ASPIRING TO EXCELLENCE

FINAL REPORT OF THE INDEPENDENT INQUIRY INTO MODERNISING MEDICAL CAREERS

LED BY

PROFESSOR SIR JOHN TOOKE

PANEL

■ CHAIR: PROFESSOR SIR JOHN TOOKE ■ SUE ASHTIANY ■ SIR DAVID CARTER ■ DR ALLAN COLE
■ SIR JONATHAN MICHAEL ■ PROFESSOR ALY RASHID ■ PROFESSOR PETER C SMITH
■ PROFESSOR STEPHEN TOMLINSON ■ CHIEF OPERATING OFFICER: DR KATIE PETTY-SAPHON

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ABSTRACT

MMC sought to reform postgraduate medical education and training to speed the production of competent specialists. Reform comprised: a two year foundation programme; centralised selection into 'run-through' specialist training; the creation of fixed term specialist training appointments (FTSTAs); revisions to the non-consultant career grade.

The Inquiry systematically analysed areas of concern arising from MMC: 1 Policy; 2 Professional engagement; 3 Workforce analysis; 4 Regulation; 5 Education and selection; 6 Training

ISSUES

1. The policy objective of postgraduate medical training is unclear. There is currently no consensus on the educational principles guiding postgraduate medical training. Moreover, there are no strong mechanisms for creating such consensus.

2. There is currently no consensus on the role of doctors at various career stages.

3. Weak DH policy development, implementation, and governance together with poor inter- and intra-Departmental links adversely affected the planned reform of postgraduate training.

4. Medical workforce planning is hampered by lack of clarity regarding doctors' roles and does not align with other aspects of health policy. There is a policy vacuum regarding the potential massive increase in trainee numbers. Planning capacity is limited and training commissioning budgets are vulnerable in England now that they are held at SHA level.

5. The medical profession's effective involvement in training policy-making has been weak.

6. The management of postgraduate training is currently hampered by unclear principles, a weak contractual base, a lack of cohesion, a fragmented structure, and in England, deficient relationships with academia and service.

7. The regulation of the continuum of medical education involves two bodies: GMC and PMETB, creating diseconomies in terms of both finance and expertise.

8. The structure of postgraduate training proposed by MMC is unlikely to encourage or reward striving for excellence, offer appropriate flexibility to trainees, facilitate future workforce design, or meet the needs of particular groups (e.g. those with academic aspirations, or those pursuing a non-consultant career grade experience). It risks creating another 'lost tribe' at FTSTA level.

commissioning and management; 7 Service implications. The Panel proposed corrective action to resolve issues in the eight domains listed below. The resulting Interim Report with its associated Recommendations was published on 8 October 2007. Consultation on the Report revealed strong agreement. 87% of the 1440 respondents agreed or strongly agreed with the 45 Recommendations:

CORRECTIVE ACTION

1. There must be clear shared principles for postgraduate medical training that emphasise flexibility and an aspiration to excellence.

2. Consensus on the role of doctors needs to be reached by the end of 2008 and the service contribution of trainees better acknowledged.

3. DH policy development, implementation and governance should be strengthened. DH should appoint a lead for medical education, and strengthen collaboration, particularly the health:education sector partnership.

4. Workforce policy objectives must be integrated with training and service objectives. Medical workforce advisory machinery should be revised and enhanced. SHA workforce planning and commissioning should be subject to external scrutiny. Policies with respect to the current bulge in trainees and international medical graduates should be urgently resolved.

5. The profession should develop a mechanism for providing coherent advice on matters affecting the entire profession.

6. The accountability structure for postgraduate training and funding flows should be reviewed. Revised management structures should conform to agreed principles but reflect local circumstances. In England Graduate Schools should be trialled where supported locally.

7. PMETB should be merged within GMC to facilitate economies of scale, a common approach, linkage of accreditation with registration and the sharing of quality enhancement expertise.

8. The structure of postgraduate training should be modified to provide a broad based platform for subsequent higher specialist training, increased flexibility, the valuing of experience and the promotion of excellence.

CONCLUSION

To deal with many of the deficiencies identified and to ensure the necessary concerted action, the creation of a new body, NHS:Medical Education England (NHS:MEE) is proposed. NHS:MEE will relate to the revised medical workforce advisory machinery and act as the professional interface between policy development and implementation on matters relating to PGMET. It will promote national cohesion In England as well as working with equivalent bodies in the Devolved Administrations to facilitate UK wide collaboration.

The Inquiry has charted a way forward and received a strong professional mandate. The Recommendations and the aspiration to excellence they represent must not be lost in translation. NHS:MEE will help assure their implementation.

EXECUTIVE SUMMARY

The Consultation on the Interim Report into Modernising Medical Careers has generated strong support for the 45 Recommendations, with 87% of respondents signalling agreement.

The Interim Report identified eight areas in which corrective action was necessary. The proposed corrective action was largely endorsed namely:

1 There must be clear, shared policy objectives and guiding principles for Postgraduate Medical Education and Training (PGMET) that are wherever possible evidence based. The original principles of 'broad based beginnings' and flexibility should endure and a guiding principle for the future should be an aspiration to excellence.

2 Outcome focused medical education and intelligent workforce planning demand consensus on the role of doctors at every career stage.

3 DH policy development and alignment, and governance should be strengthened. The lead for medical education should be explicit. Relevant interdepartmental links should be strengthened and the health:education sector partnership fostered at all levels.

4 Workforce policy objectives should be integrated with training and service objectives. Medical workforce advisory machinery should be revised and enhanced (to include HE Sector modelling expertise, and embrace mechanisms akin to the former Medical Workforce Standing Advisory Committee, (MWSAC). SHA workforce planning and medical education commissioning should be subject to external scrutiny. Policies with respect to the current bulge in trainees and IMGs should be urgently resolved.

5 The profession should develop a mechanism(s) for providing coherent advice on matters that are of major significance to medicine (and hence the health of the population) in general.

6 The accountability structure for postgraduate training and funding flows should be reviewed. Revised management structures should conform to agreed principles but reflect local circumstances. In England the interrelationships of Postgraduate Deaneries should be reviewed and service and academic links strengthened. Graduate Schools, building where appropriate on Foundation School/Specialty School experience, should be developed where supported locally.

7 PMETB should be merged within GMC to facilitate a common philosophy and approach across the continuum of medical education and achieve economies of scale both in terms of skill and financial resource. Such arrangements will enable the linkage of accreditation with registration and the sharing of quality enhancement expertise. A rapid decision on the future regulatory framework is required to provide those involved with certainty and to facilitate the work that will flow from curriculum changes in response to the Inquiry's Recommendations.

8 The structure of postgraduate training, including the relevant selection and assessment processes, should be modified to provide a broad based platform for subsequent higher specialist training, increased flexibility, the valuing of experience and the promotion of excellence.

Notwithstanding the high level of support for all the above proposals, certain key issues were raised through the consultation process:

i) Uncoupling of Foundation

Those involved in Foundation Training are opposed to its disaggregation. Whilst acknowledging the strengths of the current provision it is quite clear

that disaggregation in an employment sense is the only way to secure the priority of a pre-registration job for all UK medical graduates. The valuable elements and integrity of the current two year Foundation curriculum should be maintained with a move to a 'themed' Core year 1.

ii) Role Issues

The focus on the role of the Doctor, very strongly endorsed by the Consultation, raises issues about the roles of other members of the contemporary healthcare team which require exploration. The debate about the nature of the CCT holder role(s) has been reignited, the resolution of which is crucial.

iii) EWTD

The compounding impact of EWTD on PGMET has been broadly acknowledged, and a new Recommendation (46) made to promote the exploration of ways of legally offsetting or compensating for this legislation.

iv) National Coordination in England – A National Body for Medical Education

Notwithstanding the devolution and decentralisation of the NHS, and indeed in part because of this, and reflecting concerns about current arrangements, the Panel recommends the creation of a new body, NHS Medical Education England, NHS:MEE. This body would resolve many of the functional deficiencies identified in the Interim Report in a coherent manner including:

- Providing a professional interface with policy makers and facilitating coherent professional advice on matters relating to PGMET.
- Defining the principles underpinning PGMET.
- Ensuring that policy, and professional and service perspectives are integrated in the construct of PGMET curricula.
- Holding the ring-fenced budget for medical education and training for England.
- Promoting the national cohesion of Postgraduate Deanery activities.
- Scrutinising SHA medical education and commissioning functions, facilitating demand led solutions whilst ensuring a national perspective is maintained.
- Commissioning certain subspecialty medical training.
- Acting as the governance body for MMC and future changes in PGMET.
- Promoting UK wide cohesion of PGMET whilst facilitating local interpretation consistent with the underpinning principles.

These proposals are captured in a new Recommendation (47) which should be urgently considered not least because the governance of resulting reforms of PGMET needs rapid optimisation.

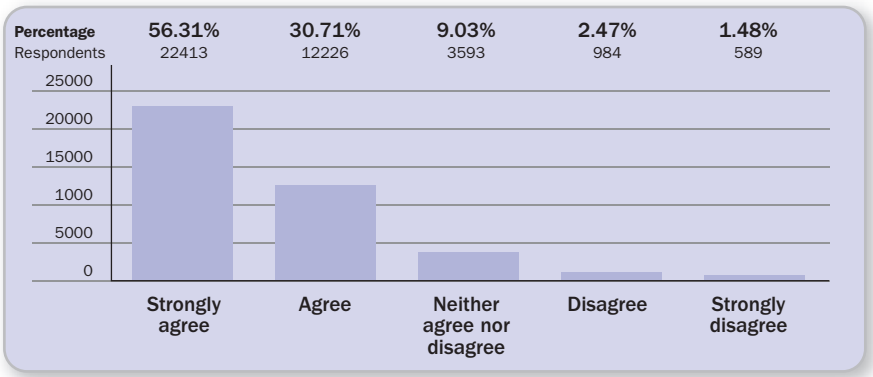
In conclusion the Recommendations stemming from the Independent Inquiry into MMC have received major support from the profession, fulfilling the Term of Reference '… to make recommendations to ensure that it has the support of the profession in the future'. There is thus a compelling mandate for the implementation of the proposals. Postgraduate Medical Education and Training in the UK is at a crossroads. A way forward has been charted that aspires to excellence. Adoption of all the Recommendations is now the priority and should be closely monitored.

INTRODUCTION

Over the last five years a new system of medical postgraduate training known as Modernising Medical Careers (MMC) has been developed and implemented across the UK. The crisis precipitated by the perceived failure and abandonment of the online Medical Training Application Service (MTAS) for selection into specialist training in Spring 2007 revealed profound concerns about MMC more generally. In response, an Independent Inquiry was established by the Secretary of State for Health in April 2007. The Terms of Reference for that Inquiry are reproduced at the back of this document.

In developing the Interim Report, evidence was drawn from forensic analysis of minutes of meetings, an e-consultation, solicited and unsolicited written submissions, oral evidence from key constituencies and individuals, and the deliberations of expert panels which dealt with service impact issues and best educational practice in terms of assessment and selection. A UK-wide perspective was gained by relating to the key authorities in all four countries. A critical element of the Inquiry involved a series of workshops throughout the UK at which junior doctors, selected by the Trusts/Hospitals in which they worked, expressed their views and preferred solutions to a range of crucial issues. The findings of the Inquiry were published in an Interim Report, *Aspiring to Excellence*, on 8 October 2007. The Interim Report was subject to consultation until 20 November 2007 involving an e-consultation, written submissions from key organisations, and meetings in England and the Devolved Administrations.

The e-consultation received 1440 responses from individuals and organisations. In addition, responses were received from 96 key stakeholder groups and a further 118 emails of support were sent to enquiries@mmcinquiry.org.uk. This contrasts with 370 consultation responses to *Unfinished Business*. Overall the e-consultation elicited 39,850 responses to the 45 Recommendations. Of these 87% agreed or strongly agreed, 9% were neutral and only 4% disagreed or strongly disagreed with the Recommendations.



The Panel is very grateful for such feedback and to those individuals and organisations that encouraged responses. To synthesise the reaction to the Recommendations, written comments, and notes from the 12 meetings across the UK where the Chair presented the findings, were considered by the Panel to extract the key issues and concerns.

This document, the Final Report of the Independent Inquiry into MMC, reflects the feedback and consultation on the Interim Report and presents the Panel's Final Recommendations. Where Recommendations have been amended or clarified compared with the original, they are identified as such, retaining the original numbering. The Interim Report contains much of the evidence base for the Inquiry Panel's final conclusions and thus this document should be considered an Addendum to the Interim Report.

In compiling this Final Report we have focused on those issues that have generated the most debate or where potential courses of action need further rationalisation. In a few instances we have introduced new evidence and proposals where applicable. We have summarised our understanding of actions already being taken to address the Inquiry's findings and/or implement the Interim Report's recommendations. And we have pointed out where urgent action needs to be taken.

KEY ISSUES AND FINAL RECOMMENDATIONS

OVERVIEW

1 Clarification of policy objectives

2 The role of the doctor

3 Policy development and governance

4 Workforce planning

5 Medical professional engagement

6 The commissioning and management of postgraduate medical education and training

7 Streamlining regulation

8 The structure of postgraduate medical training

9 New recommendations

The Inquiry has identified eight key areas which embrace the various issues and demand corrective action.

These are:

1 Clarification of the policy objectives of postgraduate medical training and the adaptation of the mechanisms (key policy instruments) by which those objectives are met.

2 Clarification of the roles of the doctor at various career stages including the service contribution of trainees

3 Strengthening of DH policy development, implementation and governance including risk management and improved collaboration between the health and education sectors.

4 Strengthening of the workforce planning capability of the DH, with an immediate priority of addressing the bulge in demand for training positions in coming years and accommodating local issues for all four nations.

