Successful completion of higher specialty training will lead to a Certificate of Completion of Training (CCT), confirming readiness for independent practice in that specialty at consultant level.

The following recommendations are being considered as part of the next stage review and a programme of work is being developed

- 21 The CMOs, as leads for medical education, will interact with NHS:MEE and equivalent structures in the Devolved Administrations.
- 47 The Panel recommends the formation of a new body – NHS:MEE.

The following recommendations require further consideration and a programme of work to be developed

- 31 The employment linkage between F1 and F2 should be broken.
- 33 F2 should be incorporated as the first year of core specialty training.

- 34 At the end of F1 doctors will be selected into one of a small number of broad-based specialty stems.
- 35 There will be opportunities for competitive transfer between the core stems during years one and two.
- 36 Colleges, specialist societies and the service should work together to provide modularised curricula for specialist training.
- 45 The length of training in general practice should be extended to five years.
- 46 The Panel recommends that urgent attention should address whether there are ways in which a more flexible approach to the EWTD could be legitimately embraced.

The following recommendations are a matter for other organisations

- 18 The medical profession should have an organisation/mechanism that enables coherent advice to be offered on matters affecting the entire profession.
- 26 Graduate schools should be created.
- 28 Responsibility for the local delivery of postgraduate medical education and training should form part of the explicit remit of medical directors of trusts.
- 44 To be eligible for a consultant senior lecturer appointment, the applicant should possess a CCT in the relevant specialty area.

Section 3: Clarification of policy objectives

Recommendations 1 to 4

1. *The principles underpinning postgraduate medical education and training should be redefined and reasserted, building on those originally articulated in Unfinished Business but in particular emphasising flexibility, 'broad based beginnings' and an aspiration to excellence. In devising policy objectives the interdependency of educational, workforce and service policies must be recognised.*
2. *Policy development should be evidence led where such evidence exists and evidence must be sought where it does not.*
3. *DH should formally consult with the medical profession and the NHS on all significant shifts in government policy which affect postgraduate medical education and training, workforce considerations, and service delivery and ensure that concerns are properly considered by those responsible for policy and its implementation.*
4. *Changes to the structure of postgraduate medical education and training should be consistent with the policy objectives and conform to agreed guiding principles.*

Response

I agree with these recommendations. In particular, the importance of evidence-based policy, of engaging key stakeholders, such as the profession, trainees and employers, and of testing change. These are the pillars of good policy making and will underpin our approach in taking forward policy for medical education and training.

Recommendation 1: Underpinning principles for postgraduate medical education and training should be redefined and reasserted

Aspiring to Excellence noted the lack of any definitive statement of the policy objectives for MMC as a contributory factor leading to the events of 2007. Without such a statement a wide range of educational and workforce objectives were attributed to MMC, both by stakeholders and also by those leading MMC, beyond its intended scope.

The MMC England Programme Board was established in July 2007. It comprises representatives of key stakeholders, including the British Medical Association (BMA), the Royal Colleges, SHAs, deaneries and employers, as well as DH.

One of the first tasks of the Programme Board was to review the principles for MMC in England. In doing this, it modified the principles outlined in *Unfinished Business* and the subsequent proposals for implementing MMC. These are set out in the following box.

MMC Principles

In the light of discussions with the Programme Board, these principles provide a modification of the principles outlined in *Unfinished Business* and the subsequent proposals for the implementation of MMC:

- MMC should have a fair, equitable and transparent recruitment basis.
- Specialty training should be programme based and designed to deliver nationally agreed standards.
- Where appropriate, specialty training should begin with broadly based programmes.
- Educational progression for individuals should be assessed by an annual review of the documented acquisition of competencies and clinical and professional competency.
- Trainers and educational supervisors should be trained and supported to fulfil their wider role as educators and assessors.
- Training programmes should be time limited.¹ Extensions associated with problems with educational progression should be restricted.
- The satisfactory completion of training should be marked by entry to the specialist or general register.
- Completion of training demonstrates that a trainee has achieved the level of clinical and professional competency appropriate to allow appointment as a consultant or general practitioner principal or academic equivalent, and for independent clinical practice.
- After entry to the specialist or generalist register, doctors will need access to continuing professional development to be able to respond to changes in clinical practice and allow for further professional development as well as revalidation, recertification and maintenance of professional regulation.
- Arrangements for postgraduate medical education and training should be flexible and facilitate movement into and out of training, and between specialty training programmes.
- The provision of education and training will be underpinned by a commitment to provide less than full-time and other types of training, where appropriate.
- The availability of specialty training opportunities will be based on a formal analysis of the needs of the service.
- Trainees will be able to access career management support prior to and during specialty training.

¹ In the context of MMC, the minimum duration of training is intended to ensure that trainees have sufficient clinical experience not only to demonstrate the competencies described in the individual curricula but also to ensure they are capable of demonstrating those competencies within the wider framework of professional and clinical competency and continuing proficiency in practise. The current duration of each specialty training programme is, therefore, indicative but is required with respect to consideration of extensions to training.

Following publication of the final report of the Inquiry, the Programme Board has reviewed and confirmed the principles. Subject to the governance arrangements in place in the future, the Programme Board is committed to reviewing the principles from time to time.

Recommendation 2: Policy-making should be evidence-led

Policy-making in the Department of Health

In April 2007 DH's Policy Committee published *Better policy-making: plans for a system of policy governance*. It recognised that DH could make better and more systematic use of the evidence base. DH has already strengthened its analytical capability by embedding analysts (economists, statisticians and operational researchers) within policy teams so that evidence and analysis are incorporated into a policy's development at the outset. DH is developing a number of courses for officials including DH Policy Process, which has a session solely on analysis and use of evidence, to raise its profile still further.

Policy-making for education and training

For MMC, ensuring that policy is evidence-led is key to ensuring that the way we train our doctors for the future is built on a solid educational foundation. It is also vital to rebuilding confidence among our key stakeholders.

The approach is of necessity incremental as the development of recruitment for 2008 and 2009 was and is constrained by timescales. None the less, the fundamentals of an evidence-based approach are being put in place.

A discussion document, issued in September 2007, considered the approaches to recruitment and selection for 2008. The document and the outcome of the consultation is on the website at: www.mmc.nhs.uk/default.aspx?page=311

The consultation used the available analysis, evidence and best practice to help inform key stakeholders about potential options; for example, the scope for enabling candidates to express preferences and the implications of doing so. It also proposed a programme of pilots. This is discussed later in the response to recommendation 7.

Underlining the importance of an evidence-based approach, the team is being enlarged to include more educationalists involved in the delivery of medical training. They will provide support to the policy development programmes underpinning MMC, implementing the recommendations from this Inquiry and supporting the work taking place in the NSR. It is also proposed to develop a medium- to long-term approach for receiving evidence as it relates to medical education and training in support of making good policy.

Recommendation 3: DH should consult with the medical profession and the NHS about significant shifts in policy that affect postgraduate medical education and training, workforce and service delivery

Events in 2007 raised questions about the extent to which the medical profession and others supported MMC during its development and implementation.

The Inquiry noted that the medical profession had broad representation on key MMC bodies, including the UK Strategy Group and the MMC Programme Delivery Board. Attendance at MMC's key advisory bodies by medical professional representatives was comprehensive.

The Inquiry also noted the complexity of the management structures and the large number of meetings and concluded that colleges were nevertheless inadequately consulted on key issues. Concerns about policy implementation did not sufficiently influence the decisions made by the UK Strategy Group and other key committees.

In addition, despite a comprehensive programme of communications by the MMC team, including roadshows, it seems clear messages were not effectively and consistently communicated to professional constituency groups and that the potential impact of the changes both on the consultants responsible for carrying out interviews and on the affected junior doctors were insufficiently assessed.

In addressing this recommendation, action is being taken by DH to engage stakeholders and with the MMC England Programme Board as a first step to begin addressing the issues for MMC.

Department-wide action

We recognise the importance of engaging our stakeholders at all levels, including patients, the public and the medical professions. Our stakeholders are our key partners in shaping a shared vision and common purpose across the health and social care system. To that end, DH is committed to being an organisation that is good to do business with, and that helps others to deliver. We have built good strategic corporate engagement with senior stakeholders through the national stakeholder forum, which I chair. We also have a continuous programme, through the policy development process and business support, of improving the focus on effective relationships with stakeholders.

The Capability Review of DH, published in June 2007, commented that many stakeholders including clinicians felt strongly that DH did not listen to them. It also criticised the patchy application of evidence-based policy-making. The work that DH has taken forward over recent months on MMC is testament to our determination to address those criticisms. We are committed to engaging consistently with clinical colleagues and other key stakeholders in this area and ensuring that evidence is central to policy development.

MMC England Programme Board

A key objective in setting up the MMC England Programme Board was to put in place arrangements that would secure full stakeholder ownership of the issues.

The MMC England Programme Board was established in July 2007 and comprises representatives of key stakeholders with the medical profession and the NHS. It does this by making clear the responsibilities and accountabilities of Programme Board members. It also sets out clearly the expectations and roles of members in relation to their constituencies.

The Programme Board's terms of reference are set out in Annex A.

The Programme Board has made progress in ensuring links are made between the programme and the stakeholder community. It made the key recommendations on how the recruitment and selection process should work for specialty training for 2008.

For 2008 recruitment and selection, the Programme Board was instrumental in ensuring that a service-wide view was brought to the policy-making process. Key to this has been the way in which Programme Board members actively engaged their constituencies in important policy issues.

All the Programme Board's recommendations have been accepted by ministers.

Wider stakeholder engagement

As already mentioned, a discussion document was issued on the proposed process for 2008 recruitment and selection. Responses to the discussion document were received from:

- 43 national and regional organisations including Royal Colleges, NHS Employers, deaneries and SHAs;
- 38 groups and local organisations including individual NHS employers, medical schools, specialty advisory committees and specialty training committees;
- the Devolved Administrations;
- 48 individuals with educational responsibilities including clinical tutors and training programme directors; and
- 120 individuals including doctors in training, consultants and general practitioners (GPs).

Proposals were also considered at a two-day workshop on recruitment and selection involving some 50 representatives from the medical profession and the NHS.

The responses from the discussion document were shared with members of the Programme Board who formulated their recommendations for 2008 in the light of the feedback.

In planning for 2009 and beyond, the Programme Board is building on the progress in stakeholder involvement achieved by the 2008 consultation exercise. Key elements of the communications and engagement strategy and action plan approved by the Programme Board in September 2007 included:

- a programme of regional and local events for doctors to have a genuine opportunity to influence processes for 2009 and beyond – this is set to roll out from May to July 2008; and
- strengthening applicant support at national and local level, including a complete overhaul of the MMC website based on feedback from doctors – this was completed by December 2007 and continues to provide an important source of clear and timely information. It has been well-received by deaneries and doctors.

The programme is making progress more generally on postgraduate education.

Stakeholder engagement with the research community

The National Institute for Health Research (NIHR) has established methods of stakeholder engagement, including the NIHR Advisory Board, the UK Clinical Research Collaboration (UKCRC) Board as well as through the Clinical Academic Careers Advisory Panel, chaired by Professor Peter Kopelman.

Recommendation 4: Changes to postgraduate medical education should be consistent with the policy objectives and conform to the guiding principles

The Inquiry found that while the educational principles of *Unfinished Business* endured, some had been eroded. In particular, the Inquiry considered that, during implementation, service imperatives had become more prominent than educational ones.

The operation of the Programme Board, and its early agreement of the guiding principles for MMC, has provided a helpful context for formulating proposals for recruitment and selection to 2008.

The Programme Board is considering the framework for 2009 and beyond. It has reviewed and confirmed the principles following the publication of the report of the Inquiry (see recommendation 1). As policy is developed, changes will be measured against the principles to ensure coherence. The principles will be kept under review.

Section 4: The role of the doctor

Recommendation 5

5. *There needs to be a shared understanding of the roles of all doctors in the contemporary healthcare team that takes due account of public expectations. Given the interdependency of professional constituents of the contemporary multiprofessional healthcare team we suggest a similar analysis extends to other healthcare professional groupings. Clarity of the doctor's role must extend to the service contribution of the doctor in training, doctors currently contributing as locums, staff grades and associated specialists, the CCT holder, the GP and the consultant. Such issues need to be urgently considered by key stakeholders. Notwithstanding the need to keep such a key issue under constant review, stakeholders should seek to reach public consensus before the end of 2008, so important is the issue for current NHS reform.*

Education and training need to support the development of the redefined roles for each professional grouping and provide the necessary educational foundations to enable them to practise safely and effectively, and to aspire to enhanced roles.

Response

The Inquiry noted the difficulty in meeting service needs now and in the future without having a clear understanding of the part each healthcare professional plays.

I accept recommendation 5 in principle. Consideration of how the roles of clinicians need to develop is key as part of the NSR.

In the recommendations, the Inquiry notes the wider agenda for modernising careers in other healthcare professions and the need to ensure overall coherence. It also noted that several professional constituencies have begun work on this issue and the work of the NSR.

The NSR work has the active involvement of a wide range of stakeholders from across the clinical profession: medical, nursing, allied health professionals and healthcare scientists, as well as employers and SHAs.

Current trends in the health system, including changing demand patterns, more care delivered closer to home, the introduction of new technologies and increasing managerial complexity, will require changes to the ways in which clinicians deliver healthcare in the future.

The work considers the drivers for change over the next 10 years and beyond, how they will impact on what patients need and expect and what this means for the roles and responsibilities of clinicians. Key to that is understanding how this translates into both how we need to train our clinicians in the future, and the implications for existing clinicians, including how their jobs will change and how we support these changes.

This work will form part of the NSR, which is due to report by the end of June.

Section 5: Policy development and governance

Recommendations 6 to 10

6. *DH should strengthen policy development, implementation, and governance for medical education, training, and workforce issues and their interface with service, embracing strong project management principles and addressing specifically a) clearer roles and responsibilities for a single Senior Responsible Officer, b) clear roles and accountability for senior DH members, c) better documentation of key decisions on policy objectives and key policy choices, d) faster escalation and resolution of 'red risks'. The CMOs should be the SROs for medical education.*
7. *The introduction of necessary changes stemming from this report should i) involve all relevant stakeholders especially professional representatives, ii) abide by best principles of project and change management and include trialling where appropriate and feasible, iii) be subject to rigorous monitoring and evaluation.*
8. *Recognising the interdependency of education, clinical service and research DH should strengthen its links not only within the Department and with NHS providers but also with other Government Departments, particularly the Department for Innovation, Universities and Skills and the Department of Business, Enterprise and Regulatory Reform. Ministers should receive annual progress reports on the development and functioning of such links.*
9. *At a local level Trusts, Universities and the SHA (or equivalent) should forge functional links to optimise the health:education sector partnership. As key budget holders SHA Chief Executives should have the creation of collaborative links between local Health and Education providers as one of their key annual appraisal targets. Success should be measured against tangible outcomes.*
10. *All four Departments of Health in the UK and the four Chief Medical Officers must be involved in any moves to change medical career structures. In many instances it seems likely that the Department of Health in England will continue to have a lead role but from time to time, collective agreement may determine that lead responsibility for specific issues passes to another Health Department and/or its Chief Medical Officer. Regardless of which Department leads, accountability should be explicit and every effort made to acknowledge the views of the four countries.*

Response

The Inquiry found deficiencies in policy development, identifying, in particular, ambiguous accountability structures for policy development and weak governance and risk management processes. It also pointed out the need to make key links at national and local level between the health and education sectors.

I accept these recommendations in principle.

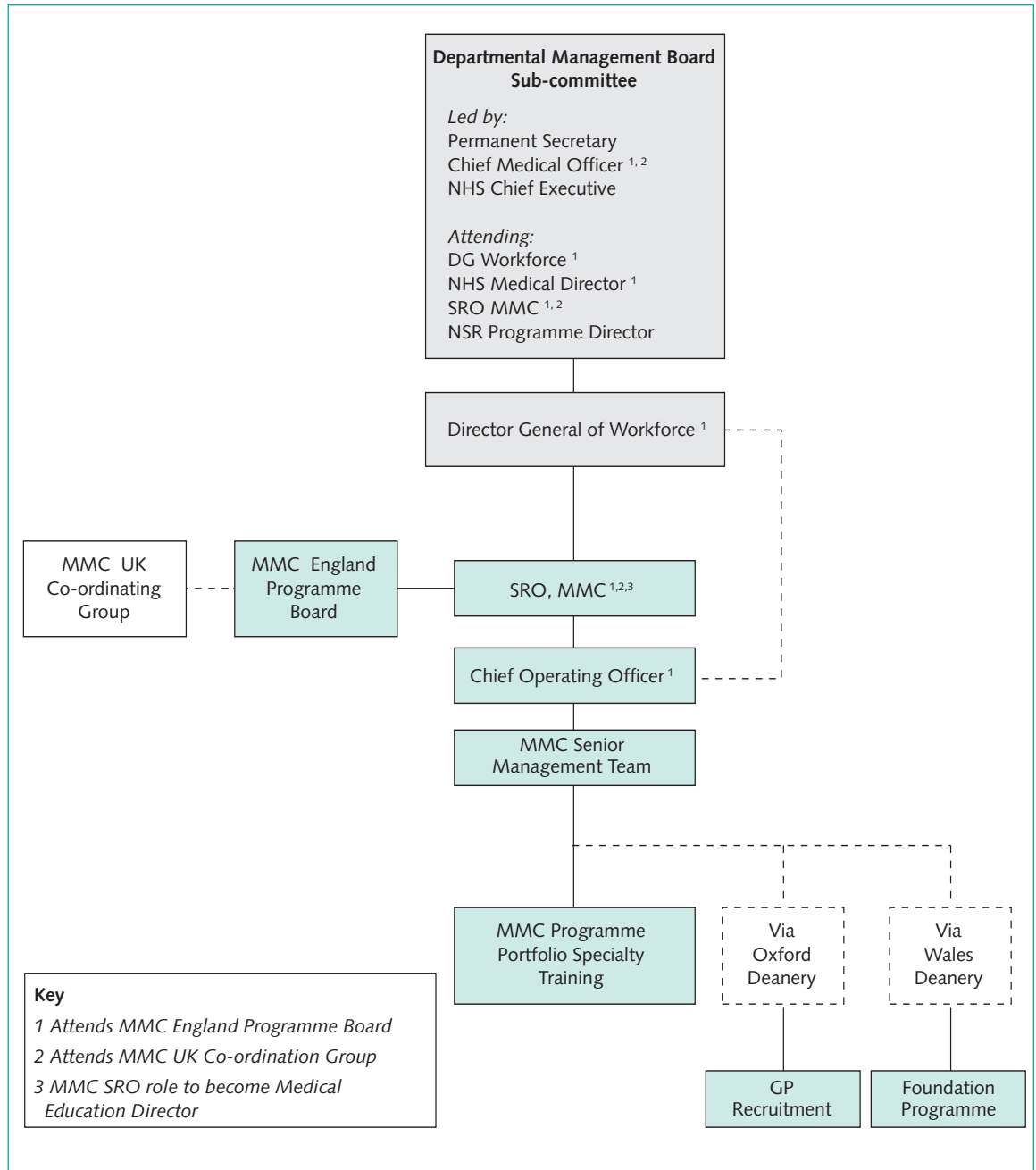
Recommendation 6: DH should strengthen policy development, implementation, and governance for medical education, training and workforce issues. The CMOs should be the SROs for medical education

Following the withdrawal of the Medical Training Application Service (MTAS) and serious concerns raised in 2007, DH appointed a chief operating officer (COO) for the MMC programme. In addition to taking forward work with the NHS and the professions to manage recruitment to specialty training for 2007, a central task for the COO, alongside the SRO for MMC, was to establish clear and workable governance arrangements for the programme.

As a result, and underpinning MMC policy development, the MMC programme has a dedicated programme office, directly managed by the COO and staffed with programme management professionals. The programme office role is to support the development and implementation of planning and risk assurance arrangements to support the policy development and implementation of MMC.

Figure 1 shows the reporting structure for the MMC programme and how it relates to the Director General of Workforce and DH's Management Board.

Figure 1: England governance of MMC



The MMC Programme Board reports via the Director General of Workforce into the Departmental Management Board Sub-committee, led by the CMO, the Permanent Secretary and the NHS Chief Executive.

Programme Board-level risks are reviewed by the Board at each meeting. They are subject to scrutiny by the MMC Programme Office and the MMC Senior Management team, which manages the programme day-to-day. MMC risks are routinely reported to the Departmental Board.

MMC Programme Board decisions take the form of recommendations to ministers. The decisions are recorded in the minutes of meetings which are published on the MMC website. They are implemented through policy guidance and documents for the NHS and junior doctors, via the MMC website and through regular bulletins.

The arrangements and terms of reference for the MMC Programme Board will be kept under review.

The final sentence of recommendation 6 says: ‘The CMOs should be the SROs for medical education’. As described, the governance for MMC in England is that there is a single SRO for MMC who reports through the Director General of Workforce to a sub-committee of the Departmental Board, which includes the NHS Chief Executive, the DH Permanent Secretary and CMO.

These arrangements will need to be reviewed in the light of the decisions on recommendation 47 (NHS:MEE).

Recommendation 7: The introduction of changes should involve all relevant stakeholders, abide by the principles of project and change management and include trialling, and be subject to rigorous monitoring and evaluation

The Inquiry’s recommendation on the need to engage stakeholders and to test and pilot approaches is one of the most powerful in the report. I am strongly persuaded of the need to ensure that we reflect its importance as we move forward.

The first step in trying to secure the involvement of key stakeholders was the establishment of the MMC England Programme Board in July 2007.

The Programme Board comprises key stakeholders, who are there, among other things, to represent their broad constituencies. Substantial effort has been put into the process of engaging with stakeholders and testing approaches.