5 Strengthening of the medical profession's ability to influence policy, in part by providing more coherent input.

6 Strengthening of the commissioning and management of postgraduate medical training.

7 Streamlining the regulation of the continuum of medical education.

8 Adapting the structure of postgraduate medical training in line with governing principles that embrace broad based foundations, flexibility and an aspiration to excellence.

In formulating the necessary corrective action the Panel believes that a presumption of an aspiration to excellence is crucially important if the health and wealth of our society is to be maximised in coming decades. Both health and higher education are now global commodities. It can no longer be assumed that the enviable position that postgraduate medical education (and related biomedical research) historically enjoyed in the UK will be sustained unless such issues are addressed.

The recommendations that appeared in the Interim report were constructed with the objective of seeking better alignment of purpose between postgraduate training and the needs of the NHS and of the population it serves. With this in mind the Panel also attempted to take account of other important imperatives, notably:

- The increasing shift of clinical care to the community against a backdrop of projected demographic change
- The sustenance of excellence in health sciences research
- The need for great flexibility in training programmes requiring broad-based beginnings followed by a more modular approach to specialist training. In this way the Panel hopes that a professional workforce will be maintained that is fully fit for purpose. Such an approach should also assist future workforce remodelling and redesign.
- The need to assimilate and fully utilise the increasing numbers of UK medical graduates
- The need to ensure value for money in the NHS and in particular ensure society receives maximum benefit from the major investment in medical education.

In addition, in framing the recommendations the Panel has been conscious of the increasing decentralisation of the NHS. This is to be welcomed where it facilitates locally responsive solutions and professional involvement. However in relation to postgraduate medical education and training which has important national dimensions, decentralisation should not become a mantra. In response to the consultation and concerns regarding past

failings, the Panel has developed the view that the resolution of many of the issues raised is best served by the formation in England of a new body, NHS Medical Education England (NHS:MEE), established for that purpose. The functions of NHS:MEE should include:

- Holding a ring-fenced budget for medical education and training for England
- Defining the principles underpinning PGMET
- Acting as the professional interface between policy development and implementation
- Ensuring coherent integration of policy with professional and service perspectives as curricula are developed
- Developing and coordinating coherent advice on matters relating to PGMET
- Promoting national cohesion of Postgraduate Deanery activities in England
- Scrutinizing SHA medical education and training commissioning functions
- Commissioning certain subspecialty medical training
- Liaising with equivalent PGMET bodies within the Devolved Administrations to facilitate coordination of activities at the policy:implementation interface

In the following sections we report on the degree of support for the Interim Recommendations. The Panel has reflected on the helpful feedback received during the consultation period and has modified some of the Recommendations where it believed this was appropriate. We identify implications for action and conclude with two new Recommendations.

1 CLARIFICATION OF POLICY OBJECTIVES

The Inquiry has revealed that the development and implementation of MMC has been hampered by a lack of clarity regarding the policy objectives. It does not have guiding principles that are shared by all stakeholders and wherever possible evidence based.

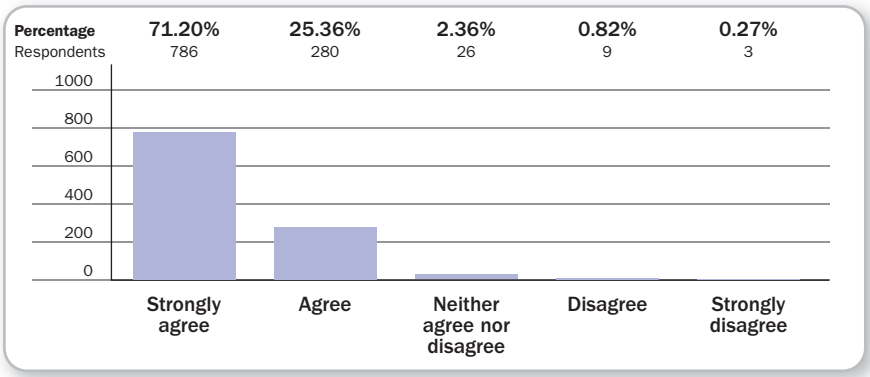
Whereas the educational principles espoused in *Unfinished Business* largely endure, critical elements e.g. broad based beginnings and flexibility, were eroded and workforce imperatives rose in prominence. In a rapidly changing world, policy will evolve but clear articulation of shared founding principles provides the reference points against which to consider such evolution. Furthermore if sufficiently well couched, such guiding principles should inform the activities of all stakeholders involved in development, implementation, management and governance, facilitating coherence of purpose. It is crucially important that the guiding principles are co-developed and co-owned.

CONSULTATION RESPONSE

The Interim recommendations associated with this area were strongly supported as summarised below:

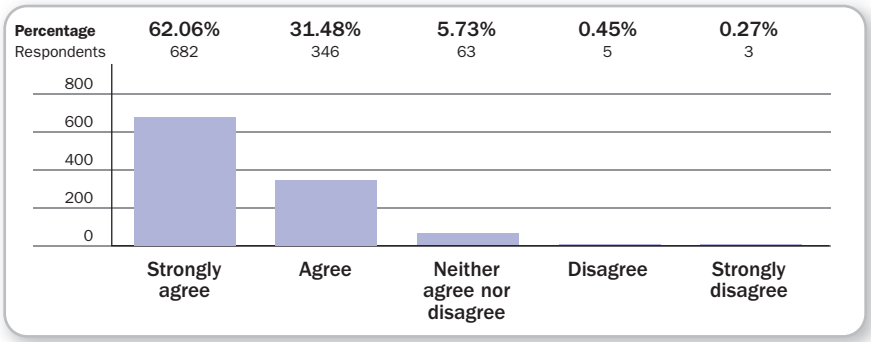
Interim Recommendation 1

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, and an aspiration to excellence. In devising policy objectives the interdependency of educational, workforce and service policies must be recognised.



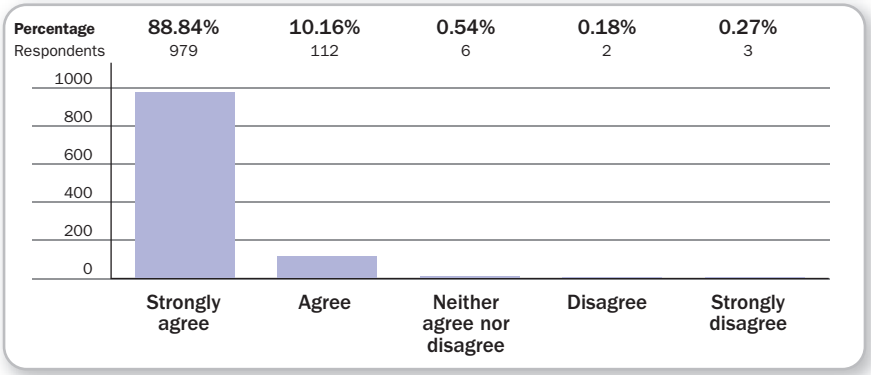
Interim Recommendation 2

Policy development should be evidence led where such evidence exists and evidence must be sought where it does not.



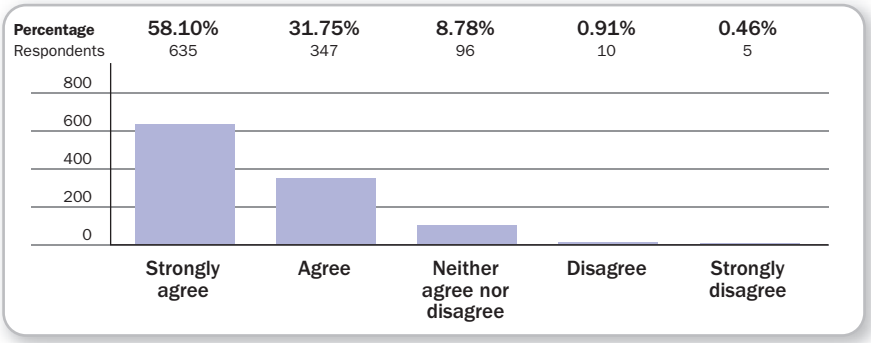
Interim Recommendation 3

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.



Interim Recommendation 4

Changes to the structure of postgraduate medical education and training should be consistent with the policy objectives and conform to agreed guiding principles.



COMMENT

Notwithstanding the overwhelming support for increased flexibility in PGMET several respondents pointed out the need to balance flexibility for the individual against national service demands, and to retain an awareness that flexibility for one may impose inflexibilities for others. The precise definition of what constitutes flexibility and excellence should not be dictated by the Inquiry Panel but co-developed by relevant stakeholders.

Some criticised Interim Recommendation 2 on the basis that sometimes action is merited in the absence of evidence (as indeed is the case in medical practice). This does not, in the Panel's view, preclude aspiring to the ideal world in which policies are evidence based.

FINAL RECOMMENDATIONS

In the light of consultation the Final Recommendations remain unchanged apart from the inclusion of the phrase 'broad based beginnings' which was inadvertently omitted from Recommendation 1.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 2

Policy development should be evidence led where such evidence exists and evidence must be sought where it does not.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 4

Changes to the structure of postgraduate medical education and training should be consistent with the policy objectives and conform to agreed guiding principles.

IMPLICATIONS FOR ACTION

It is suggested that a body such as NHS Medical Education England (NHS:MEE) [see Recommendation 47] is rapidly formed to redefine the guiding principles that should govern the nature and conduct of postgraduate medical education and training in the future.

2 THE ROLE OF THE DOCTOR

Service needs cannot be met now or in the future unless there is a clear understanding of what part each healthcare professional plays. This is particularly true for doctors and needs to be articulated for each career phase, including doctors in training and those certified as having completed specialist training.

Without such definitions it is impracticable to pursue outcome focused medical education or attempt to plan the workforce. The Inquiry revealed evidence of non-resolution of these fundamental definitions, and a lack of acknowledgement of the essential professional attributes the doctor brings to the healthcare team.

The doctor's role as diagnostician and the handler of clinical uncertainty and ambiguity requires a profound educational base in science and evidence based practice as well as research awareness. The doctor's frequent role as head of the healthcare team and commander of considerable clinical resource requires that greater attention is paid to management and leadership skills regardless of specialism. An acknowledgement of the leadership role of medicine is increasingly evident.

Role acknowledgement and aspiration to enhanced roles be they in subspecialty practice, management and leadership, education or research are likely to facilitate greater clinical engagement. Encouraging enhanced roles will ensure maximum return, for the benefit society will derive from the investment in medical education.

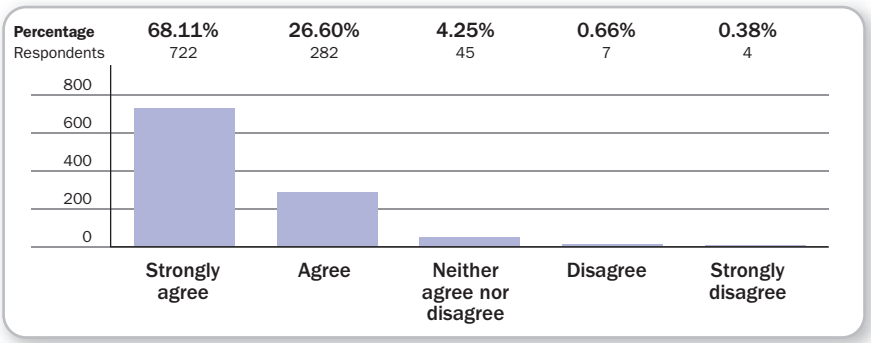
Greater acknowledgement of the service contribution of trainees will help reverse the emerging trend wherein some young doctors in training seem to see themselves as trainees first and doctors second.

CONSULTATION RESPONSE

Interim Recommendation 5 associated with this issue was very strongly endorsed, with 95% of e-consultees agreeing/strongly agreeing and only 1% disagreeing or strongly disagreeing:

Interim Recommendation 5

There needs to be a common shared understanding of the roles of the doctor in the contemporary healthcare team. Such clarity must extend to the service contribution of the doctor in training, the certificated specialist, the



GP and the consultant. Such issues need to be urgently considered by key stakeholders and public consensus reached before the end of 2008. Education and training need to support the development of the redefined roles.

COMMENT

The concerns expressed in this section resonated strongly within the profession. There is a collective sense that the acquisition of responsibility by doctors in training is 'being pushed to the right'. It is taking longer before appropriate responsibility under appropriate supervision is being taken. Role clarity is required for all doctors including those in SAS grades and locum posts.

The consultation also revealed evidence that education and training opportunities for doctors were being diminished by such experiences being used for other healthcare professionals substituting for medical practitioner roles. Although such skill mix solutions may be superficially attractive to meet service performance imperatives, they call into question the clarity of role of other contributors to the healthcare team, and whether role 'substitutors' have the necessary educational foundations to execute the roles to the required high standards. EWTD will increasingly make it harder for medical trainees to be exposed to sufficient training opportunities, further compounding this problem. It follows that given that contemporary healthcare relies upon multi-professional teamwork, clarification of the role of the doctor (and the education and training implications that stem from such an analysis) must be accompanied by similar clarification of the roles and training requirements for other professional 'clusters'. Given that other professions are to embark on 'modernising' their own 'careers' it is strongly recommended that such analysis precedes such work.

The service contribution of trainees (including undergraduates, appropriately supervised) needs to be recast as an integral part of their training, supported by highly professional education and feedback which Trusts/hospitals are motivated to provide.

Some reassurance, however, comes from a recent survey conducted since the Interim Report which suggests that more than 85% of young doctors feel they are making a significant contribution to patient care. The contemporaneous review of *Tomorrow's Doctors*, the GMC blueprint for medical undergraduate education, provides an opportunity to explore whether greater and more challenging service experience can be gained under appropriate supervision during the later stages of the undergraduate programme. This would promote earlier acquisition of responsibility and compensate in part for lost exposure through EWTD.

As with the consultation response to *Unfinished Business*, considerable concern focused on the nature of the CCT holder, the contemporary interpretation of the consultant role and fears regarding the creation of a 'sub-consultant' grade. The specialist/consultant debate needs, in the view of the Panel, to separate out issues of nomenclature and terms and conditions from functional roles.

In the Panel's view CCT holders must be capable of independent practice in their specialty area. In the past on completion of specialist training and appointment as a consultant, individuals often assumed a broader set of responsibilities e.g. for service development and management, regardless of their attributes for such roles. Most consultants on appointment today are joining a team and it is unlikely that they will lead service development in the early years of their tenure. There are several implications from this analysis:

i) The 'consultant role' may be variously interpreted.

ii) There needs to be professional preparation for the enhanced roles to which consultants aspire e.g. in education, management and research.

iii) Not all consultants will aspire to, and/or have the attributes to pursue enhanced roles.

iv) Hospitals (and GP partnerships) will have an increasingly clear view of the contribution they wish the new appointee to assume; in some specialties this may mean the assumption of a set of responsibilities commensurate with the historic role of the consultant, in others a more confined service provision role may be preferred.

If this new interpretation of the consultant role can be acknowledged, the nomenclature does not need to change, rather the functional content made more explicit. If the consultant contract is used as intended to facilitate pay progression primarily on the basis of contribution rather than seniority this too does not need to change, nor does a new specialist grade and contract need to be negotiated. Clarity on these issues is urgently required to provide trainees with clear goals and to inform the educational preparation required for enhanced roles.

The broader issue of the roles of the doctor in the contemporary healthcare team, and how this relates to other members, needs wide discussion and societal engagement. Several consultees commented that it would be difficult to reach resolution on such important issues by the end of 2008. In the Panel's view resolution is urgent given the current Review of the NHS which must reflect on the contribution of members of the healthcare team. Although such clarity is necessary for planning purposes we accept that it is an issue that needs continual review as the different roles evolve.

FINAL RECOMMENDATION

In the light of consultation the Final Recommendation 5 has been amended as detailed below:

FINAL RECOMMENDATION 5

There needs to be a common 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.

IMPLICATIONS FOR ACTION

Several professional constituencies have started work on this pivotal issue including the Royal College of Physicians, the Medical Schools Council, the BMA, and others.

Work is also being conducted by the NHS Review team on this topic and the related consideration of the roles of other members of the healthcare team.

A meeting is planned for 21/22 October 2008 to celebrate the 150th Anniversary of the Medical Act of 1858 to draw together the various workstreams and hopefully to establish consensus.

3 POLICY DEVELOPMENT AND GOVERNANCE

The Inquiry revealed evidence of DH deficiencies in policy making with ambiguous accountability structures for policy development, and very weak governance and risk management processes. The added complexity of the four nation nature of MMC was not properly accounted for in project management terms. Regardless of the future structure of postgraduate medical education and training these issues must be addressed and steps taken to restore the trust of the profession in the Department's capability.

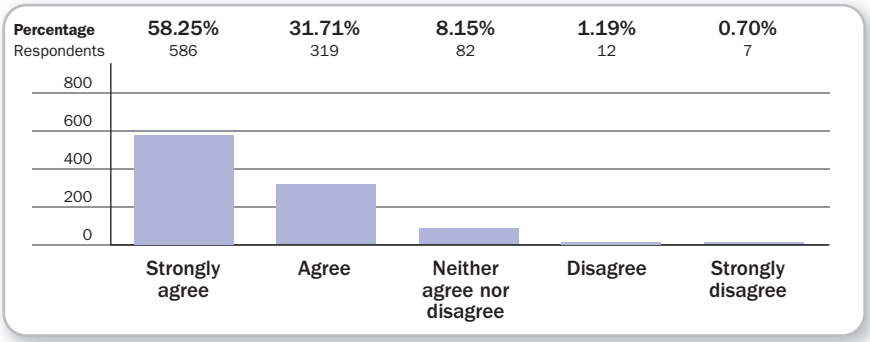
Postgraduate medical education and training is closely integrated with the NHS, involves the University sector and is of key relevance to certain UK industries. The Inquiry revealed that educational links with service are suboptimal and there has been an erosion of the health:education sector partnership in recent years. These key linkages need to be re-established at national and local level if policy development and implementation is to reflect such interdependence.

CONSULTATION RESPONSE

The relevant interim recommendations (6–10) received strong support:

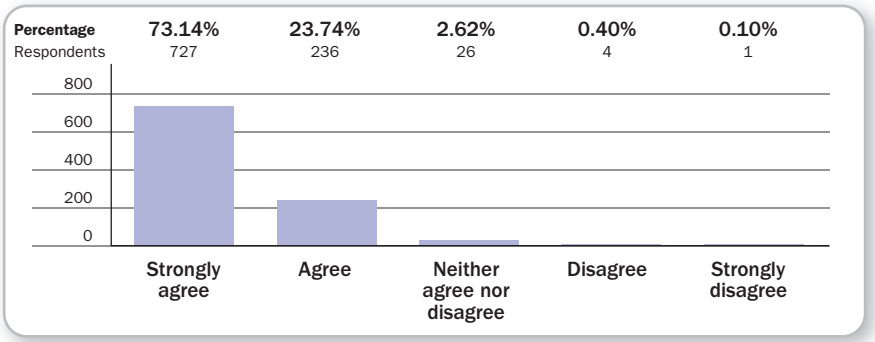
Interim Recommendation 6

DH should strengthen policy development, implementation, and governance for medical education, training, and workforce issues, 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'.



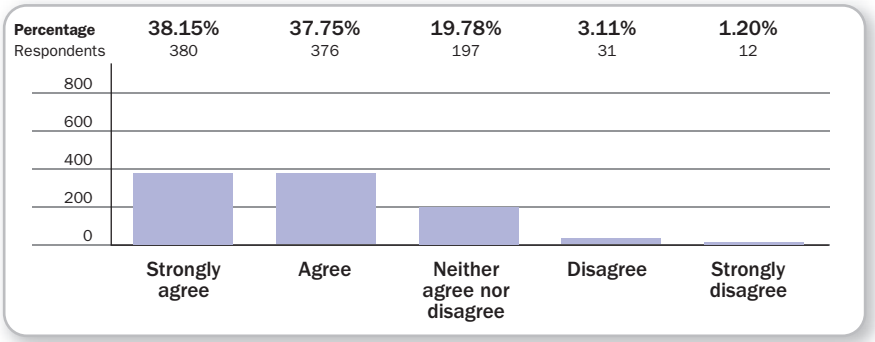
Interim Recommendation 7

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 include trialling where appropriate and feasible, iii) be subject to rigorous monitoring and evaluation.



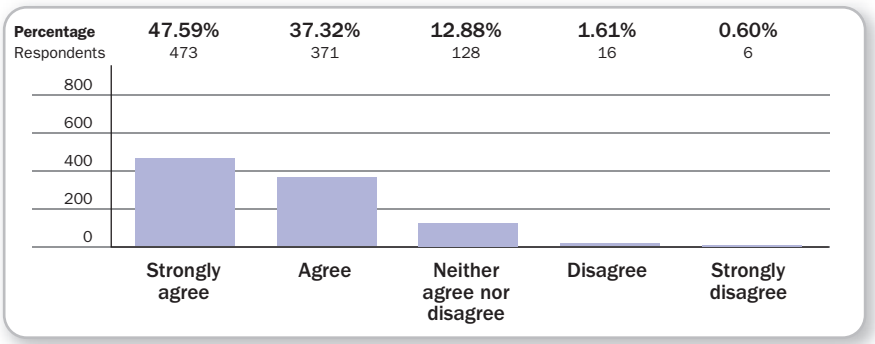
Interim Recommendation 8

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.



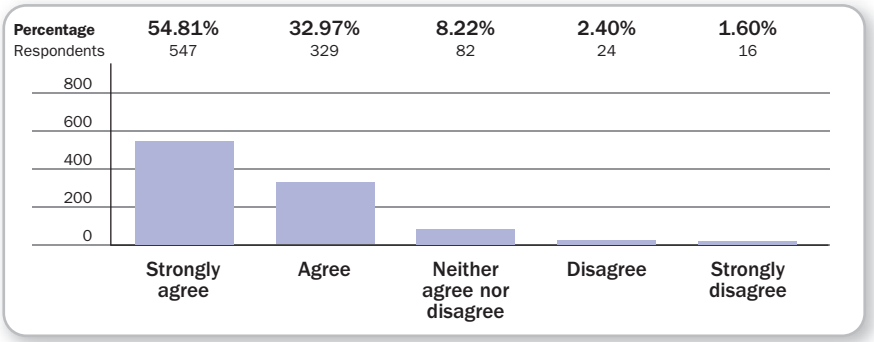
Interim Recommendation 9

At a local level Trusts, Universities and the SHA 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.



Interim Recommendation 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.



COMMENT

Recurring themes to emerge from the consultation were the need to separate Policy Development (co-developed by the Department of Health and the profession) from implementation, and the need to professionalise implementation particularly with respect to project management. There is a prevailing concern that implementation issues have resulted in policy shifts by DH to suit one constituency at the expense of another.

The Panel has received strong representations that the CMOs should be accountable for matters relating to medical education.

Recent reports suggest that better links are being forged between SHAs and Higher Education Institutions in England although scrutiny and oversight of these developments is needed and solid evidence needs to be provided. Such links remain to be replicated at national level.

In view of the overwhelming professional support for the Recommendations and anxieties expressed regarding their implementation, progress checks will be required in the coming months.

FINAL RECOMMENDATIONS

In the light of consultation Recommendations 6 and 9 are changed as follows. Recommendations 7, 8 and 10 remain unchanged.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

IMPLICATIONS FOR ACTION

DH has initiated workstreams to strengthen governance and accountability and will need to make explicit the structures and terms of reference. The Panel believes that the creation of NHS:MEE will assure a better professional interface with matters relating to policy, appropriate scrutiny of SHAs with regard to PGMET and facilitate UK-wide collaboration. The CMOs' responsibilities for medical education should be made explicit to avoid any ambiguity moving forward.

Discussions have commenced on the future of the Strategic Learning and Research Advisory Group (StLaR) to ensure appropriate links between DH, DIUS (and service) at National level.

Given, in the Panel's view, the importance of implementing the Recommendations of this Final Report and the substantial support they have received, the Panel proposes to report publicly on progress towards implementation in mid 2008.

4 WORKFORCE PLANNING

In addition to the fundamental necessity of agreement on the future roles of doctors and other healthcare professionals, is the need for consistent policies for the workforce. Such workforce policies need to embrace a long term vision for the size/structure of that workforce linked not only to service objectives but also the other roles doctors undertake in management, education, research and out of programme activity such as overseas work.

The Inquiry revealed inconsistent policy objectives regarding self sufficiency in relation to doctor supply and the absence of explicit plans to deal with a burgeoning production of UK doctors secondary to medical school expansion.

The fate of those in Fixed Term Specialist Training Appointments is a particular cause for concern and they are in danger of becoming the next 'lost tribe', the very category of doctor MMC sought to avoid. The core feature of specialist training devised by MMC – 'run-through', with its reduced exposure to broad based foundations for specialist practice is in conflict with the possible future requirement to re-differentiate specialist practice as health needs and technological advance dictate.

The Panel concluded that specialty training structures and opportunities inadequately reflect the service shift towards the community and the need to deal with growing chronic disease co-morbidity in that setting. Contrary to some service perspectives, such work is in fact complex and cannot easily be subject to simple protocol led management. It is likely that the traditional distinctions between primary and secondary care will disappear as a result of the move to more integrated care pathways. The need to deliver more specialty care in the community will require the creation of more intermediary care medical roles. MMC as currently structured fails to address this future.

The complexity of medical workforce planning in an increasingly devolved NHS raises two issues: i) the adequacy of the resources allocated and ii) the siting of the function. The Inquiry believes current resources, both financial and modelling capacity, have been insufficient to deliver quality outcomes. Strong professional involvement in this activity is essential to ensure plans are co-owned and supported and to ensure that those with insight into the likely evolution of specialty practice are able to influence policy.

The Inquiry is not convinced that dividing the workforce planning and the training commissioning functions between the new SHAs will guarantee either a better outcome or national consistency in coming years. Whereas the early stages of Postgraduate Training might be handled in a devolved manner on a per capita allocation basis, a case can be made for central commissioning of higher specialist training awarded on a competitive basis reflecting the track record of the applicant Trust in service, education, innovation and research and development. Such an approach would be consistent with the competitive redistribution of NHS R&D resources and would help regenerate clinical academia in a coherent manner.

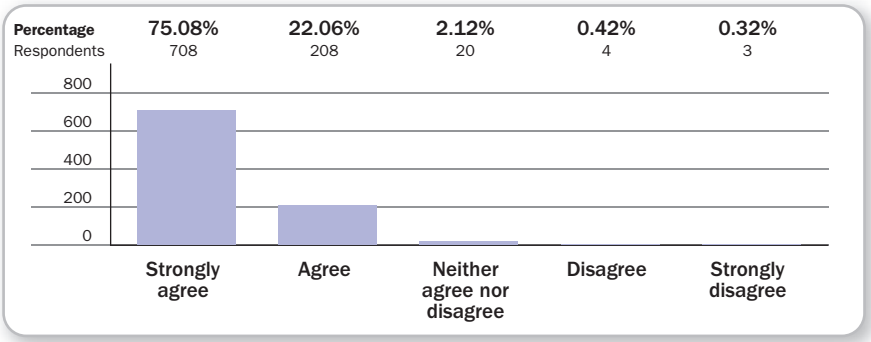
Related to workforce planning is the issue of workforce aspiration. The Panel has been struck by the inconsistency and dearth of information on career opportunities made available to medical students and doctors in training. Without such information, they are unable to make informed judgements on the likelihood of realising their first ambition.