Changes in 2008

For recruitment and selection in 2008, the scope for making changes to the processes which had been used for Round 2 of 2007, was limited by the length of time that would have been required to plan, design and test any major changes.

A discussion document was published in September 2007, setting out options for 2008. It set out the key areas where policy decisions needed to be taken, for example around the use of a national computer system, national application forms, the timetable and whether

applicants would be able to state preferences. For each issue the options were set out and stakeholders were invited to comment.

A stakeholder workshop was held on 17 and 18 September 2007 to consider and make recommendations on the proposals for 2008, and to start developing ideas for 2009 recruitment and selection.

The Programme Board took account of comments on the discussion document and from the workshop in formulating their recommendations to ministers. Analysis of feedback on the discussion document and the Programme Board recommendations can be found at: www.mmc.nhs.uk/default.aspx?page=311

Wider stakeholder engagement

Wider work to engage stakeholders since July 2007 has included the following:

- The development of a communications and involvement strategy and action plan approved by the Programme Board in September.
- A stronger infrastructure for stakeholder relations, for example, with new distribution mechanisms and establishing contacts with a wider range of stakeholders. This has included building personal relationships with communications leads in key representative organisations such as the BMA, the PMETB, NHS Employers, the Royal Colleges, Doctors.net and Remedy UK. There are better communications and closer relationships with deaneries, SHAs and trusts through regular bulletins and network meetings.
- A series of stakeholder workshop sessions, including a focus group exercise with junior doctors.
- A review of guidance for applicants and general information. The MMC website has been improved with the involvement of stakeholders and junior doctors. The site has been better designed around the needs of applicants and stakeholders and has received positive feedback from users.
- A programme of events to enable junior doctors, consultants and stakeholders to influence plans for 2009 and beyond.

Recruitment and selection pilots

The key criticism of the MMC reforms concerned the extent to which stakeholders were engaged in implementing change and the lack of trialling and evaluation.

The report of the Douglas Review Group² noted in its comments on the future appointment process:

² See Appendix 9 of the Inquiry Report

‘a key, if obvious, lesson is that major changes to medical training and appointment systems should be introduced only after careful planning and where appropriate should be phased. The rapid synchronous introduction of a new computer system across all specialties and geographies and at all levels of training without piloting was overambitious.’

The MMC England Programme Board has established a programme of recruitment and selection pilots as part of a paced approach to policy and change management. The intention is to test different approaches to discriminating between candidates for specialty training and to be able to take account of candidates’ aptitudes for particular specialties.

There is already a considerable body of work around selection methodologies that has been acknowledged.

- The General Practice Programme uses clinical problem solving (CPS) testing, Situational Judgment machine-markable tests and a selection centre. These approaches have been developed over seven years.
- Scotland has piloted a selection centre approach for surgeons. Early indications are that it demonstrates strong evidence of reliability and criterion-related validity. Trainees have also commented on the fairness and equity this approach brings.
- A number of deaneries and Royal Colleges use selection-centre-type approaches and some deaneries have trialled the GP clinical problem-solving test within specialty recruitment exercises. Some Royal Colleges have also run pilots.
- In a small number of specialties, for example, obstetrics and gynaecology, national recruitment methods have been developed. There are lessons to be learned that might be transferable to other specialties.

The pilots are intended to help establish the efficiency and effectiveness of various methods of selection and their suitability for selection to specialty training. There will be a national evaluation across pilots.

The pilots will cover:

- machine-markable tests: invigilated shortlisting ranking tests that are machine-marked, similar to the CPS test developed for GP training selection.
- selection centres: a combination of selection methods used together to assess an applicant against defined requirements.

In the first wave, four pilots have been selected that cover core medical training, core surgical training, acute care specialties and trauma and orthopaedic surgery. It is proposed to recruit a second wave of pilots for 2009.

The evaluation team is expected to be selected in early April. Selection will be by a panel, comprising key stakeholders nominated by the MMC England Programme Board.

Recommendation 8: DH should strengthen its links with education, clinical service and research and with other government departments

DH has been working on improving relations with other government departments through a series of partnership agreements with key stakeholder departments. Capability Reviews across Whitehall over the past year, coupled with the emphasis on cross government working in new PSAs, have refocused our work in this area. We are in the process of reviewing and updating agreements or putting in place new partnership agreements where they did not previously exist.

Good progress has been made in agreeing new or revised agreements with the Department for Communities and Local Government, the Department for the Environment, Food and Rural Affairs, the Home Office, the Ministry of Justice and the Department for Children, Schools and Families. There are plans to take forward work with the Department for Work and Pensions and the Department for Culture, Media and Sport. In addition, DH has put in place a new strategic approach to the work of the Ministry of Defence/DH Partnership Board, including revised terms of reference for the Board itself, and it has set up three working groups to take forward key issues.

DH liaises regularly with the Department for Innovation, Universities and Skills (DIUS). A joint DH/DIUS work programme looking into higher skills for new roles has led to local pilots being set up to develop Foundation degrees for assistant practitioners to meet service needs. There is ongoing liaison on student support, an important element of the arrangements for helping to attract staff into a career in the NHS.

DH is also working with DIUS to implement Lord Leitch's recommendations for wider participation in education and training in the healthcare sector (*Prosperity for all in the global economy – world class skills*, 2006). This is being done through the Learning and Skills Council and Skills for Health. Together we are promoting the recommendations and encouraging NHS employers locally to take up the Skills Pledge.

At a strategic level, there is a Health Education Interface Group. This is chaired jointly by the Director Generals of DH and DIUS who have commissioned work to put in place a new national operating model. The operating model includes the arrangements for funding undergraduate and postgraduate education and the terms of reference and membership for a new national health/education forum.

DH has strong and long-standing research links with other government departments and agencies. The DH Director General of Research and Development, in her capacity as DH Chief Scientific Adviser, has close working relationships with the Government Chief Scientific Adviser, based in DIUS, and with the Chief Scientific Advisers of other

government departments. She also has regular one-to-one meetings with the Chief Executive of the Higher Education Funding Council for England (HEFCE). HEFCE is also represented on the UKCRC, which DH chairs. DH is strongly represented on all the research assessment exercise panels related to health research.

DIUS and DH have jointly established the Office for Strategic Co-ordination of Health Research and sit together on its Board. The single health research fund comprises the research budgets of the Medical Research Council (through DIUS) and NIHR (through DH). DH has a formal strategic partnership with each of the research councils and has an effective partnership with the Technology Strategy Board.

DH and the Department of Business, Enterprise and Regulatory Reform work closely together on a range of issues including: the Biosciences Technology Innovation and Growth Team, the Ministerial Industry Strategy Group, the Ministerial Medical Technology Strategy Group and Healthcare Technology Co-operatives.

We will consider whether further arrangements need to be put in place with other government departments in discussion with them and others. Arrangements will need to take account of the impact of wider policy drivers, including the implications of decisions around recommendation 47 (to establish an NHS:MEE).

Recommendation 9: Universities and the SHAs should forge functional links to optimise the health:education sector partnership. SHA chief executives should have the creation of collaborative links between local health and education providers as key annual appraisal targets

The work of the NHS and the higher education sectors are inextricably linked. The sectors share responsibility for teaching, research and service delivery. Higher education is integral to planning for workforce education and training and producing a sustainable health service workforce. The NHS provides a unique environment for research that stretches across the range of disciplines underpinning healthcare, sustaining new treatments and improved patient care.

The Inquiry notes that better links are being forged between SHAs and higher education institutes (HEIs) in England. It also notes that the links need to be replicated at national level. Future national arrangements need to be considered as part of the work being carried out to consider recommendation 47 (the proposal to establish an NHS:MEE).

Links between SHAs and HEIs

The arrangements for commissioning higher education vary across professions, with some commissioned by HEFCE and others such as nursing, midwifery and allied healthcare professionals by SHAs. The numbers of places commissioned by HEFCE for medical and dental students are agreed with DH through the joint implementation group process, which

includes key stakeholders. The number of places for others, such as pharmacists and scientists, are set by HEFCE based on bids from HEIs.

Both SHAs and HEIs have acknowledged that there are failings in the current system. These include differing educational and service requirements and poor communications. Both sectors are keen to develop a new framework that improves collaboration at all levels. A longer-term perspective combined with collaborative working is regarded as essential if systems are to sustain learning and education that is responsive to changing service needs.

Universities UK and the Office of the SHAs have been commissioned to develop an action-based work plan which will consist of a national agreement on:

- strategic partnership: an ambitious vision of what the higher education sector and SHAs want to achieve through a collaborative, forward-looking national partnership which complements locally-shaped, regional relationships; and
- strategic investment plans for education and training: to meet modern needs and promote flexibility and innovation in skills mix and financial stability.

Annual appraisal objectives for SHA chief executives

SHA chief executives are accountable to DH for the outcomes of the Service Level Agreement (SLA) around the multi-professional education and training (MPET) funding stream.

In 2006/07 an SLA was introduced around the MPET funding for SHAs. However, pressure on SHA budgets meant that some funding in some places, intended to support training, was diverted. In 2007/08 the SLA was strengthened in negotiation with the SHAs so that the outputs expected from each SHA in developing the workforce in its area were explicit, rather than specifying particular levels of funding for specific activities. This supports a wider approach that underpins local decision-making and encourages innovation.

There are 26 key performance indicators (KPIs) in the SLA. These include requirements for SHAs to publish their annual investment plans for education and training, with plans based explicitly on planning for delivering services to patients and on long-term workforce need and local financial plans.

There has been positive feedback from the education sector, revealing an increase both in partnership working and a rise of about 2 per cent in pre-registration nursing commissions, which DIUS has also acknowledged.

The strategy for 2008/09 is to build on the SLA, developing the work on partnership, accountability and transparency. The arrangements are being reviewed with education providers. We expect to finalise the revised SLA shortly.

A KPI monitoring exercise in summer 2007 showed that all SHAs had produced and published a training and investment plan. In many cases the KPIs have already been achieved, or plans are in place to achieve them by 31 March 2008.

The NHS Chief Executive, David Nicholson, oversees the objective-setting process for SHA chief executives. He will ensure, in conjunction with their Chairs, that appraisals reflect the need for partnership working between the health and education sectors.

Recommendation 10: All four Departments of Health in the UK and the four CMOs must be involved in changes to medical career structures

This is agreed in principle. The precise arrangements for doing so will depend on decisions about recommendation 47 (the proposal to establish an NHS:MEE) and the outcomes of the consultations by Scotland and Wales on their approach to taking forward the Inquiry's recommendations.

For MMC England, the SRO will also play a leading co-ordinating role.