CONSULTATION RESPONSE

The interim recommendations received strong support as summarised below:

Interim Recommendation 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. The position of overseas students graduating from UK medical schools needs to be clarified with regard to their eligibility for postgraduate training.

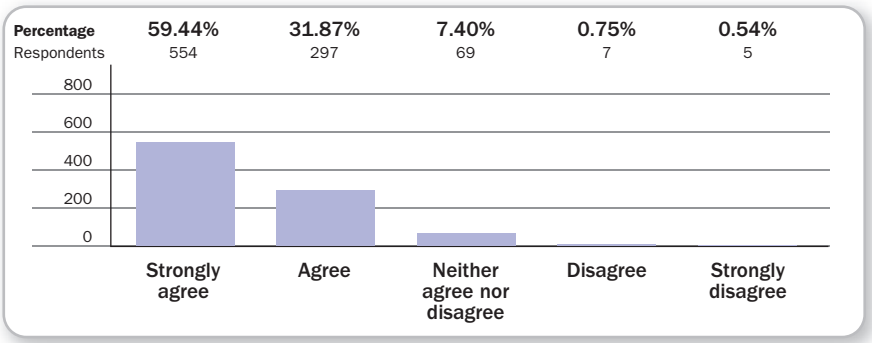


Interim Recommendation 12

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:

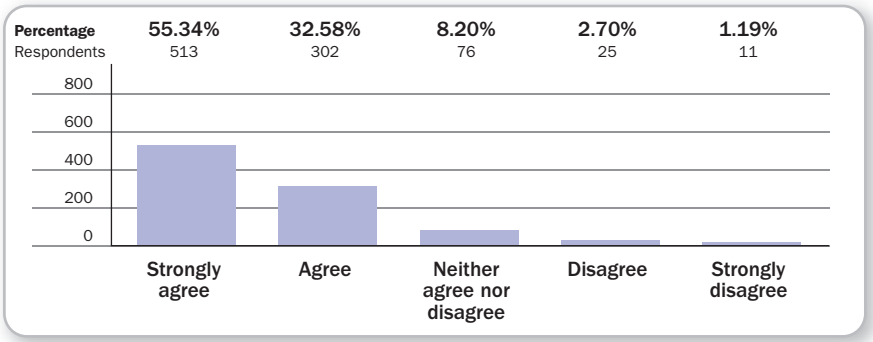
- Medical workforce planning needs to embrace the consensus view of the role of the doctor referred to in Recommendation 5
- Plans should be based on robust information on available and projected medical specialist skills, requiring relevant databases.
- Whilst recognising that doctors are just one part 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, 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, a National Institute for Health Education, NIHE, 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.

- 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.



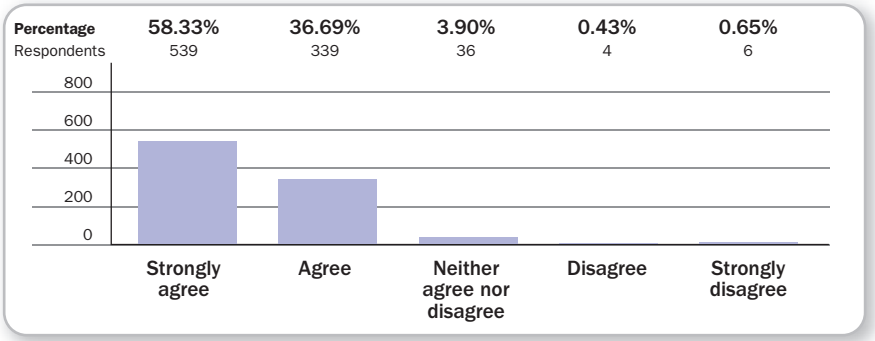
Interim Recommendation 13

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.



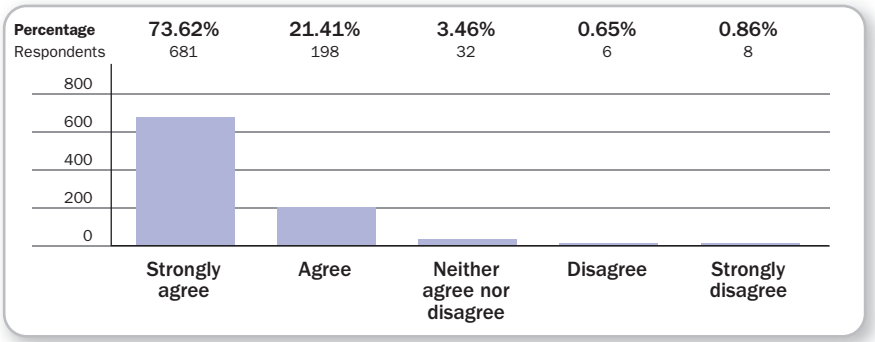
Interim Recommendation 14

The content of higher specialty training and the numbers of positions will be informed by dialogue between the Colleges, 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.



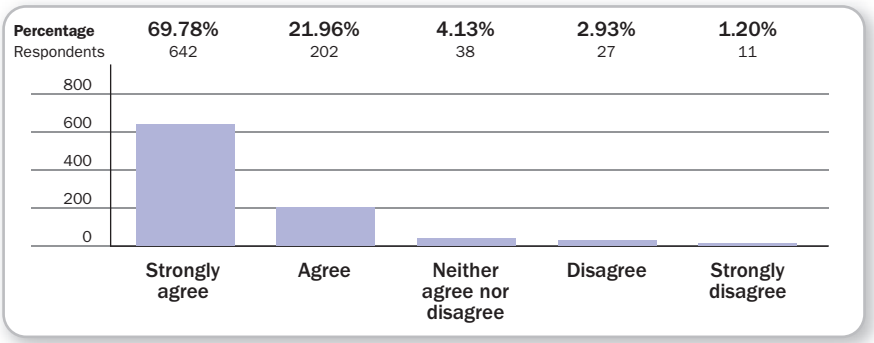
Interim Recommendation 15

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.



Interim Recommendation 16

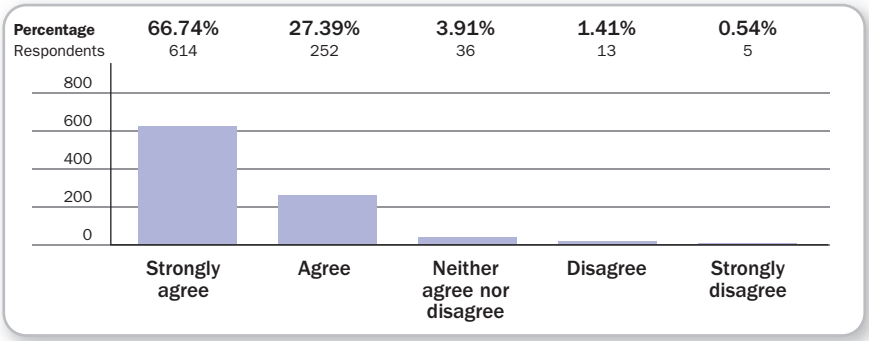
DH should recognise the burgeoning supply of medical graduates it has commissioned and make explicit its plans for the optimal use of their skills for the benefit of patients. It is recommended that sufficient numbers of Core Specialty training posts (see Recommendation 33) should be made available to accommodate doctors successfully completing FY1 and the use of commissioning funds for this purpose should be monitored.



Interim Recommendation 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.



COMMENT

Since the publication of the Interim Report the appeal against the Judicial Review ruling on the eligibility for Specialist Training of non EEA International Medical Graduates (IMGs) has been upheld. As a result it is likely that the applicant:trainee place ratio will be higher for the 2008 round for recruitment to specialist training than for 2007. Such a situation makes it even more urgent that the eligibility status of those non EEA IMGs not in educationally approved posts is finally resolved so that a coherent policy on workforce supply can be enacted.

A special case not referred to in the Interim Report is that of refugee doctors with leave to remain in the UK. It is the Panel's view that this small number of doctors should be eligible to compete for postgraduate training places, regardless of the ultimate ruling on IMGs not in this category.

The Panel also concurs with feedback that International Students who have graduated from UK medical schools should be eligible to apply for training positions until the completion of Core training on a par with indigenous UK graduates, and should be able to compete for posts thereafter.

Inevitably the SHAs wish to exercise their new workforce planning function. Such an approach is consistent with a 'demand led' strategy which is appropriate in the Panel's view. The Panel is however concerned that SHAs refer frequently to the need for new roles to provide local solutions, in the absence of agreement on what even 'old' roles should do. Notwithstanding the need for a local demand led (and service informed) analysis, in the Panel's view both a local and national perspective are necessary, not least because of the mobility of the healthcare workforce.

In Interim Recommendation 12 we referred to a National Institute for Health Education (NIHE) to undertake the commissioning of higher specialist training not required in every locality. Whereas we believe that such a solution may also be appropriate for other health professions (and would need to relate to NHS:MEE), the need for NHS:MEE is pressing and should be instigated as a priority.

In the wake of the Inquiry have come suggestions that entry into medical school be curtailed. It is the Panel's view that such an action would be precipitate. It is impossible to know whether the projected increase in medical trainees is surplus to requirements until:

- The roles of the doctor are clarified
- The impact of projected service change is modelled
- The impact of EWTD, the demands of education and training, and less than full time working are accurately assessed.

FINAL RECOMMENDATIONS

In the light of the consultation, amendments were made to Recommendations 11, 12 and 14.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.
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- 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.

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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.

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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.

IMPLICATIONS FOR ACTION

The DH has initiated a workstream as part of the NHS Next Stage Review to redesign the medical (and other healthcare professional) workforce advisory machinery.

Both NHS Employers and the Academy of Medical Sciences provide career information on their websites. The Medical Schools Council has agreed to do more to inform potential and current students about the broad range of career opportunities open to the medical graduate. They will also indicate the historic specialty distribution (including General Practice) of doctors at different career stages as well as roles outwith the NHS.

5 MEDICAL PROFESSIONAL ENGAGEMENT

Some doctors who have reported to the Inquiry fear systematic deprofessionalisation of medicine and believe this has contributed to a sense of alienation. This perception has been fuelled by changes in the regulatory environment, the consultant contract and the failure sufficiently to acknowledge the particular attributes a doctor may bring to the healthcare team. A central target driven culture may also have eroded engagement, particularly when such targets conflict with perceived clinical priorities.

In an increasingly decentralised NHS it is important that local mechanisms facilitate the involvement of doctors in the implementation of training (and service) policies, their management and adaptation for the local environment.

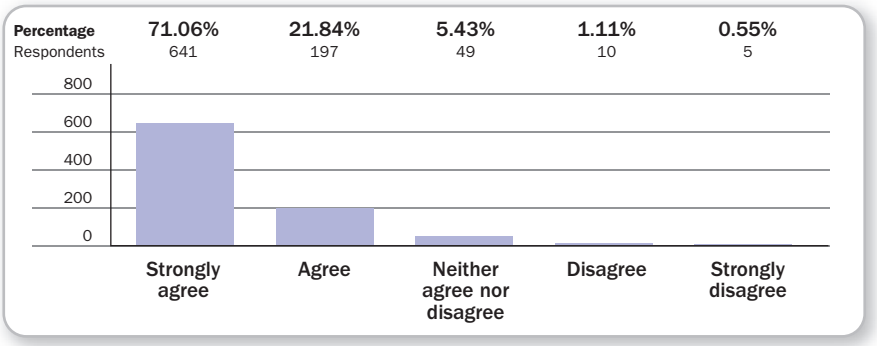
At a national level the Inquiry acknowledges that the medical profession has frequently failed to proffer coherent advice on key issues of principle, reflecting in part a very complex organisational structure, which owes more to history than necessarily function or purpose. There has been a dearth of medical professional leadership over this period. Too often opinion that could influence policy has reflected the interests of a particular constituency rather than the profession and service as a whole.

CONSULTATION RESPONSE

The Interim Recommendations resulting from these issues received strong support:

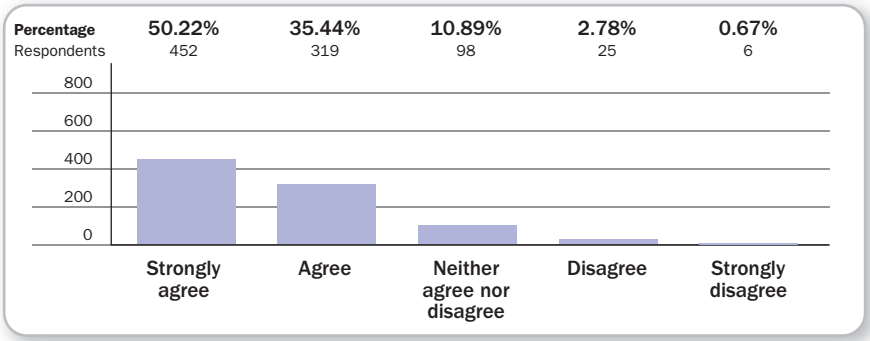
Interim Recommendation 18

The medical profession should have an organisation/mechanism that enables coherent advice to be offered on matters affecting the entire profession, including postgraduate medical education and training.



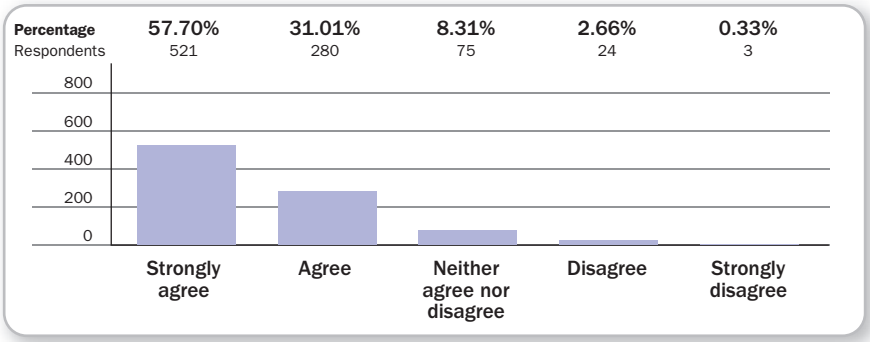
Interim Recommendation 19

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.



Interim Recommendation 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.



COMMENT

Although the consultation responses broadly acknowledged that coherent medical professional advice is crucial, the difficulty of achieving this goal was recognised. Many commented that the Academy of Medical Royal Colleges was an obvious organisation to contribute to such advice if it could find a mechanism to integrate constituents' views. An alternative or complementary approach proposed to the Panel was the creation of time limited Boards to deal with particular issues. The Panel believes that NHS:MEE could act as the locus for the development of coherent professional advice relating to PGMET.

FINAL RECOMMENDATIONS

Recommendation 18 has been amended.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

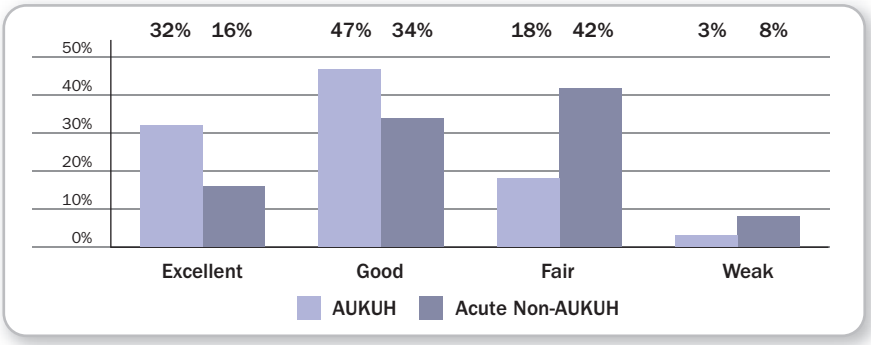
6 THE COMMISSIONING AND MANAGEMENT OF POSTGRADUATE MEDICAL EDUCATION AND TRAINING

The majority opinion of those involved in the delivery of medical education and training is that training budgets remain vulnerable if not ring-fenced for the purpose. With the devolution of training budgets to SHAs in England and cutbacks imposed in 2006/07 to resolve overall NHS financial balance that vulnerability was realised. It is not clear that the SHA is the appropriate level to commission all postgraduate medical education. Furthermore the funding structure in England is flawed and there are insufficient incentives to become involved in postgraduate medical education.

In addition to the anxieties about the current commissioning arrangements the management and governance of postgraduate medical education and training is complex involving, in England, SHAs, Postgraduate Deaneries and service providers. At present Deanery arrangements in England do not encourage career flexibility nor the necessary collaboration to optimise equity of access to specialist expertise across the country. Central accountability is unclear. Such complexity is enhanced by the lack of co-terminosity between SHA and Deanery boundaries. Employer and service links with Deaneries are suboptimal. The cohesion of Deanery function across England is also lacking.

NHS Trusts' engagement does not adequately recognise their accountabilities as employers of trainees. Employer and service links with management structures for postgraduate training must be strengthened.

There is little relationship to local Universities/Medical Schools other than in the first Foundation year in the majority of Deaneries in England (in contrast to the Devolved Administrations) despite clear demands throughout the history of the NHS for close collaboration. On the other hand, medical schools' involvement in Foundation training has been largely token, and other than in highly specialist centres, their contribution to postgraduate training limited, with the exception of clinical academic careers. Such arrangements are in marked contrast to the situation in many other developed countries. The value of such linkages is obvious in relationship to access to educational expertise and relevant bespoke courses that reflect local needs. In recent years there have been several expensive, poorly evaluated healthcare training initiatives. Cost efficiencies are likely to flow from adopting evidence based or critically evaluated approaches to education and training that acknowledge the necessary educational foundations for a particular professional role. Such approaches demand close dialogue with Higher Education providers. Notwithstanding the



Quality of Service 06/07 (Source: Healthcare Commission data)

educational benefits that could derive from a stronger partnership there is also increasing evidence that solid health:education sector partnerships drive up healthcare quality: those Trusts in England which major on education and research achieve higher scores in Healthcare Commission ratings compared to those that do not.

CONSULTATION RESPONSE

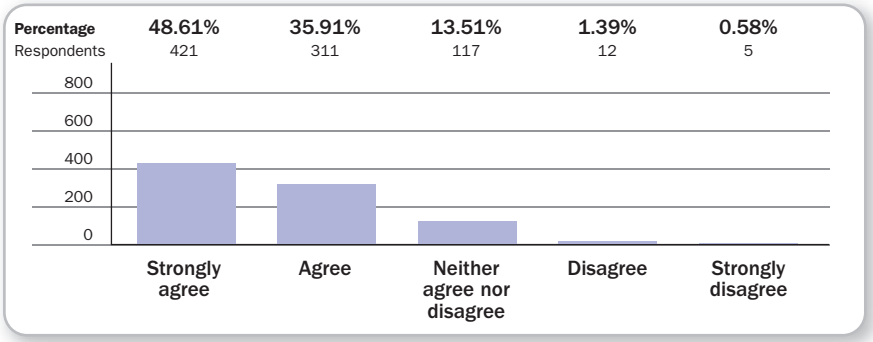
The creation of a DH Director level lead for medical education, review of SHA commissioning of training and contracts for PGMET, as well as review of the English Medical Postgraduate Deanery relationships and accountabilities received strong support.

Support for the trialling of 'Graduate Schools' was slightly less enthusiastic (69% in agreement/strong agreement compared with 9% in disagreement/strong disagreement).

There was very considerable support for introducing mechanisms to incentivise Trusts to engage fully in PGMET and for Medical Directors assuming a key role in this regard.

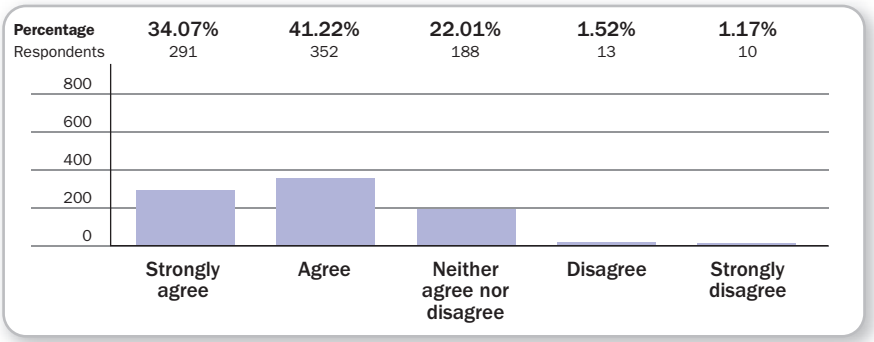
Interim Recommendation 21

A suitably qualified Director level lead for medical education within DH should be identified and act as the reference point for interactions with the medical profession including postgraduate Deans. The relationship and accountability of this lead to the following should be explicit: CMO, DH Head of Workforce, NHS Medical Director, and medical educational leads within devolved administrations.



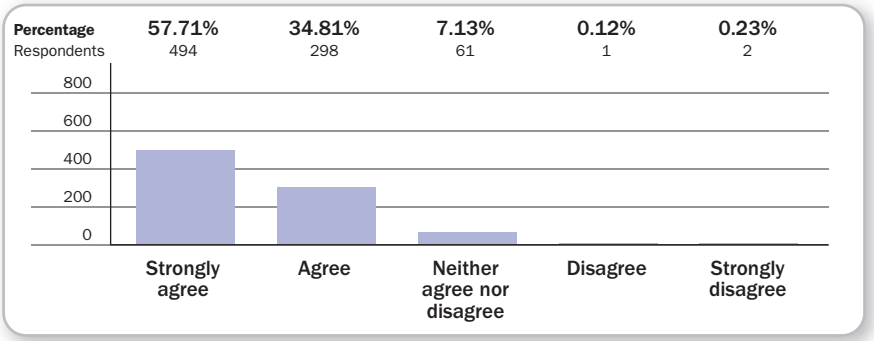
Interim Recommendation 22

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. Any deficiencies should prompt urgent consideration of a National Institute for Health Education (as outlined in Recommendation 12) assuming the commissioning function.



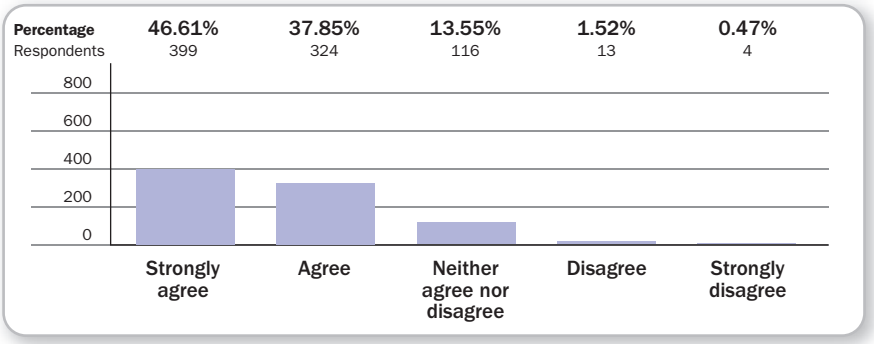
Interim Recommendation 23

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.



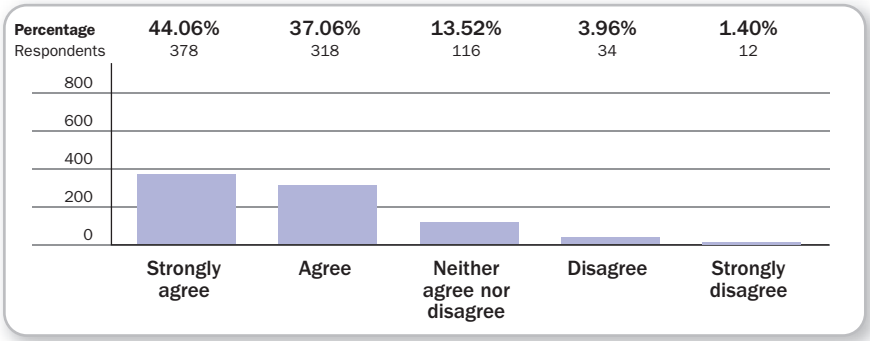
Interim Recommendation 24

The Medical Postgraduate Deanery function in England should be formally reviewed to address 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.



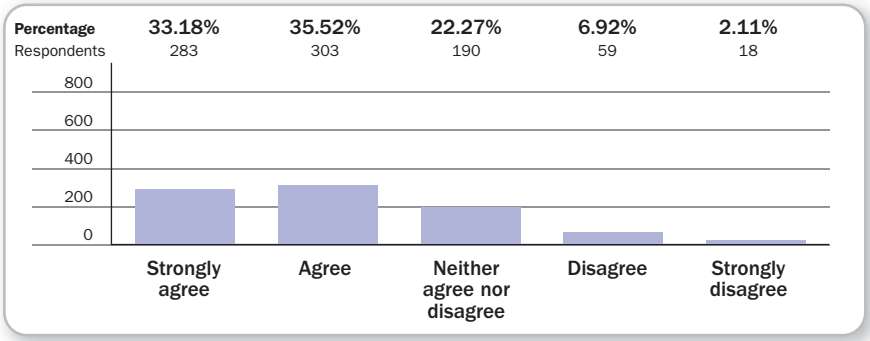
Interim Recommendation 25

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 pedagogical expertise and will facilitate the educational continuum from student to continuing professional development.



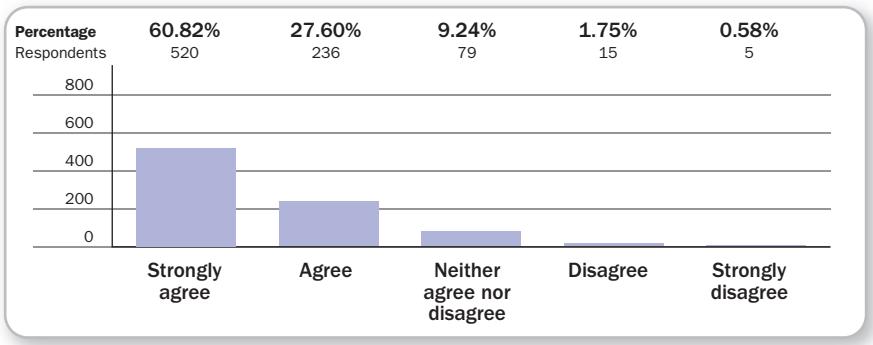
Interim Recommendation 26

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.



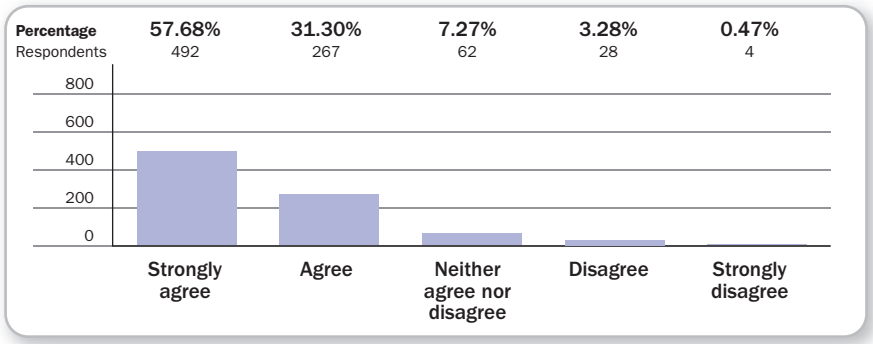
Interim Recommendation 27

To incentivise Trusts to give education and training sufficient priority they should be integrated into the Healthcare Commission's performance reporting regime.