Section 6: Workforce planning

Recommendations 11 to 17

11. *DH should have a coherent model of medical workforce supply within which apparently conflicting policies on self-sufficiency and open-borders/overproduction should be publicly disclosed and reconciled. We recommend that overseas students graduating from UK medical schools should be eligible for postgraduate training as should refugee doctors with the right to remain in the UK.*
12. *DH Workforce should urgently review its medical workforce advisory machinery to ensure that it receives integrated and independent advice on medical workforce issues to inform/complement SHA and local deliberations. Both national and devolved workstreams must be adequately resourced. The medical workforce advisory machinery should also take account of national policies impacting on the workforce such as the shift of more care to the community. Revisions to the current arrangements need to reflect the following principles:*
 - *Medical workforce planning needs to embrace the consensus view of the role of the doctor and roles of other healthcare professionals referred to in Recommendation 5.*
 - *Plans should be based on robust information on available and projected medical specialist skills, requiring relevant databases.*
 - *Whilst recognising that doctors are just one part of the workforce, sufficient attention and resource needs to be devoted to medical workforce planning reflecting doctors' crucial roles and the expense involved in their development.*
 - *A national perspective needs to be integrated with regional requirements including the views of service, particularly with regard to the maintenance of sufficient subspecialty expertise to meet the needs of the nation, and the overall health of clinical academia. Consideration should be given to the creation of an arm's length body, NHS Medical Education England, NHS:MEE, mirroring NIHR to undertake commissioning of higher specialist training that is not required in every locality. The criteria for the award of such training positions should reflect the Trust's performance in relation to training, innovation and clinical outcomes.*
 - *Professional advice to the medical workforce advisory machinery needs to include that from doctors at the cutting edge of their discipline with the foresight to project potential developments in healthcare. The Panel believes that this might best be accomplished through arrangements that mirror those in place for the previous Medical Workforce Standing Advisory Committee (MWSAC).*
 - *Regional workforce plans should be subject to a national oversight and scrutiny advisory committee with service, professional and employer representation. Such*

oversight should encourage local responsiveness and acknowledge issues facing the devolved administrations whilst ensuring national consistency on roles and standards.

- *Modelling capacity should be enhanced by drawing on the expertise in the University sector, e.g. health economists, epidemiologists, modellers etc. The assumptions underlying projections should be subject to professional scrutiny and regular review.*

13. *The Panel recommends that DH should work with the GMC to create robust databases that hold information on the registered/certificated status of all doctors practising in the UK. This will provide an inventory of the contemporary skill base and number of trained specialists/subspecialists in the workforce, as well as those in training for such positions, to inform workforce planning.*
14. *The content of higher specialty training and the numbers of positions will be informed by dialogue between the Colleges, Deaneries, employers, and medical workforce advisory machinery to allow finer tuning of the nature of the specialist workforce to reflect rapidly evolving technical advances and the locus of care.*
15. *Explicit policies should be urgently developed and implemented to manage the transitional 'bulge', caused by the integration of eligible doctors into the new scheme, with appropriate credit for prior competency assessed experience.*
16. *DH should recognise the burgeoning supply of medical graduates it has commissioned and make explicit its plans for the optimal use of their skills for the benefit of patients. It is recommended that sufficient numbers of Core Specialty training posts (see Recommendation 33) should be made available to accommodate doctors successfully completing FY1 and the use of commissioning funds for this purpose should be monitored.*
17. *Career aspirations and choices should be informed by accurate data on likely employment prospects in all branches of the profession and the likely competition ratios based on historical data, supplemented by professionally agreed foresight projections. Such information should be updated annually by the redesigned medical workforce advisory machinery and made publicly available so as to inform would be medical students, students and trainees.*

Medical schools should play a greater role in careers advice including i) information in prospectuses concerning career destinations and likely competition ratios, ii) offering selective components of the programme to allow experience in discrete specialties, iii) formal personalised advice/mentoring.

Response

The Inquiry noted the need for consistent policies for the workforce and for those policies to embrace a long-term vision for its size and structure. The vision should be linked to service objectives and to the other roles doctors undertake, including those in management, education and research and overseas work.

I accept these recommendations in principle. The importance of a clear approach to workforce planning cannot be overstated. In his interim report *Our NHS, our future: NHS next stage review – interim report*, published in October 2007, Lord Darzi identified workforce planning and education as areas that need strengthening.

Work is under way with experts in these areas as part of the second stage of Lord Darzi's review to produce a new approach that will sustain the NHS in the future. I am looking to this work to put in place the means of developing the longer-term vision and supporting infrastructure for the workforce.

Precisely how these proposals will be taken forward depends on decisions to be taken on recommendation 47 (proposals for an NHS:MEE).

Recommendation 11: Coherent model of medical workforce supply

The Inquiry identified that the implementation of MMC was hampered by ambiguities in policy around the eligibility of International Medical Graduates (IMGs) to participate in the selection processes. It states, '*the inadequacies of MTAS were exposed in large part by the excess of applicants over trainee places. The difficulties of integrating SHOs was compounded by underestimates of the IMGs that would apply ...*'

The government has been working to clarify the position.

Self-sufficiency of training versus wider recruitment

In Autumn 2007, DH invited feedback from the medical profession and other stakeholders on the principles involved in applying controls not only to future migrant doctors from outside the European Economic Area (EEA), but also to migrant doctors already in the UK.

On 6 February 2008, the Home Office announced changes to the immigration rules that will come into effect on 29 February, subject to the Parliamentary process. Highly skilled migrants, Tier 1 (general) migrants and their dependants will in certain circumstances have a condition imposed on their leave to enter or remain in the UK prohibiting them from taking employment as a doctor in training. 'Employment as a doctor in training' means employment in a medical post or programme offered by the NHS that has been approved by PMETB as a training programme or post.

Departmental guidance

DH has reviewed the options for managing migration more effectively. At present, the preferred option is to implement guidance that will give priority to UK-trained doctors.

A detailed consultation began on 6 February on the issue of managing medical migration more effectively. The consultation document setting out the detailed options assessment is available on the MMC website at www.mmc.nhs.uk. The consultation will close on 6 May 2008.

Draft guidance is appended to the consultation document. In summary, the guidance is intended to restrict doctors outside of the following categories from taking up postgraduate training posts in the NHS, unless there is no suitable applicant from the following categories:

- UK nationals
- applicants who have completed a medical degree in the UK
- applicants with indefinite leave to remain in or indefinite leave to enter the UK
- applicants granted leave to enter or remain in the UK under the paragraphs of the immigration rules relating to spouses or civil partners of persons settled and present in the UK
- applicants with the right of abode in the UK
- EEA and Swiss nationals
- family members of EEA nationals (residing in the UK) with a valid UK resident document confirming that the individual in question has a right of residence in the UK
- dependants of non-EEA nationals with indefinite leave to remain or indefinite leave to enter the UK
- refugees.

The guidance will not prevent migrant doctors who are not in the categories listed above from working in a service post in the NHS or from filling a training post in a shortage area or specialty.

Potential legal constraints

DH issued similar guidance in 2006 that had the effect that doctors from outside the EEA, including those on the Highly Skilled Migrant Programme (HSMP), should be considered for specialty training programmes only if there was no suitable UK or EEA applicant. The guidance was not intended to prevent migrant doctors on the HSMP from applying for service posts in the NHS.

This guidance was challenged by way of judicial review proceedings. In February 2007 the High Court found the DH guidance to be lawful. The guidance was not implemented in 2007 because the Court's judgement was received after the 2007 specialty recruitment process had started. On appeal, the Court of Appeal decided that the Secretary of State for Health had no power to issue the guidance and that it was unlawful.

DH has appealed against the Court of Appeal ruling. The House of Lords granted leave to appeal and the case will be heard on 28 February 2008.

The eventual decision as to whether or not to implement guidance, and if so then in what form, will be taken in the light of the decision of the House of Lords, an equalities impact assessment and the outcome of the consultation exercise.

DH will continue to investigate alternative solutions for the future as well as seeking ways to improve workforce planning.

Recommendation 12: Review of medical workforce advisory machinery

Recommendation 13: Databases of registered/certificated doctors practising in the UK

The Inquiry report cites Sir Derek Wanless, who said:³

‘The Department of Health has not yet been able to find effective ways of linking forecasts of service development with the education and training of health professionals.’

In *Our NHS, our future: NHS next stage review – interim report*, Lord Darzi identified workforce planning and education and training commissioning as areas that needed strengthening. Work is under way with experts in these areas as part of the second stage of Lord Darzi's review to produce a new approach that will sustain the NHS in the future.

Assessing the immediate and longer-term health needs of the population is a complex task, requiring an actuarial understanding of demography and health needs alongside a grasp of technological advance and future policy. Workforce planning is more complex still, requiring in addition an understanding of future skills mix, likely efficiency, roles and responsibilities and service preferences.

I am also clear about the necessity of working closely with the service, both in developing assumptions and in engaging them in ongoing strategy. Whatever model is chosen to take this forward will be collaborative.

The final report of the NSR is due to be published by the end of June.

Recommendation 14: Training content and numbers to be informed by dialogue between colleges, deaneries, employers and medical workforce advisory machinery

I agree that training content and numbers should be informed by key stakeholders. The regulators have the key role in securing the content and standards of education and training.

The content and standard of postgraduate medical training is the responsibility of PMETB, which is the competent authority for postgraduate medical training in the UK. PMETB

³ *Our Future Health Secured?* Sir Derek Wanless, King's Fund, 2007

exercises its role as custodian of quality standards in postgraduate medical education and practice as an independent medical body.

In addition, the GMC's Education Committee has the general function of promoting high standards of medical education and co-ordinating all stages of medical education to ensure that students and newly qualified doctors are equipped with the knowledge, skills and attitudes essential for professional practice.

Both bodies have a vested interest in ensuring that doctors are equipped to deal with the problems they will encounter in practise.

Commissioning education training is being reviewed in the NSR to ensure that it secures high-quality education and training that is better linked to service needs. This will acknowledge the need to take account of the views of a wide range of stakeholders.

Recommendation 15: Explicit policies should be developed and implemented to manage the transitional 'bulge'

I accept the recommendation that action should be taken to manage the transitional 'bulge'.

The MMC changes were intended to provide better structured, competence-based training, with the aim of improving the safety of doctors and the effectiveness and efficiency of their training. These changes included:

- linking educational progression to an annual review competency;
- time limiting training programmes;
- marking the completion of training by entry to the specialist or general register; and
- linking the number of available specialty training opportunities to the needs of the service.

They defined the size of the pool of doctors in specialty training. Immediately preceding MMC recruitment for 2007 there was a cohort of Senior House Officers (SHOs) who would want to apply for posts in the third year of specialty training (ST3 posts). This group is known as the 'transition bulge'.

Steps have been taken in 2007 and 2008 to minimise this problem.

2007

The number of specialty training opportunities were maximised at all levels, including ST3/4. This was done by creating extra ST3/4 posts and delaying recruitment to a number of established vacancies. An additional 215 ST3/4 posts were centrally funded as part of the 2007 transition package, with a further 1,050 fixed term specialty training appointment (FTSTA) and GP run-through posts being made available at the end of the recruitment episode for England.

However, the large number of IMGs who play a valuable role in providing services across the UK were also able to compete in 2007 for specialty training places with applicants from UK medical schools. This has meant that a considerable proportion of the transition group remains for 2008 and beyond.