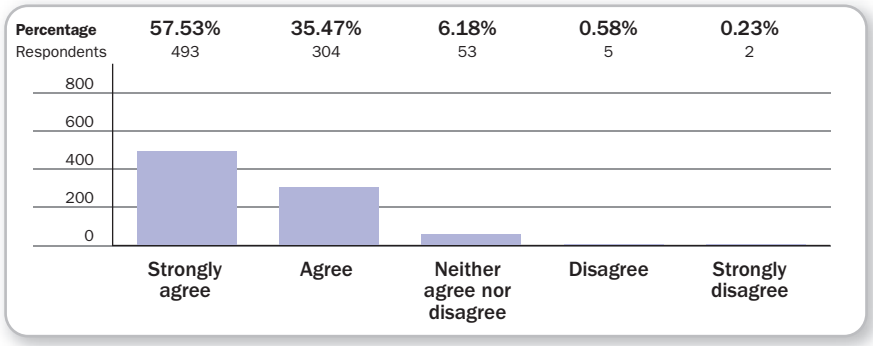
Interim Recommendation 28

Responsibility for the local delivery of postgraduate medical education and training should form part of the explicit remit of Medical Directors of Trusts. Part of that responsibility should include regular reporting to Trust Boards on the issue.



Interim Recommendation 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.



COMMENT

Inevitably feedback reflected the impact of these proposals on the relevant constituencies. SHAs claim that productive links are being forged with Deaneries, a view echoed by several Deaneries themselves. Provider organisations tend to stress that Deaneries should be more provider focused.

SHAs also maintain that they are consulting with Medical Schools. Although as intimated in section 3, relationships between Universities and SHAs appear to be improving, a survey of Medical Schools suggests that in England much remains to be achieved. Some Deaneries in England report that they are currently exploring relationships with Medical Schools, suggesting recognition of the fact that such relationships are currently suboptimal.

Several respondents have maintained that the new Specialty Schools are the same as the proposed trial Graduate Schools. It is conceivable that they might be in some interpretations but in others they appear to be simply an extension of the Postgraduate Deanery quality assurance function with little in the way of academic engagement. The Graduate School model proposed would involve all relevant constituencies and build on the success of Specialty Schools. The arguments for greater involvement with academia reflect the advantages of such partnership evident in the Devolved Administrations (and parts of England), international comparators, and the growing appreciation of the uplift in service, education and training and research that stems from a robust academic health partnership.

In the light of the amendment to Recommendation 6 wherein it is suggested that the CMOs are the SROs for medical education, Recommendation 21 has been amended as shown below.

FINAL RECOMMENDATIONS

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 26

Reflecting the fact that Postgraduate Medical Education and Training involves service, academic and workforce dimensions, it is proposed that the Foundation/Specialty 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.

FINAL RECOMMENDATION 27

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FINAL RECOMMENDATION 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.

IMPLICATIONS FOR ACTION

The NHS Next Stage Review workstream on Education and Training Commissioning will deliberate on the nature of the Service Level Agreement (SLA) between DH and SHAs in England and the contractual basis for training. It will reflect on Deanery accountabilities and relationships and the need for a national commissioning and scrutiny body. As intimated, the creation of trial Graduate Schools will reflect local circumstance and enthusiasm but several regions have, or are planning such arrangements from which others will learn.

The adoption of performance measures to incentivise Trusts to prioritise PGMET remains unresolved and needs to be addressed.

7 STREAMLINING REGULATION

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

Arguments in favour of GMC providing the overarching role are that

i it already regulates two of the three components of medical education (undergraduate and CPD);

ii it would facilitate links with registration and the creation of a medical skills database to aid workforce planning functions;

iii it has a strong reputation for quality enhancement in relation to undergraduate education;

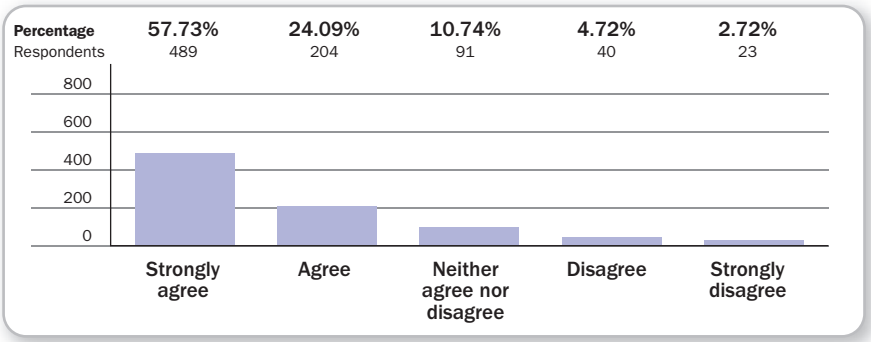
iv it is a body that reports to Parliament, rather than through the monopoly employer, relevant given the non-NHS roles doctors may pursue (e.g. pharmaceutical medicine).

CONSULTATION RESPONSE

The Interim Recommendation that PMETB should be assimilated in a regulatory structure within GMC was strongly supported:

Interim Recommendation 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.



COMMENT

Other aspects of the Inquiry have argued for better fusion of undergraduate and early postgraduate education and training and potentially an accelerated assumption of responsibility under appropriate supervision. Such calls create a further reason for a common regulatory mechanism.

Implicit in the strong support for the Recommendation is a recognition by the profession that the regulatory process must fully embrace the lay perspective, whilst retaining links with professional expertise.

Such an amalgamation is welcomed by the GMC. PMETB argues that further change would interrupt essential workstreams, particularly on the new quality framework. Of particular concern is the uncertainty for staff and organisations when such proposals are mooted. This argues for a prompt resolution of the issue particularly in view of the need for wider curricular changes resulting from the Recommendations.

FINAL RECOMMENDATIONS

In the light of consultation no amendments were made to Recommendation 30.

FINAL RECOMMENDATION 30

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IMPLICATIONS FOR ACTION

The Healthcare Regulatory Environment is being considered as part of the NHS Next Stage Review but account needs to be taken of the need for certainty and early resolution as described above.

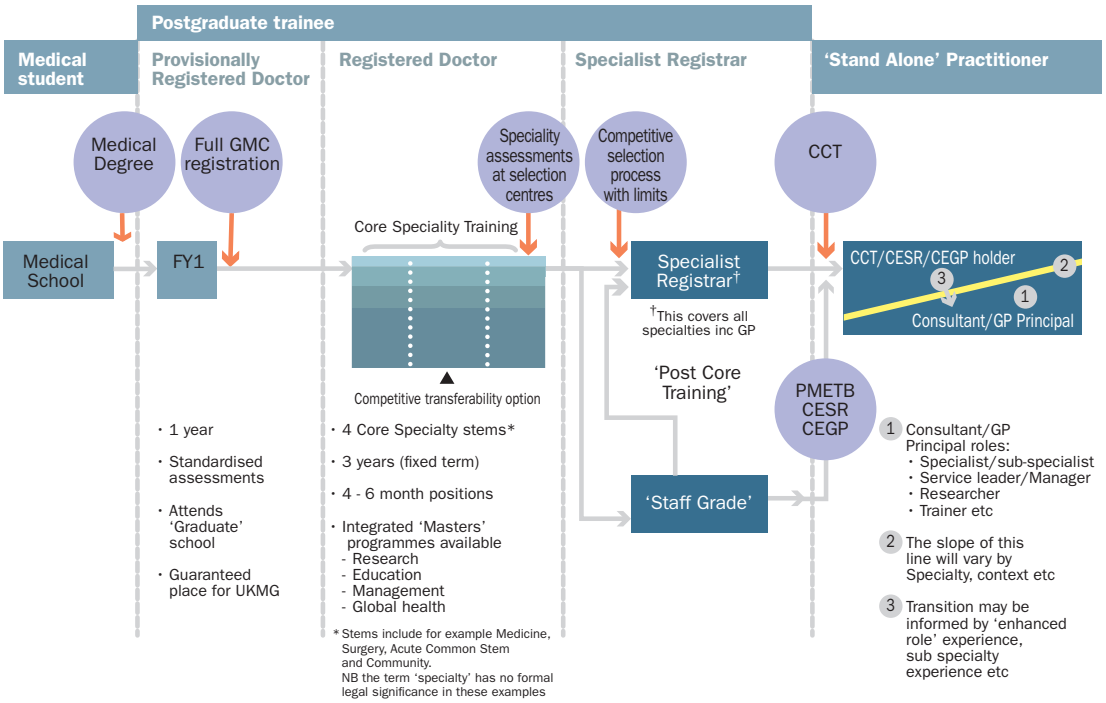
8 THE STRUCTURE OF POSTGRADUATE MEDICAL TRAINING

In considering, in the light of consultation, the future structure of postgraduate medical training the Panel's abiding concern has been that the following Core principles should be embraced: broad based beginnings, flexibility and an approach that encourages an aspiration to excellence.

Inevitably the Interim Report's proposals on the future structure have generated the most feedback although taken in the round the relevant Interim Recommendations (31–45) registered an average 82% agreement/strong agreement, with 10% registering disagreement/strong disagreement. The Panel acknowledges nonetheless that much of the 'devil will be in the detail', and a great deal will depend on the care taken to harmonise new structures with those that currently exist. Several respondents pointed out that adequate time should be allowed to introduce any new changes, with phasing and trialling as appropriate, to avoid the pitfalls that characterised the last two years of the implementation of MMC. Furthermore whatever the resulting structure it must be capable of adoption in the four nations, even If the detail differs, to enable smooth movement of trainees throughout the UK if they so desire.

To take account of the detailed comments received on the various stages of the postgraduate career we consider the different stages and their related recommendations separately below.

Postgraduate training – Inquiry recommendations



8.1 Foundation Training

A crucial consideration in formulating the Interim Report's Recommendations regarding Foundation Training was the need to guarantee an FY1 position for UK medical graduates so that they have the opportunity to progress to full registration as doctors. Universities are required under the Medical Act to assure the quality of the FY1 placement and at the end of the year of provisional registration affirm (or otherwise) that the new doctor is suitable for full registration with the GMC (see Sections 10 and 11 of the Medical Act of 1983). EU medical graduates requiring provisional registration are currently legitimately able to compete for FY1 positions. If that situation is maintained it is only a matter of time before a UK medical graduate is excluded from a FY1 position. This would prevent Universities from fulfilling their obligations to the new graduate. It would also create a situation which is totally unacceptable in the view of the Panel, namely, the new graduate, who is likely to have incurred tens of thousands of pounds debt in graduating, would be denied the opportunity to achieve registration upon which future employment will depend. By uncoupling FY1 and FY2 in an employment sense, UK medical students at entry to medical school can be guaranteed an FY1 position. The Panel has been unable to confirm any other legally defensible way in which this situation can be assured.

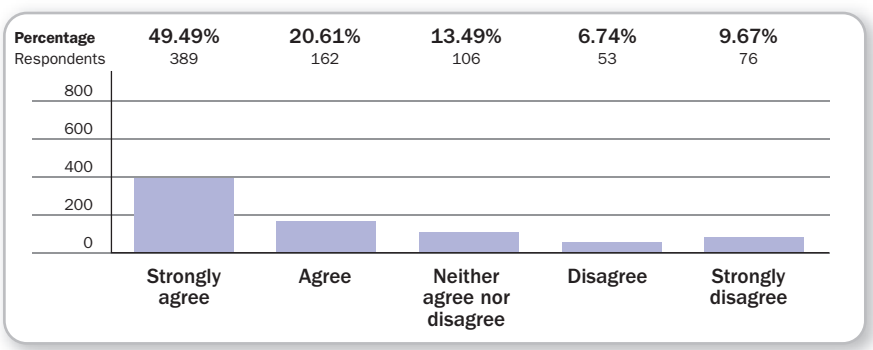
The Interim Report expressed concern that the Foundation Programme was viewed by some as a perpetuation of studenthood and may not sufficiently promote the assumption of an appropriate level of clinical responsibility. However it must be stressed that it was the need to assure FY1 placements for UK medical graduates that was the critical factor in formulating the Interim Recommendations. The Interim Report also concluded that there should be better fusion of the final year of the undergraduate curriculum with FY1. Furthermore, the assignment of clinical rotations, which in FY2 were perceived by many as too short, may not match preferences, nor provide a sufficient base upon which to make a specialty training decision (into one of 57 specialty areas) for the majority of trainees.

CONSULTATION RESPONSE

Both relevant recommendations (31 and 32) received support through the e-consultation as detailed below.

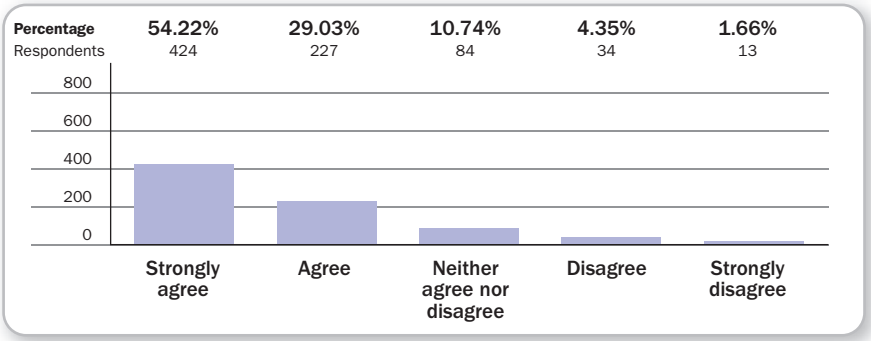
Interim Recommendation 31

Under the Medical Act, Universities already have responsibility with regard to FY1. By breaking the 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 linkage between FY1 and FY2 should cease for 2009 graduates.



Interim Recommendation 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 Pre-Registration Doctors.