2008

Specific steps taken for 2008 include the following:

- Staged recruitment to the maximum number of available ST3 posts at the earliest opportunity and allowing multiple recruitment rounds throughout the year.
- ST3 expansion – an extra 165 ST3 posts in the over-subscribed specialties, providing additional capacity to help the transition between systems.
- Post-CCT training – up to 100 one-year post-CCT training places to meet the need for further specialty training in specific specialties where there is a strong clinical need, for example in trauma and orthopaedics for complex orthopaedic surgical procedures. This will free up national training numbers when doctors achieve their CCT and move straight into a fellowship, freeing up a training post.
- Transit posts – potentially up to 100 posts to provide applicants in over-subscribed specialties with experience and training to change specialty, for example surgery to anaesthetics. This provides wider opportunities for candidates.
- Specialty-specific solutions – for example paediatrics are rescheduling posts to take out the need for Locum Appointments for Training (LATs) to provide up to 25 extra places at ST4 and above. Scope in other shortage specialties is being explored.

Future strategy

To manage the issue for the future, a strategy will be developed on a specialty-by-specialty basis, based on the evidence of the size and nature of the problem. It will take account of the work on how the roles of clinicians need to develop as part of the NSR.

The strategy will consider:

- the need for doctors in the future in particular specialties, including the shape of the workforce required to deliver high-quality and efficient services in each specialty;
- the need in some cases to reduce training posts. This means working closely with the service to ensure that service is not disrupted and that the reduction in training posts is met by an increase in service posts where that is required;
- any need for more doctors in primary and community settings. As well as more GPs, there may be the need for other types of community doctors and specialists. This has implications for those who will train in the future and for those who are training or practising now; and

- whether services in the future – in hospitals and the community – might be provided by fully trained specialists, or by more appropriately trained trust and staff grade doctors. This includes considering the mix of generalist, specialist and junior grade posts.

Next steps

Following the first recruitment round in 2008, data will be collected on the competitiveness of medical graduates. This will be derived from interview information collected by deaneries.

This data will indicate the size and form of the problem and will be used to formulate plans to consider:

- supply against future service demand – some services will want bigger trainee rotas to comply with the EWTD in 2009;
- the impact of IMG policies on service provision in the light of the forthcoming decision of the House of Lords and the immigration rule changes;
- whether there is a case for creating additional posts in any particular specialty as a transitional measure;
- geographical issues;
- the scale of potential retraining initiatives to enable competent doctors who are not competitive in a highly competitive specialty to change career;
- the extent to which doctors may need further career counselling; and
- the consequences for potential strategies for planning and delivering services.

This will be done through a time-limited transition workforce planning group that will make recommendations by September 2008 on managing the ‘bulge’, for 2009 and future recruitment rounds. This group will also take account of the work of the NSR on workforce planning and primary care.

Recommendation 16: DH should make explicit its plans for the optimal use of the skills of the medical graduates it has commissioned. There should be sufficient numbers of core specialty training posts to accommodate doctors who complete F1

I accept this recommendation.

The number of core specialty training places is determined by the future demand for doctors at ST3 level and above. DH and the workforce review team will continue to work with the SHAs to review the numbers of posts to ensure that sufficient posts are available.

Recommendation 17: Career choices should be informed by data on employment prospects and competition ratios for the specialties. Medical schools should play a greater role in careers advice

I agree with this recommendation in principle.

The Inquiry noted there was an inconsistency and dearth of information on careers opportunities made available to medical students and doctors in training.

I agree how important it is that junior doctors can make informed decisions about which foundation schools and specialties to apply to.

Competition ratios by foundation school are published on the Foundation Programme website (www.foundationprogramme.nhs.uk).

This year we have been able to provide potential applicants to specialty training with information about the levels of competition in 2007. We will continue to develop this information by talking to junior doctors to find out what they find helpful when deciding which foundation schools and specialties they would like to apply to.

In particular, as the UK becomes more self-sufficient in training doctors, we need to ensure that opportunities across all specialties are attractive, and that trainees have the information to support making career choices from the full spectrum of medical disciplines.

I am pleased that Sir John has acknowledged the role that medical schools have to play in providing careers advice. I look forward to hearing more about their plans in this area shortly.

Section 7: Medical professional engagement

Recommendations 18 to 20

18. *The medical profession should have an organisation/mechanism that enables coherent advice to be offered on matters affecting the entire profession. In relation to postgraduate medical education and training we recommend that NHS:MEE assumes the coordinating role.*
19. *There should be enhanced opportunities for training in medical management during postgraduate training years to fuel an increase in clinically qualified managers and an awareness of the interdependency of clinicians and managers in the pursuit of optimal healthcare.*
20. *Doctors in training should be better represented in the management structures of Trusts to ensure that they better understand service pressures and priorities and Trusts better appreciate their service role and training needs.*

Response

Recommendation 18: The medical profession should have a mechanism to facilitate coherent advice on profession-wide matters. For PGMET, NHS:MEE might assume the co-ordinating role

I agree with this recommendation in principle. However, it is directed at the medical profession.

The Inquiry noted that the advice derived from individual medical professional constituencies during the implementation of MMC frequently reflected the narrow interests of that grouping, rather than the interests of medicine and medical care as a whole.

DH values the input of the medical profession. The input of the medical profession on the MMC England Programme Board has been effective in demonstrating how the medical profession can provide coherent advice on profession-wide matters.

A full response can only be given after recommendation 47 (the proposal for an NHS: MEE) has been further considered.

Recommendation 19: There should be opportunities for training in medical management during postgraduate training years

Recommendation 20: Doctors in training should be better represented in the management structures of trusts

The Inquiry's recommendations arise from the concerns of some doctors that, in an increasingly decentralised NHS, doctors need to be increasingly involved in implementing training and service policies and local management and planning.

I agree with both these recommendations and the importance of the development of medical management skills.

The leadership workstream of the NSR is considering how more clinicians at all levels within the NHS might be encouraged to take up leadership roles.

The emerging view is that leadership development should be focused both on improving current leadership, through improved opportunities, and by making sure that leadership and management development is initiated at undergraduate level. This development needs to continue as a constant throughout the course of undergraduate and postgraduate training and throughout medical careers.

There are already a number of initiatives under way to develop medical management skills.

- South Central SHA has for two years been taking forward a policy of engaging medical trainees in an innovative multi-professional, comprehensive programme of leadership development spanning all the years of training. Over 1,000 trainees a year are taking part in more than 15 different programmes. These include taking part in service improvement programmes within their own trusts. Feedback from clinicians has been very positive.
- In February 2008, the British Association of Medical Managers (BAMM) launched its BAMMbino service to provide a medical management and leadership support service for doctors in training.

I will also ensure there is further liaison with NHS Employers to consider how this may be encouraged.

Section 8: The commissioning and management of postgraduate medical education and training

Recommendations 21 to 29

21. *The CMOs as leads for Medical Education will interact with NHS:MEE and equivalent structures in the Devolved Administrations as the reference point for interactions with the medical profession over matters relating to PGMET.*
22. *Recognising i) the importance of linking workforce supply and demand, ii) the very recent devolution of workforce commissioning function to SHAs in England, we recommend that this situation prevails for the moment for initial Postgraduate Medical Training subject to the forging of closer links at all levels with the Higher Education Sector. A formal review of the compliance with Service Level Agreements between DH and the SHAs relating to commissioning training and the functionality of the arrangements should be undertaken in 2008/9.*
23. *Funding flows for postgraduate medical education and training should accurately reflect training requirements and the contributions of service and academia. The current MPET Review should lead to a clearer contractual basis reflecting both agreed volumes and standards of activity and should recognise the service contribution of trainees and the resources required for training.*
24. *The Medical Postgraduate Deanery function in England should be formally reviewed with respect to whether i) the relationships and accountabilities are currently optimal, ii) the present arrangements meet redefined policy objectives of optimal flexibility in postgraduate training and aspiration to excellence, and the NHS imperative of equity of access. Any new arrangements should conform to redefined principles, referred to in Recommendation 1, co-developed to govern postgraduate training.*
25. *Postgraduate Medical Deans should have strong accountability links to medical schools as well as SHAs in line with Follett appraisal guidelines for clinicians with major academic responsibilities. Such arrangements will improve links with medical academic expertise and will facilitate the educational continuum from student to continuing professional development.*

26. *Reflecting the fact that Postgraduate Medical Education and Training involves service, academic and workforce dimensions, it is proposed that the Foundation School concept be developed further as Graduate Schools, on a trial basis initially, where supported locally. The characteristics of such Schools, the precise nature of which would depend upon local circumstances and relationships, need to reflect the crucial interface function played by the Medical Postgraduate Deanery between the service, the profession, academia and workforce planning/commissioning. Graduate Schools would involve Postgraduate Deans, Medical Schools, Clinical Tutors, Royal College and Specialist Society representatives and would have strong links to employers/service and SHAs. The Graduate Schools could also oversee the integrated career development of the trainee clinical academic/manager (see Recommendation 41), as well as NIHR faculty.*
27. *To incentivise Trusts to give education and training sufficient priority they should be integrated into the Healthcare Commission's performance reporting regime.*
28. *Responsibility for the local delivery of postgraduate medical education and training should form part of the explicit remit of Medical Directors of Trusts. Part of that responsibility should include regular reporting to Trust Boards on the issue.*
29. *Training implications relating to revisions in postgraduate medical education and training need to be reflected in appropriate staff development as well as job plans and related resources. Compliance with these requirements should form part of the Core Standards.*

Response

The Inquiry noted a number of concerns about the management and commissioning of postgraduate medical education and training. The concerns included the funding and incentive structures for postgraduate medical education and training, links between SHAs and deaneries, employer accountability and the links with medical schools.

These recommendations are linked to recommendation 47. Therefore, decisions will need to be made on the proposal to create NHS:MEE before a full response can be given.

Recommendation 21: The four CMOs will interact with NHS:MEE and equivalent structures in the Devolved Administrations over matters relating to PGMET

It is agreed in principle that the CMOs should work together to take forward the development of postgraduate medical education.

My response to recommendation 6 also notes that in England the SRO reports, through the Director General of Workforce, to a sub-committee of the Departmental Board which includes the NHS Chief Executive, the DH Permanent Secretary and CMO.

Recommendation 22: Devolved workforce commissioning should continue for the time being. Compliance with Service Level Agreements between DH and the SHAs should be reviewed in 2008/09

I agree with the recommendation.

SHAs do not directly commission undergraduate medical and dental *education*, which is commissioned via HEFCE (with DH input into numbers required). They do, however, commission and fund clinical *training places* for undergraduate medical and dental students, and for postgraduate doctors, from service providers.

SHAs have been encouraged to balance achieving financial stability and investing in the development of the local workforce. This is to be done in ways that do not adversely affect students or damage the medium- and long-term ability of HEIs to provide the level of education to which they and the SHAs are committed. DH is confident that they can work together to achieve this.

An SLA and accountability framework was issued with the 2007/08 allocations. This was to ensure that SHAs planned their investment in workforce development based on the workforce needed to deliver services required by patients, rather than on the spending of particular amounts of money.

The SLA requires SHAs to demonstrate that they have planned their investment in workforce development based on the workforce needed to deliver services required by patients and that they are supporting national policies such as the expansion of undergraduate medical and dental education and expanding numbers of postgraduate foundation training places. They are expected to work in partnership with HEIs in delivering the workforce and to provide opportunities for development for staff at all levels as part of their overall investment plan.

In 2007/08, a range of KPIs for the MPET allocation were agreed with SHAs. Performance against these indicators was first assessed in summer 2007. A further review is under way. There is good evidence about the effectiveness of the arrangements for 2008. Most SHAs have achieved most of their KPIs or are on track to do so by 31 March.

The MPET allocations (excluding student bursaries) for 2008/09 have been uplifted by 6 per cent. This provides the resource for SHAs to develop the workforce required to deliver patient services, to offer routes into professional training and other training opportunities for staff at all levels.

The arrangements for 2008/09 are being agreed.

Recommendation 23: Funding flows for postgraduate medical education and training should reflect training requirements and the contributions of service and academia. The current MPET review should lead to a clearer contractual basis reflecting both agreed volumes and standards of activity and should recognise the service contribution of trainees and the resources required for training

I accept the importance of having a clear approach to the funding and commissioning of education and training. Work is under way with experts in this area as part of the NSR to develop a new approach that will sustain the NHS in the future.

The NSR will report by the end of June 2008.

Recommendation 24: The Medical Postgraduate Deanery function in England should be formally reviewed

Recommendation 25: The Medical Postgraduate Deanery accountability links to deaneries should be reviewed

The Medical Postgraduate Deanery function in England was formally reviewed in 2004, leading to the current arrangements of deanery accountability to SHAs.

These recommendations are linked to considering the appropriate infrastructure for postgraduate medical education as a whole. This will be considered more widely with recommendation 47 (to establish an NHS:MEE) as part of the NSR.

Recommendation 26: The foundation school concept should be developed further as graduate schools on a trial basis

A graduate school is a managerial unit for delivering foundation programmes at a level that is smaller than a deanery but functions alongside local deaneries, colleges, service bodies and academia to inform workforce planning and commissioning.

This is a matter for SHAs, postgraduate deaneries and other stakeholders.

Recommendation 27: To incentivise trusts to give education and training sufficient priority they should be integrated into the Healthcare Commission's performance reporting regime

Recommendation 29: Training implications relating to revisions in postgraduate medical education and training need to be reflected in appropriate staff development and job plans. Compliance should form part of the core standards

Performance assessment by the Healthcare Commission has been a powerful incentive for levering up the performance of healthcare organisations.

As part of the annual health check, the Healthcare Commission performance assesses healthcare organisations' compliance to core standard 11 as set out in *Standards for Better Health* by ensuring that:

- ‘staff concerned with all aspects of the provision of health care
- (a) are appropriately recruited, trained and qualified for the work they undertake;
 - (b) participate in mandatory training programmes; and
 - (c) participate in further professional and occupational development commensurate with their work throughout their working lives.’

This informs the Healthcare Commission's overall judgement of whether or not organisations have given the education and training of staff sufficient priority.

We will discuss with the Healthcare Commission how education and training performance might be assessed for the 2008/09 annual health check.

Legislation is currently going through Parliament to establish a care quality commission. Future arrangements for reporting through a care quality commission performance assessment will need to be considered in due course.

Recommendation 28: Responsibility for the local delivery of postgraduate medical education and training should form part of the explicit remit of medical directors of trusts

It is important that trusts take responsibility for delivering postgraduate medical education and training. The responsibilities of medical directors are a matter for those individuals and their employers.

Changing the balance of incentives for education and training will raise its profile within organisations.

NHS Employers may wish to consider how they take this recommendation forward with employers.

Section 9: Streamlining regulation

Recommendation 30

30. *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.*

The Inquiry report sets out the regulatory context for medical education. The importance of an independent UK-wide statutory regulator that ensures standards across postgraduate medical education and works with colleges and deaneries is not in question. The Inquiry was positive about the contribution PMETB has made to postgraduate medical education. It has demonstrated that it is operating increasingly effectively across its range of responsibilities.

PMETB's key achievements include:

- publishing the first-ever generic standards for postgraduate training across all medical specialties, bringing consistency and greater transparency to the postgraduate training of doctors;
- approving curricula for all 57 medical specialties, plus 33 subspecialties, against new standards for curricula drawn up by PMETB. When PMETB assumed its statutory powers in 2005, fewer than half of the specialties in the UK had a defined curriculum;
- ensuring input from lay and service representatives as part of its approval process;
- ensuring clear career pathways for those wishing to pursue a career in academic medicine;
- undertaking the first-ever national survey of postgraduate medical trainees. The first survey in 2006, which was organised with the support of the Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD), attracted nearly 25,000 usable responses – a 64 per cent response rate;
- reaching agreement on a comprehensive quality framework for postgraduate medical education which builds from the first two years of PMETB's work;

- issuing over 11,200 certificates in all specialties (including general practice) since it went live in September 2005;
- handling of the GP CCT 'bulge', ensuring a high standard of service and rapid turnaround for these and all CCT applications;
- developing and introducing new equivalence routes to specialist registration. Prior to PMETB's establishment there were limited pathways for doctors who had not followed a traditional training programme to join the specialist or general practice registers and consequently their career development opportunities were limited. Since September 2005, PMETB has reached decisions on over 1,800 applications for equivalence to the specialist and general practice registers.

The issue raised by the Inquiry was not about the undoubted contribution of PMETB, but about where its function should fit. It took the view that the regulator should sit across the continuum of medical education, from undergraduate studies through to revalidation and continuing professional development.

The report sets out the arguments in favour of the GMC taking on the overarching role. The White Paper *Trust, Assurance and Safety* proposed reviewing the effectiveness of the arrangements in 2011. There is an important work programme for postgraduate medical education over the next few years. In considering change and timing we need to take account both of the need for service and continuity and also the need to make progress over the next few years.

I have accepted the Inquiry's recommendation to merge PMETB with the GMC at the soonest possible time. The legislative process means that this will not be before 2010. We will publish a timetable for doing so once a plan has been worked through.

I am very conscious of the progress PMETB has made and the significant contribution they have made to postgraduate medical education. They have put in place a much-needed and valued programme of work. Their work on the quality framework and their toolkit in particular are excellent achievements. This is work that needs to be continued, both in the run-up to and after the merger. I look to their stakeholders and to the GMC to work with PMETB during this time to ensure that this success is built on. The PMETB contribution to the regulation of medical education has been significant and I will be looking to both organisations to establish a joint business continuity plan to ensure that the good work PMETB has begun can continue.

Section 10: The structure of postgraduate medical training

Recommendations 31 to 45

31. *Under the Medical Act, Universities already have responsibility with regard to FY1. By breaking the employment linkage with FY2, it will be possible to guarantee an FY1 position in the new graduate's local Foundation School subject to prevailing local selection processes. The employment linkage between FY1 and FY2 should cease for 2009 graduates.*
32. *FY1 should be reviewed to ensure that i) harmonisation with year 5 is optimised; ii) the curriculum more clearly embraces the principles of chronic disease management as well as acute care; iii) competency assessments are standardised and robust. In future, doctors in this role should be called 'Provisionally Registered Doctors'.*
33. *Foundation Year 2 should be incorporated as the first year of Core Specialty Training. This will require broad based 'theming' of the current FY2 provision. The acquisition of competences of the current Foundation Programme should continue across FY1 and first year of Core pending formal review of this curriculum and development of detailed Core curriculum objectives.*

The current commitment to FY2 GP placements should continue as part of Core Specialty Training and be developed further as resources permit. Doctors in Core Specialty Training should be called Registered Doctors.
34. *At the end of FY1 doctors will be selected into one of a small (e.g. 4) number of broad based specialty stems: e.g. medical disciplines, surgical disciplines, family medicine, etc. During transition, 'run-through' training could be made available after the first year of Core, for certain specialties and/or geographies that are less popular than others. Core Specialty Training will typically take three years and will evolve with time typically to encompass six six-month positions. Care will be taken during transition to ensure that the curricula already agreed with PMETB are delivered and the appropriate knowledge, skills, attitudes and behaviours are acquired in an appropriately supervised environment.*
35. *For those who remain uncertain regarding career destination there will be opportunities for competitive transfer between the Core stems during years one and two. For a minority, therefore, Core training might thus extend to 3.5 to 4 years.*
36. *Colleges, Specialist Societies and Service should work together to provide modularised curricula for Specialist Training, overseen by NHS:MEE working in conjunction with the relevant authorities in the Devolved Administrations. In this way it will be ensured that the curricula forwarded to the Regulator for approval will embrace the necessary transferability/flexibility as well as the needs of service.*

37. *Satisfactory completion of assessments of knowledge, skills, attitudes and behaviours will allow eligibility for*
- i selection into Staff Grade positions in the relevant broad area or*
 - ii selection into Higher Specialist Training.*

Doctors in Higher Specialist Training, in all specialties including general practice, will be known as Specialist Registrars.

38. *Staff grade positions must be destigmatised and contract negotiations rapidly concluded. A new nomenclature should be agreed with those in such positions. The advantages of the grade (accrual of experience in chosen area of practice, consistent team environment) need to be made clear. Doctors in these posts should have access to training overseen by Postgraduate Deaneries and CPD opportunities. They should be able to make a reasonable limited number of applications to Higher Specialist Training positions according to the normal mechanisms. The capacity to achieve CESR through the Article 14 route and CEGP through Article II should be retained.*
39. *Doctors should be allowed to interrupt their training for one year or longer by agreement to seek alternative experience that enhances their career and contribution to the NHS, having regard to service need. The Regulator in conjunction with the Royal Colleges will determine whether experiences should contribute to completion of training subject to appropriate competency assessment. Postgraduate Deaneries and the Regulator should positively facilitate such experiences.*
40. *Selection into Higher Specialist Training to the role of Specialist Registrar will be informed by the Royal Colleges working in partnership with the Regulator. The Panel proposes that in due course this will involve assessment of relevant knowledge, skills and aptitudes administered several times a year via National Assessment Centres introduced on a trial basis for highly competitive specialties in the first instance. A limited number of opportunities to repeat the National Assessment Centre tests following further experience will be determined.*

Candidates will apply via Postgraduate Deaneries or Graduate Schools. Application will take place three times a year on agreed dates. Save in the most exceptional of circumstances, candidates will be restricted in the number of local programmes to which they may apply (and to the number of occasions on which they may apply). They will use a common national form with specialty specific questions and will provide their standardised assessment score/ranking along with a structured CV. This will avoid the once a year appointment system with its inherent risks to service delivery. Graduate Schools linked to the 30 UK Medical Schools would reduce the size of Units of Application and address the family-unfriendly situations that arose therefrom. Shortlisted candidates will be subject to a structured interview for final selection.