COMMENT

The Interim Report's Recommendations relating to Foundation Training, although broadly supported by e-consultees, have come under the strongest criticism, particularly from those directly involved in the current Foundation programme. It needs to be emphasised that the key driver for this proposal was the need to ensure that the UK medical graduate could progress to full registration.

The Interim Report acknowledged that the introduction of Foundation training "has gone reasonably well" and that the Programme possesses "inherent strengths designed to address perceived deficiencies in the PRHO and first year SHO experience". Furthermore the Interim Report acknowledged that the Foundation Programme, unlike other MMC policy instruments, delivered against the stated training objectives and the workforce objective of a 'safe' doctor delivered service. The Panel commends those involved in devising and delivering this complex change and understands the reaction of those who have committed so much, to the suggestion that the current arrangements need revision.

The evidence relating to the operation and value of Foundation is limited and that relating to FY2 inevitably so, as the Inquiry was conducted coincident with the first iteration of this part of the programme. It is possible that the attitudes of the 450 trainees (independently identified by their Trusts/hospitals) who reflected on Foundation as part of eight separate workshops around the UK may have been coloured by the prevailing distress over MTAS. However, their views were entirely consistent with those received from the e-consultation, recorded in the Interim Report. Sub analysis of the e-consultation response from 398 FY2 doctors revealed that 60% did not feel that the year had added value over and above further patient exposure whereas 24% agreed that it did add value;16% had no opinion. Since the Interim Report further evidence has been reviewed, some of which relates to pilot schemes. Peer reviewed studies (*Beard J, et al, Med Educ 2005 Aug; 39(8): 841-51*) revealed much that was positive about the new FY2 programme but involved a very small sample (23 PRHOs) and by the authors' own admission involved a highly motivated group of trainers and trainees. A further study of 35 out of 36 trainees involved in a 2 year pilot in the Oxford Deanery (*Limbert C et al, Br J Hosp Med 2005; 9: 534-536*) reported positive views but raised concerns about ability to attend training sessions, assessments and accreditation. Whereas some trainees valued the opportunity to experience different specialties others viewed FY2 as 'a gap year', and/or wished to see rotations map into a theme.

Further evidence has now come from PMETB Pilot Inspections in W Midlands, North of Scotland and Wales and from a number of Foundation Schools in the form of surveys of Foundation doctors. The overall picture is of a programme that is increasingly valued by trainees although the inspections did find concerns about assessments and about the mechanisms used to assign FY2 rotations. A very recent study, as yet unpublished involving 36 FY2 doctors, concluded that Foundation instilled clinical confidence in the majority of trainees. On the question of duration of attachments, the study suggests confidence and a sense of meaningful contribution is greater with 6 month attachments. This differs from the counter case made by respondents that four month attachments give adequate exposure.

In the Panel's view the current Foundation curriculum is commendable at this stage of development. Furthermore the emphasis on self-directed learning and workplace assessment is welcomed. But concerns remain, as highlighted in the Interim Report, that the assessments are non-standardised, not fully owned by the assessors and at worse regarded as a tick box process.

The emphasis on competency in managing the acutely ill patient is a laudable objective but despite a statement in the Introduction to the Foundation Curriculum acknowledging the importance of chronic disease management, a burgeoning issue in contemporary healthcare, the curriculum identifies few specific learning objectives in relation to this theme. Future iterations of the early curriculum should embrace this requirement.

In consultation responses much was made of the opportunity afforded by Foundation for exposure to specialties trainees may not have considered. In the view of the Panel such an approach is random. What is required is a more systematic approach to ensure that students in particular can experience 'tasters' that may, in combination with earlier and better careers advice, enable graduates to select *broad based* Core specialty training.

The dilemma faced in relation to the future of the Foundation years embraces a number of issues:

1 The unequivocal requirement to guarantee the new UK medical graduate a pre-registration post, the fundamental reason for suggesting the 'uncoupling' of FY1 and FY2 from an *employment* standpoint.

2 The worrying statement by Foundation School Directors, submitted as evidence to the consultation, that as a result of the working time directive and other factors the 12 month pre-registration year no longer guarantees that a doctor at the point of registration will have the same level of competence as the old PRHO, implying that a two year programme is necessary to reach the standards worthy of full registration.

   A two year period of provisional registration would require an amendment to the Medical Act which could take several years, would perpetuate a sense of 'studenthood' and is unlikely to be acceptable to the new graduate. In the Panel's view it is also unacceptable if GMC registration is to mean the same thing.

   The Panel strongly believes that the issue should be addressed by enhancing the undergraduate curriculum (necessitating the better fusion of undergraduate experience with FY1 as proposed) with 'pulling back' of supervised FY1 experience into the final undergraduate year rather than perpetuating a pre-registration style status for two years. The concerns raised by Foundation Directors about the standards being reached at the end of FY1 strongly support the arguments for *standardised* competency assessment proposed in the Interim Report. *MMC, The Next Steps,* called for 'valid and reliable formative and summative assessments'. These clearly must be a priority now to be certain that the young doctor is achieving standards worthy of full registration.

3 The widely acknowledged and supported requirement for 'broad based beginnings' to postgraduate medical training in preparation for higher specialist training.

4 The need to avoid premature choice of *particular* specialty. Several respondents to the Interim Report maintained that choice of Core programme during FY1 would exacerbate premature decision making. The Panel believes there is a world of difference between choice of one of, say, four broad based common stems with transferability between Core at the end of the first or second year, and commitment to one of the 57 specialties.

The resolution of these issues will demand both change and compromise. The Panel acknowledges concerns that solutions should, where possible, be phased and evidence based. We support the Foundation Programme Directors' proposal "that a more flexible training structure may be achieved in alternative ways … (which) may include developing themed F2 programmes", These the Panel believes should be integrated into 'Core'. In this way curriculum continuity would remain despite 'uncoupling' in employment terms. We advocate that the curriculum for the Foundation years to date should form the 'foundation' for the experience of FY1 and in the future the first year of themed Core, so that valuable experience to date is not lost.

Foundation Directors also fear that the integrity of the Foundation curriculum will be lost because the Colleges will wish to enforce their own interpretation on first year 'Core' training. The Panel believes that NHS:MEE could facilitate appropriate integration to offset these concerns and those of service.

Movement to 'themed Core year 1' to replace FY2 needs to be accomplished in parallel and synchronous with i) earlier career advice and 'taster' opportunities, and ii) creation of more robust, standardised competency assessment, not only to assure that full registration standards are being achieved, but also to aid selection into Core. The aspiration to GP exposure for all Core trainees should be maintained.

'Provisionally Registered Doctor' would be a more appropriate descriptor for the FY1 doctor than 'Pre-Registration' as originally suggested.

FINAL RECOMMENDATIONS

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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'.

8.2 Core Training

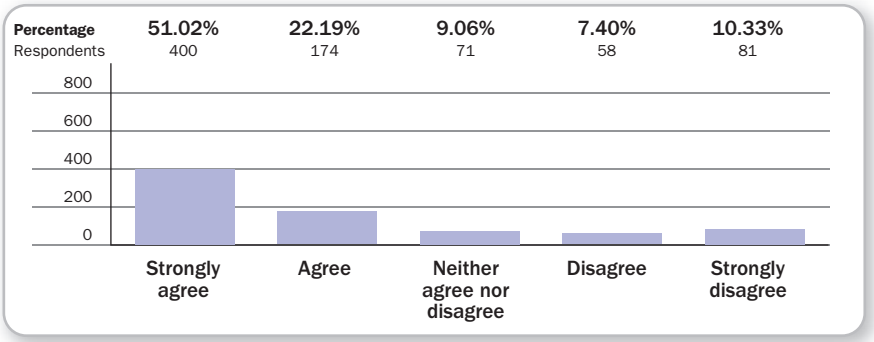
The concept of Core Training replacing current FY2/ST1/ST3 is entirely consistent with the 'broad based beginning' principle expressed by *Unfinished Business.*

CONSULTATION RESPONSE

The relevant Interim Recommendations received strong support, albeit with a significant minority (18%) disagreeing with the 'abolition' of FY2.

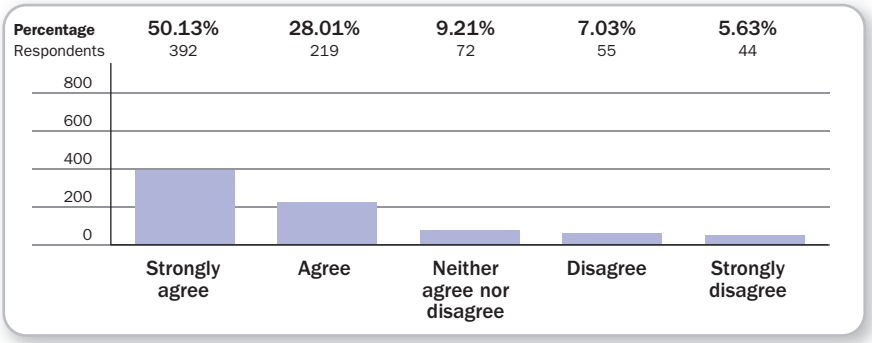
Interim Recommendation 33

Foundation Year 2 should be abolished as it stands but incorporated as the first year of Core Specialty Training. The current commitment to FY2 GP placements should continue as part of Core Specialty Training and developed further as resources permit. Doctors in Core Specialty Training should be called Registered Doctors.



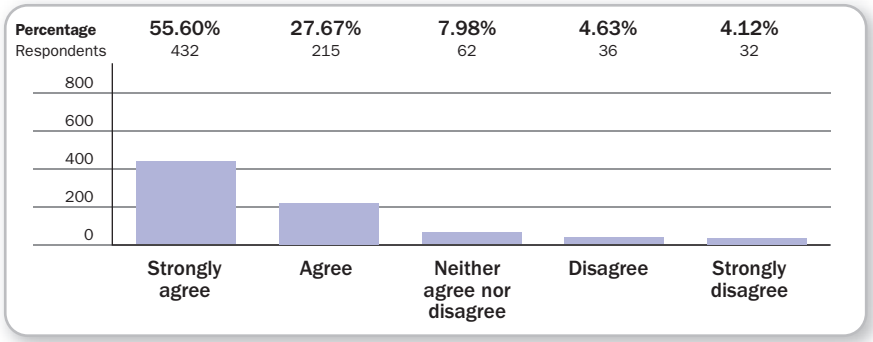
Interim Recommendation 34

At the end of FY1 doctors will be selected into one of a small 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 to encompass six six-month positions. Care will be taken during transition to ensure the curricula already agreed with PMETB are delivered and the appropriate knowledge, skills, attitudes and behaviours are acquired in an appropriately supervised environment.



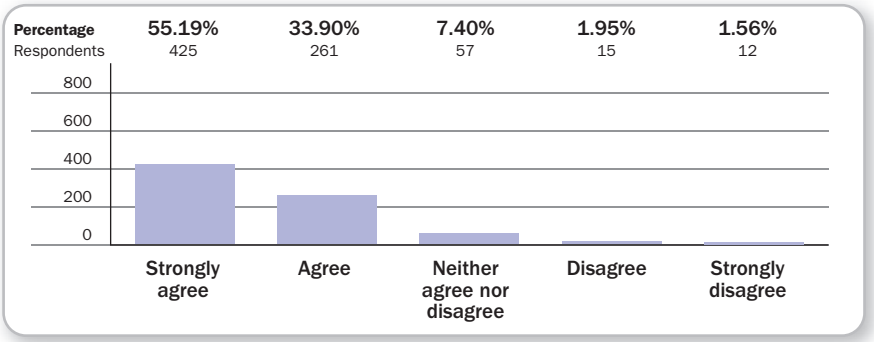
Interim Recommendation 35

For those doctors who do not know to which Core Specialty to commit at the end of FY1 there will be the capacity to take up to 2 years in hybrid rotations allowing experience in four main Core areas. Experience in the subsequently selected Core area will count towards the completion of Core Specialty training subject to successful competency assessment.



Interim Recommendation 36

Colleges should work together with the Regulator and service to devise modularised curricula for Specialist Training to aid flexibility/transferability. They should also devise common short-listing and selection processes that have been standardised across the country to allow sharing of assessments between Deaneries. This work should be completed within two years.



COMMENT

The development of Core programmes must not allow the experience and educational value gained from the introduction of Foundation to be lost, although, as with any curriculum, revision will be necessary in the light of experience and the evolution of health and service needs.

We propose that the first year of Core should evolve from a 'themed FY2' as such curriculum revision occurs, and should be made available within the current Foundation School environment. The first year of Core should preserve and indeed seek to extend opportunities for all themes to include experience in General Practice. Successful and valued academic FY2 programmes should be integrated with the new arrangements. Rotation duration should not be rigidly defined but a model that involves 4 months' exposure to each of Acute Care, General Practice and a 'theme' for year 1, moving towards longer placements in years 2 and 3, should be explored. Work should be initiated to pilot two start dates each year rather than concentrating the changeover on 1 August.

Strong views have been expressed that a test of applied medical knowledge half way through FY1 to aid selection into Core would divert the new graduate's attention from the acquisition of practical experience and would be too soon after graduation. The Panel is persuaded by these arguments but believes that developmental work should continue on a common test of applied medical knowledge that could be embedded in final exams, the ranked results of which could help inform selection into Core. Such a question bank, suitably developed, could provide the foundation of a formative progress test of the acquisition of applied medical knowledge to

inform the trainee's progress and learning needs, consistent with the Expert Advisory Panel's advice included in the Interim Report (Appendix 4).

Until such tools are available the Panel proposes that selection into Core should be informed by i) satisfactory achievement of standardised FY1 competencies, and ii) satisfactory performance at *standardised* OSCE type assessments, which applicants who had not graduated from the UK, would also be required to pass in the UK together with the FY1 competencies. The results together with academic record would be used in conjunction with an interview to select into Core programmes, the availability of each of which would reflect the proportion of subsequent higher specialty training positions. Every effort should be made to make sufficient Core places available for UK graduates achieving full registration.