41. *Integrated clinical academic training pathways in all specialties including General Practice should be flexibly interpreted and transfer to and from conventional clinical training pathways facilitated. The current Academic Clinical Fellowships in England allowing c25% of programme time for research methodology training and development of research proposals will map onto Core Specialty Training in the majority of cases but opportunities should also be available for those seeking to pursue a research career on entry to Higher Specialist Training. Strong, valued FY2 academic programmes should be integrated within Core training where desirable. Other interpretations of the Integrated Academic Training Pathway (e.g. as in Scotland) are welcomed and outcomes of the various interpretations of the pathway should be kept under review to inform future development. Opportunities during Core equivalent to ACFs should be competitively available for those wishing to develop educational, management, and public and global health skills, subject to available resource through, for example, modular Masters programmes.*
42. *Clinical lecturer posts in England will normally be coincident with higher specialist training (ST3 and beyond).*
43. *Successful completion of Higher Specialty Training as confirmed by assessments of knowledge, skills and behaviours will lead to a CCT, confirming readiness for independent practice in that specialty at consultant level. Higher specialist exams, where appropriate, administered by the Royal Colleges, may be used to test experience and broader knowledge of the specialty and allow for credentialing of subspecialty expertise. Recruitment to consultant positions may be informed by the extent of experience, by skills suited to enhanced roles, and by subspecialty expertise.*
44. *To be eligible for a Consultant Senior Lecturer appointment, the applicant should possess a CCT in the relevant specialty area. Higher specialist College exams could be tailored to limited subspecialty expertise, recognising the narrower scope of practice that some clinical academics may need to embrace.*
45. *The length of training in General Practice should be extended to five years, (three years in Core plus two years as a GP Specialist Registrar supervised by a Director of Postgraduate GP Education). Extension to five years would bring GP training in line with the other developed European countries. Opportunities should exist to accommodate late entrants to GP training with other specialist skills.*

Response

Recommendations 31 and 33 to 35: Changes to the training structure

These recommendations concern changes proposed to the postgraduate training structure. They should also be read with the response to recommendation 45, GP training (which recommends extending).

We have given particular thought to these proposals. The structures that support and facilitate training are key to the training of our future doctors.

The Inquiry heard concerns that, contrary to its aims, MMC had made training less flexible. It was felt that ‘run-through’ training forced trainees to make career decisions too early, with little scope for later changes of direction, instead of enabling them to undertake broader-based training that supported more informed career choices later, based on experience.

The recommendations propose addressing this by revising the training structure to break the link between the current two foundation years and incorporating F2 in four new core specialty stems. This would be followed by open competition to specific programmes of higher specialty training (although for a transition period, run-through training would continue where required by certain specialties and in certain locations). In this way, it is proposed that the core principles identified in the Inquiry report – broad-based beginnings, flexibility and an approach that encourages an aspiration to excellence – would be embraced.

The structure of training is the visible face of MMC – visible to those who want to train, those in training and those who deliver and supervise training. The training structure needs to be sufficiently flexible both to enable the development of the workforce required to meet patient and service needs and to match the aspirations of doctors in training so far as this is possible. It is important that this balance is right so that we are able to select the right doctors at the right stage of their training and then to train them well.

I am also conscious of other key messages from the Inquiry and the lessons learned from the experience in 2007.

Firstly, until the work to define the future roles of doctors generally (recommendation 5) is complete, there is a strong argument that it is unclear to what ends and outcomes postgraduate training is being delivered. It seems wise to reach a conclusion on these questions before considering the training structure required to produce that workforce.

I have also been struck by what the Inquiry says about the need to consult with the medical profession and to achieve consensus (where possible) before implementing major change. I strongly support the recommendation that policy development be evidence-based, and I agree with the clear messages from the Inquiry report that caution against rushing implementation of further change.

I am also aware that there is some contentiousness about these specific proposals.

For example, recommendation 31 about the Foundation Programme found that 60 per cent of its 398 F2 respondents did not feel that F2 added value. However, in PMETB's evidence to the health select committee, a larger survey of 2,500 F2 doctors undertaken by PMETB was cited. They found that 75 per cent of respondents thought it was 'very good'. There have also been representations from the organisations responsible for managing the delivery of training (for example COPMeD, the Committee of General Practice Education Directors (COGPED), English deans and the National Association of Clinical Tutors (NACT)) that report encouraging feedback from foundation trainees and have requested a full five years of development and evaluation for the current Foundation Programme.

Similarly, I am conscious that some specialties believe that run-through training will best meet their needs beyond the 'transition period' suggested in the recommendation. This was demonstrated in the DH consultation in September 2007, which gave a broad consensus on the proposals that will be implemented in August 2008 for a 'mixed economy' of training structures to meet the needs of individual specialties (ie allowing the continuation of run-through training in some specialties). Those specialties which most need flexibility have already started the process of decoupling. Consequently, it seems sensible to evaluate whether the MMC 2008 model of training meets the needs of stakeholders before making further changes.

Maintaining the 2008 structure for a further period also has the advantage of minimising disruption and reducing the confusion implicit in having different cohorts undertaking training within different structures. I believe a period of stability would be welcomed by trainees and the service alike. It also provides the opportunity to explore other options. I am aware of support for this approach from the deaneries and other NHS organisations.

Finally, the Inquiry's recommendation is that training arrangements should be UK-wide. I understand that the Devolved Administrations are proposing that there should be no immediate changes to the training structure for the reasons cited above. The Scottish Government and Welsh Assembly Government are consulting stakeholders on this point. I agree that ideally a UK-wide training structure should be sought, and I would be concerned about making changes in England that were not reflected in Scotland, Wales and Northern Ireland.

I am conscious of the reasons underpinning the Inquiry's recommendations and agree with the sentiments that underpin much of the thinking. However, the arguments – also presented in the Inquiry report – for deferring a decision on this group of recommendations are persuasive.

For these reasons, I have decided to defer the decision on these recommendations at this stage. I believe all stakeholders (the profession, the service and the Devolved Administrations) will welcome a period of stability after the turbulence of 2007. That said, these are important recommendations and, following the principles set out in the Inquiry report, we will return to them in the light of evaluation of the current arrangements, exploration of alternatives (particularly linked to the debate about the future role of the doctor) and piloting and testing of any new proposals. In this way, decisions will be based on evidence and informed consensus.

Recommendation 32: Elements of F1 should be reviewed

I agree with this recommendation.

The UK Foundation Programme Office has been commissioned to lead on all three elements of the recommendation and the necessary action has been agreed as part of its business plan for 2008/09.

Recommendation 36: Colleges should work together to provide modular curricula for specialist training, to ensure transferability and flexibility and to meet the needs of the service

I agree with this recommendation in principle.

I understand that some work has been already been done by the colleges on transferable competencies. However, underpinning further work should be a better understanding of the roles of clinicians in the future, as described in recommendation 5. I look forward to this being developed further by the Royal Colleges.

**Recommendation 37: Satisfactory completion of assessments will determine eligibility to staff grade positions or selection into higher specialist training
Doctors in higher specialist training should be known as 'Specialist Registrars'**

Recommendation 38: Staff grade contract negotiations should be concluded and a new nomenclature should be agreed. The opportunities to gain experience through working in the grade should be better articulated. Doctors in these posts should have access to training and be able to make a reasonable limited number of applications to higher specialist training

I agree with these recommendations.

There is a strong desire to support staff grade doctors. Proposals on a new contract have been approved for transitional implementation in England. The titles of the training grades are linked to the national contracts agreed by NHS Employers and the BMA. The

nomenclature for staff grade doctors has been changed by NHS Employers, with the BMA's agreement, to 'Specialty Doctor'.

Subject to ballot, the new contract will be implemented from 1 April 2008. The proposed contract supports the thrust of the recommendation.

In addition, DH has:

- provided recurrent funding to support the development of staff grade and associate specialist doctors. £5m was provided by DH from 2007/08. A further £7m for specialty doctors and associate specialists was announced on 26 February for 2008/09 and beyond as part of the contract package; and
- worked in collaboration with NHS Employers to produce *An Employer's Best Practice Guide for Specialty Doctors*. This guide provides advice and information on how the additional funding can be best used. It will be published shortly after agreement of the contract.

Doctors occupying specialty doctor posts will be eligible to apply for specialty training posts in the same way as other people seeking these posts.

Recommendation 39: Doctors should be allowed to interrupt their training to gain experience that enhances their career and the contribution they make to the NHS

The arrangements for defining breaks in training are set out in *A Guide to Postgraduate Specialty Training in the UK* ('the Gold Guide').

Arrangements have to be approved locally by the postgraduate dean. They cover taking time out of training to support trainees in:

- undertaking PMETB prospectively approved clinical training which is not a part of the trainee's specialty training programme;
- gaining clinical experience which is not approved but may benefit the doctor (for example working in a different health environment or country) or help support the health needs of other countries (for example with Médecins Sans Frontières, Voluntary Service Overseas or supporting global health partnerships – ie in line with the Crisp Report);
- undertaking a period of research; and
- taking a planned career break from the specialty training programme.

Recommendation 40: Selection into higher specialist training will be informed by the Royal Colleges working in partnership with the regulator

I agree this recommendation in principle.

The MMC England Programme Board has agreed a programme of work to pilot and evaluate new selection methodologies. This is set out in the response to recommendation 7. The pilots comprise Royal College and deanery-led projects to test recruitment and selection methods.

The recruitment process for specialty training programmes will be developed in partnership with stakeholders through the MMC England Programme Board and informed by the pilots and experience of recent national recruitment processes.

The Programme Board has already agreed in principle that there should be multiple recruitment rounds.

Recommendation 41: Integrated clinical academic training pathways in all specialties including general practice should be flexibly interpreted and transfer to and from conventional clinical training pathways should be facilitated

The Government welcomes and supports the recommendation.

The academic clinical training programme will continue to evolve to ensure that supportive career management and mentoring of junior doctors is core to the programme. Medical school leadership and involvement will be key to delivering this, working in partnership with their local NHS to ensure full clinical training opportunities for these young doctors.

Recommendation 42: Clinical lecturer posts in England will normally be coincident with higher specialist training (ST3 and beyond)

I agree with this recommendation.

Recommendation 43: Completion of higher specialty training will lead to a CCT. Higher specialist exams may be used to test experience and broader knowledge and allow credentialing expertise. Recruitment to consultant positions may be informed by experience, skills and expertise

I agree with this recommendation in principle. However, it also requires that there be an understanding of the types of roles and posts doctors will fill in the future. This links to recommendation 5.

As I noted in my response to recommendation 5, consideration of how the role of clinicians needs to develop is under way as part of the NSR.

Recommendation 44: To be eligible for a consultant senior lecturer appointment, the applicant should possess a CCT in the relevant specialty area. Higher specialist college exams could be tailored to limited subspecialty expertise, recognising the narrower scope of practice that some clinical academics may need to embrace

I agree with this recommendation in principle. However, the universities are responsible for setting the criteria for consultant senior lecturer appointments.

Recommendation 45: The length of training in general practice should be extended to five years

I think that this recommendation warrants serious consideration.

The Inquiry also intimated that the design of general practice training should be resolved by the relevant Royal Colleges. General practice has a notable record of developing and implementing training, including curricula development and the general practice selection process. I therefore also agree that, in principle, further work should be profession-led, under the auspices of the Programme Board arrangements, and with the relevant general practice and general practice education partner organisations such as COGPED and the BMA's General Practitioners Committee and wider stakeholders.

I am also conscious of the need for the extended general practice training programme to be developed alongside other changes. The work taking place on how the roles of clinicians needs to develop (see recommendation 5) is important in deciding exactly how this recommendation is taken forward, particularly given the significance of and value to primary care of the wider team.

I am also clear that there are good reasons for ensuring that general practice training is developed to a timescale and in a way that allows the right links to be made to the further development of specialty training. There are shared issues of workforce planning, transition, cost and wider service impact to be considered for the service as a whole.

For that reason, I envisage that the work should take place in a way that allows common issues to be considered alongside the work to take forward the development of recommendations 31 and 33 to 35. This will also allow training as a whole to be developed in the light of evidence and testing and built on a consensus-based approach. I also envisage implementation beginning – on whatever basis is appropriate – from 2011.

Section 11: New recommendations

46. *The Panel recommends that urgent attention should be given both to ways in which a more flexible approach to EWTD could be legitimately embraced (e.g. separation of service and educational contracts). Due regard should also be given to whether additional compensatory mechanisms (which have been the subject of valuable but as yet unpublished scoping studies) can offset any further reduction in clinical experience. DH should explore contractual solutions. The profession, service, Medical Schools and Deaneries should come together to define compensatory approaches.*
47. *The Panel recommends the formation of a new body, NHS Medical Education England (NHS:MEE). This body would fulfil the following functions [the relevant related recommendations are referred to in square brackets]:*
- *Hold the ring-fenced budget for medical education and training for England [recommendation 23]*
 - *Define the principles underpinning PGMET [recommendations 1, 2]*
 - *Act as the professional interface between policy development and implementation on matters relating to PGMET [recommendations 3, 18]*
 - *Develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery [recommendations 12, 13, 17]*
 - *Ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the Regulator on the resultant synthesis [recommendation 14]*
 - *Coordinate coherent advice to Government on matters relating to medical education [recommendation 18]*
 - *Promote the national cohesion of Postgraduate Deanery activities [recommendations 24, 25]*
 - *Scrutinise SHA medical education and training commissioning functions, facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained [recommendation 22]*
 - *Commission certain subspecialty medical training [recommendation 12]*
 - *Act as the governance body for MMC and future changes in PGMET [recommendation 6]*

- *Work with equivalent bodies in the Devolved Administrations thereby promoting UK wide cohesion of PGMET whilst facilitating local interpretation consistent with the underpinning principles*

NHS:MEE would be accountable to the SRO for medical education [recommendation 21] and be advised by an Advisory Board with professional, service, academic, employer, BMA and trainee representation [recommendation 7]

Recommendation 46: European Working Time Directive (EWTD)

The Government supports using legitimate flexibility within the EWTD legal requirements. We negotiated an extension of up to 12 years to help the NHS prepare for full implementation of the EWTD for doctors in training.

In addition, the Government will continue to seek amendments to the EWTD to address the remaining problems from the SiMAP and Jaeger (European Court of Justice) cases. This includes more flexibility over the timing of compensatory rest breaks (for missed rest) and ensuring that time on-call in the workplace (not spent on active duty) is not counted as working time.

However, the specific suggestion that training time be discounted from working hours is unrealistic as it does not have the agreement of all Member States, which would be required to amend the Directive.

I agree that lessons must be learnt from studies to ensure that doctors in training get the most out of available training time. There are a number of projects under way to support this, including one led by the Royal Colleges of Surgeons and Anaesthetists. In addition, Sheffield University is researching how doctors can maximise learning from 'on the job' training and the benefits of 'wet lab' simulation exercises for trainee surgeons. I welcome the impetus given to these projects by this recommendation. The Government will work with the NHS and medical leaders to ensure that lessons from the scoping studies to support clinical experience are shared widely.

Recommendation 47: NHS Medical Education England

As mentioned in Section 1: Context, this new recommendation is the single most significant addition to the interim report and, as such, requires very careful consideration to ensure that decisions are informed by evidence and evaluation before DH responds fully.

The Workforce Planning, Education and Training (WPET) work, which is part of the NSR, is addressing many of the substantial issues raised by this Inquiry recommendation and others under its four workstreams:

- future clinical roles;
- workforce planning;

- education commissioning and funding; and
- education structure and professional regulation.

The proposal for an NHS:MEE needs to be considered alongside this work. The NSR is due to report by the end of June.

To take this forward, we need to be clear about the medical education functions that will be needed in the future, and how they relate to other parts of the wider health, education and training system. Proposals will be taken forward in a way that reinforces the Inquiry's approach, that is, it will be evidence-based and built on consensus among the key stakeholders.

Annex A: Terms of reference of MMC England Programme Board

In terms of high-level responsibilities, the Programme Board will:

- be accountable for providing governance to the programme and for identifying the policies and practices that are to be recommended to ministers;
- provide professional and service leadership for the design, testing and implementation of the programme and be accountable for the changes; and
- be the forum where all interests are considered and where any trade-offs between different interests are reconciled.

At a detailed level, the Programme Board is responsible for ensuring that:

- training posts for 2008 are filled by high-quality and appointable candidates;
- the principle of curriculum-based training is supported and delivered;
- training is supported by capacity in the service to deliver training to a high standard;
- the needs of academic medicine are recognised in order to promote the excellence of medical care; and
- progress in programme implementation is monitored and that the risks to delivery of the programme are reviewed regularly and managed within acceptable levels.

Membership of the Programme Board

Members of the Programme Board will:

- have a high level of credibility with their constituency;
- be able to allocate sufficient time and have the flexibility required to make an effective contribution;
- be able and willing to represent broad professional and service interests and not just the interests of their particular constituency;
- have a good understanding of postgraduate medical education and support the high-level principles of MMC; and
- be willing to compromise and negotiate solutions to issues which may have no 'right answer' and often no consensus, even within constituencies.

The Programme Board is co-chaired by David Sowden as SRO and David Haslam as an Academy representative.

The names and representative bodies of Board members are given in **Annex B**.

The group will have ready access to legal advice.

Deputies will only be allowed exceptionally, on a named basis and by agreement of the Chairs.

When required, external experts may be invited to attend meetings in order to contribute to specific items.

Membership will be reviewed as considered appropriate by the Board.

Openness and confidentiality

The principle underlying the working of the Programme Board will be one of openness and transparency. Members will be encouraged to consult with their constituencies on specific issues raised in the meetings, while being sensitive to the risks of discussing ideas in development. Where it is necessary for papers or specific information presented or discussed at meetings to be kept confidential, this will be clearly indicated.

Accountability

Ultimate responsibility for the programme as a whole at official level will rest with Clare Chapman, Director General of Workforce and senior sponsor for MMC on the NHS Management Board. She will have a formal role in recommending changes to workforce policy to ministers. This is reflected in the overall programme governance arrangements. David Sowden is MMC SRO and is accountable for the programme to Clare Chapman. He is also accountable professionally to the CMO, the Government's principal medical adviser.

Clare Chapman is accountable for consulting with the NHS Management Board and is accountable for progress to the Department of Health's Departmental Board. The CMO is a member of both Boards.

The Secretary of State and ministers will expect regular progress reports.

UK governance

Congruence across the UK is desirable and will be achieved through a UK Co-ordinating Group. In governance terms, this group lies alongside the Programme Boards or their equivalents in each of the four countries.

The purpose of the UK Co-ordinating Group will be to ensure excellent communication between the four Departments of Health, to ensure that the principles of MMC are adhered

to, to identify commonalities and to recognise and manage any divergence in policy or implementation. This arrangement ensures commonality for the benefit of trainees and the programme and allows the flexibility required to support a more devolved approach in the future.

Meetings take place virtually on a monthly basis, and quarterly face-to-face. Monthly meetings comprise the four CMOs, their lead officials and the MMC England SRO. The quarterly meetings include cross-UK organisations and the Chairs of the separate Programme Boards.

Terms of reference, membership and minutes of meetings will be shared between the UK Co-ordinating Group and the Programme Boards or their equivalents in each of the four countries.

Wider engagement and working practices

It is proposed that the Programme Board will convene time-limited topic-based working groups, drawn from a wide range of partners, to address key issues in detail. It is also proposed that the groups will produce and present papers to the Programme Board for discussion. The working groups will have the additional benefit of engaging a wider group of stakeholders, given the need to restrict the size of the Programme Board in order to ensure that it functions effectively.

Agenda

The agenda and papers will be circulated at least four days before each meeting.

Minutes and actions

The draft minutes and actions will be circulated to the Board within four working days of the meeting. The Secretariat will be provided by DH.

Annex B: Membership of MMC England Programme Board

Members

David Haslam, President, Royal College of General Practitioners (Co-Chair)
David Sowden, Senior Responsible Owner MMC, Department of Health (Co-Chair)

Mary Armitage, MMC Senior Clinical Adviser, Department of Health
Steve Barnett, Director, NHS Employers
Clare Chapman, Director General of Workforce, Department of Health
Paul Dimitri, Academy of Medical Royal Colleges, Trainee Doctors' Group
Neil Douglas, President, Royal College of Physicians of Edinburgh
Ian Gilmore, President, Royal College of Physicians of London
Barbara Hakin, Chief Executive, NHS East Midlands
Jacky Hayden, Dean of Postgraduate Medical Studies, North Western Deanery
(Interim Deputy for Deans)
Judith Hulf, President, Royal College of Anaesthetists
Johann Malawana, Deputy Chair, BMA Junior Doctors Committee
Patrick Maxwell, Academy of Medical Sciences
Ram Moorthy, Chair, BMA Junior Doctors Committee
Anne Rainsberry, Director of People and Organisation Development, NHS London
Geraint Rees, Deputy Chairman, BMA Medical Academic Staff Committee
Bernard Ribeiro, President, Royal College of Surgeons of England
John Rostill, Chief Executive, Worcestershire Acute Hospitals NHS Trust
Graham Smith, Chief Operating Officer MMC, Department of Health
Ian Wilson, Deputy Chairman, BMA Central Consultants and Specialists Committee

Deputies

Lisa Cotterill, Director, National Co-ordinating Centre for Research Capacity Development
Ron Kerr, Chief Executive, Guy's and St Thomas' NHS Foundation Trust

Observer

Peter Rubin, Chairman, PMETB

In attendance

Sir Liam Donaldson, Chief Medical Officer, Department of Health
Professor Sir Bruce Keogh, NHS Medical Director, Department of Health



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