The number and nature of Core themes has inevitably been the subject of much representation and the Panel is mindful of the fact that original MMC intentions of 'broad based beginnings' became eroded because of a multitude of 'special cases'. The same risk remains today.

To resolve this debate the Panel suggests that the Specialty Training Board of the AoMRC develops proposals that are then shared with the relevant constituencies. Preliminary discussions suggest that there should be a limited number (4) of very broad based Core stems (e.g. medicine, surgery, community, acute common stem) with transferability of competencies after the first or perhaps second year and increasing differentiation as Core progresses. Exceptions would have to be argued on a case by case basis. For example it is arguably not necessary for those pursuing histopathology to have extensive experience of clinical practice prior to this career path. For certain other specialties e.g. obstetrics and gynaecology and paediatrics, which are relatively hard to recruit to, retention in *the short term* of a dedicated career track for those who knew their final destination or were attracted by such certainty might be considered.

We believe that our proposal to have a very limited number of core stems and permit competitive transferability between them represents a practical way of interpreting 'hybrid' rotations.

Importantly Core should not repeat the errors of previous SHO arrangements and *must be time limited* e.g. to three years for the majority, four years for those transferring or in need of remediation. Flexibility should be 'regulated in' through the competitive availability of 25% time tracks, as originally described, to accommodate research and education skilling, management and leadership opportunities and public and global health exposure. Such a track could also be available for revamped general practice training to include an opportunity to contextualise Core specialty learning in the community setting.

FINAL RECOMMENDATIONS

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

8.3 Selection into Higher Specialist Training

We deal with this Issue here and so consider Interim Recommendation 40 out of sequence.

In the Interim Report it was stated that the selection system for Specialty Training needs to take greater account of clinical experience, CV and academic achievement. It was insufficiently tailored to take account of the particular aptitudes required for particular specialisms and the specialist professional viewpoint. Inclusion of both would enhance face validity of such a high stakes exercise.

It was also asserted that in general terms the selection system overweighted competence, a concept with limited discriminatory function, over excellence. Such considerations are particularly relevant for highly competitive specialties. The single annual application date and the very large size of some Units of Application created problems both for organisations and for candidates.

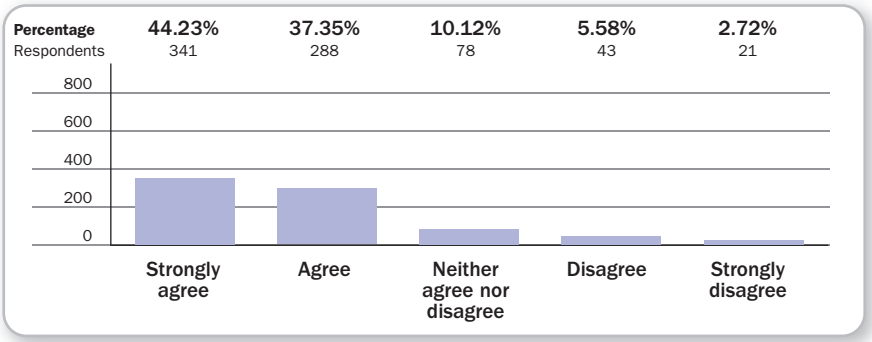
CONSULTATION RESPONSE

81% of consultees agreed/strongly agreed with the proposals for the development of selection into higher specialty training.

Interim Recommendation 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 Core/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.



COMMENT

Detailed questions remain over the place of College exams which will need to be resolved between the College concerned and the Regulator.

FINAL RECOMMENDATIONS

There is no change to the Recommendation.

FINAL RECOMMENDATION 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.

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8.4 'Post Core' Careers

The Panel believes that subject to the fulfilment of relevant competency assessments all UK medical graduates should have the opportunity to complete Core postgraduate medical training. Satisfactory completion of Core will allow eligibility for selection into Higher Specialist Training or redefined Staff Grade positions that we termed 'Trust Registrar'. The Interim Report identified the risk that those appointed to FTSTA posts in August 2007 could become the new 'lost tribe' as they may not all have accrued the same postgraduate experience as those completing Core training in the future, nor necessarily spent sufficient time in postgraduate positions to be eligible for staff grade positions.

The potential attraction of Staff Grade positions was revealed at the trainee workshops that informed the Interim Report. To realise that potential there must be clear opportunities to compete for Specialist Training positions for those so inclined and the maintenance of the CESR route to the Specialist Register. All doctors should be in receipt of some training. Training and development opportunities will be a crucial part of the new contract which still remains to be agreed.

To build on career enhancing opportunities during Core training, and in the interests of flexibility, 'out of programme' activity should be facilitated for those in 'post Core' careers.

CONSULTATION RESPONSE

There was strong support for the relevant recommendations (37–39)

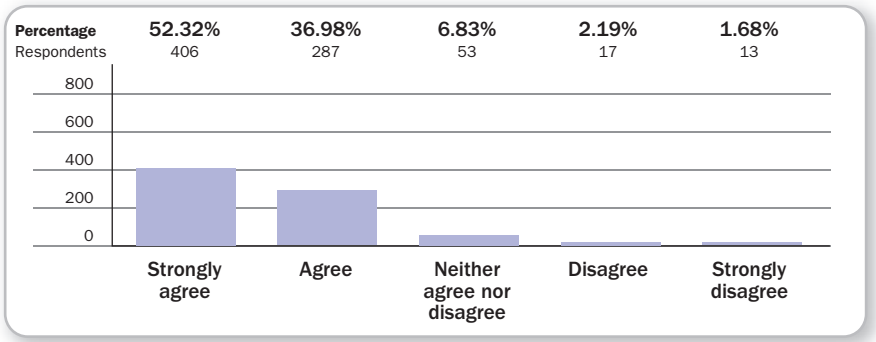
Interim Recommendation 37

Satisfactory completion of assessments of knowledge, skills, attitudes and behaviours will allow eligibility for

i selection into Trust Registrar positions in the relevant area or

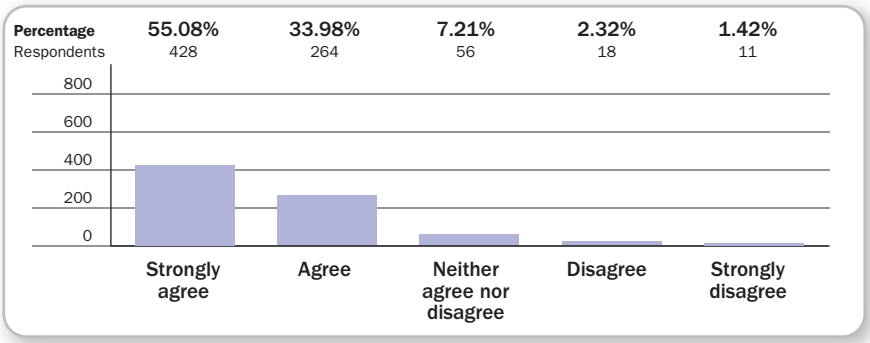
ii selection into Higher Specialist Training.

Doctors in Higher Specialist Training will be known as Specialist Registrars, those selected into General Practice specialty training will be known as GP Registrars (equivalent to ST3 and beyond).



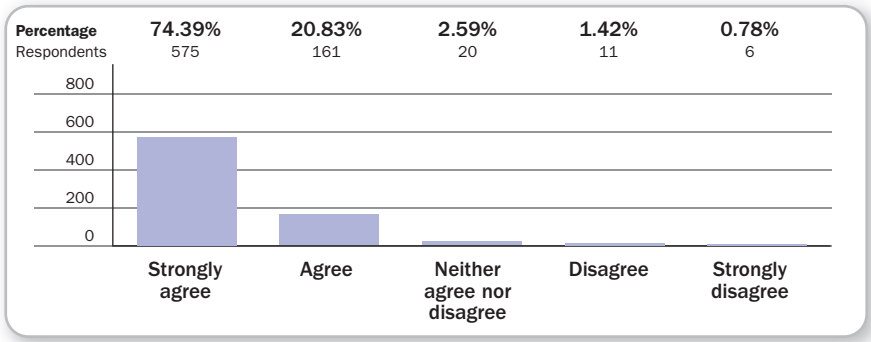
Interim Recommendation 38

The newly named Trust Registrar position (formerly termed Staff Grade) must be destigmatised and contract negotiations rapidly concluded. The advantages of the grade (accrual of experience in chosen area of practice, consistent team environment) need to be made clear. Trust Registrars should have access to training and CPD opportunities. They should be eligible for a reasonable limited number of applications to Higher Specialist Training positions according to the normal mechanisms and also to acquisition of CESR through the Article 14 route.



Interim Recommendation 39

Doctors should be allowed to interrupt their training for up to one year (or by agreement longer) to seek alternative experience. The Regulator in conjunction with the Royal Colleges will determine whether experiences should contribute to completion of training subject to appropriate competency assessment.



COMMENT

The Inquiry has generated significant support for the principle of uncoupling Core training from higher specialist training. Entry into a narrow specialty area at ST1 is too early to decide on a career specialty for the majority of doctors. Compounding this problem is the inherent inflexibility in 'run-through' training, making it difficult to change specialty.

It has been pointed out that the current regulations do allow out of programme activity. This should be positively facilitated and encouraged, given that such out of programme activity enriches the skill base and professional life of doctors, as well as promoting R&D and the global health agenda.

The consultation provoked adverse comments about the suggested title 'Trust Registrar' for those non Specialist Trainee service roles. Indeed, such a title is inappropriate in Scotland, where Trusts do not exist. Change in nomenclature alone will not destigmatise the role. This will be predicated on

clearer opportunities to re-enter specialist training to progress to the Specialist Register, and to enhance the postholder's career and contribution to the NHS, enshrined in a long overdue new contract. Arrangements for the accommodation of people who need to work flexibly should be enhanced.

The Panel accepted the suggestion that General Practice is a specialty like any other. There is therefore no need to differentiate between Specialist Registrars and GP Registrars.

FINAL RECOMMENDATIONS

FINAL RECOMMENDATION 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 specialities including general practice, will be known as Specialist Registrars.

FINAL RECOMMENDATION 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.

FINAL RECOMMENDATION 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.

IMPLICATIONS FOR ACTION

To ensure that those in ST1 FTSTA positions have the opportunity to compete on level terms with those receiving 'Core training', further FTSTA positions at ST2 level should be made available In August 2008.

The NCCG contract has recently been subject to ballot and rapid resolution of contract negotiations is now essential. Mechanisms need to be established to assure the quality of the experience in such positions, as they should involve development and training opportunities and provide an alternative route to the Specialist Register.

Workforce plans need to address the proportion of Specialist Training versus Staff Grade positions 'post Core', having regard to both local and national requirements. Specialist Training positions should form the majority although the balance in a particular locality and specialty will reflect service need.

8.5 Clinical Academic Careers

NHS Institutions are not suitably incentivised to value clinical academic endeavour as a source not only of teaching and the direct outputs of research, but also for the cultural gains such engagement brings.

We also maintained that sufficient opportunities for broader clinical involvement in academic activity do not exist, rather a binary divide between academics and non-academics is being created.

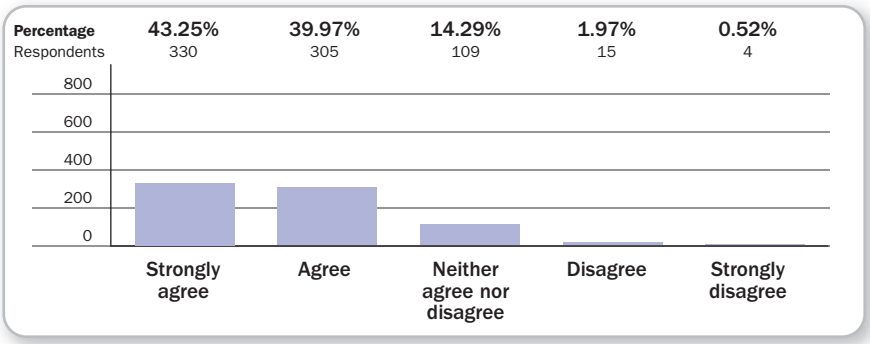
Furthermore flexibility of entry into academia, and return to mainstream clinical practice is limited. Inadequate attention has been given to potential means of shortening the time to complete clinical and academic training.

CONSULTATION RESPONSE

The relevant Interim Recommendations (41, 42, 44) received strong support

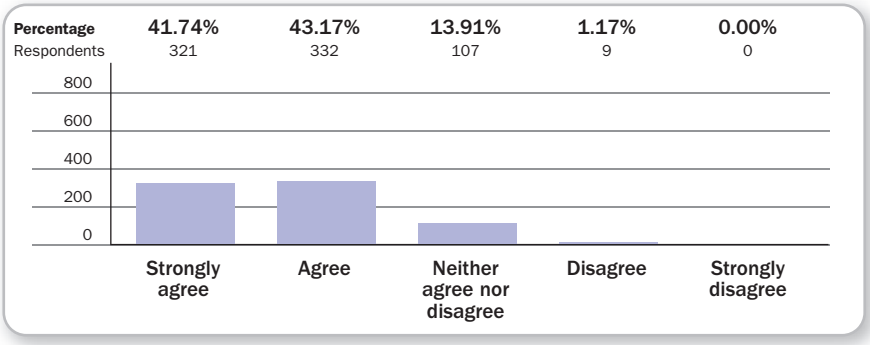
Interim Recommendation 41

The current Academic Clinical Fellowships in England allowing *c*25% of programme time for research methodology training and development of research proposals should be integrated with Core Specialty Training. There will be a need to ensure that those entering an academic training path in the devolved nations are not disadvantaged when moving between research and clinical activities. Opportunities 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 modular Masters programmes.



Interim Recommendation 42

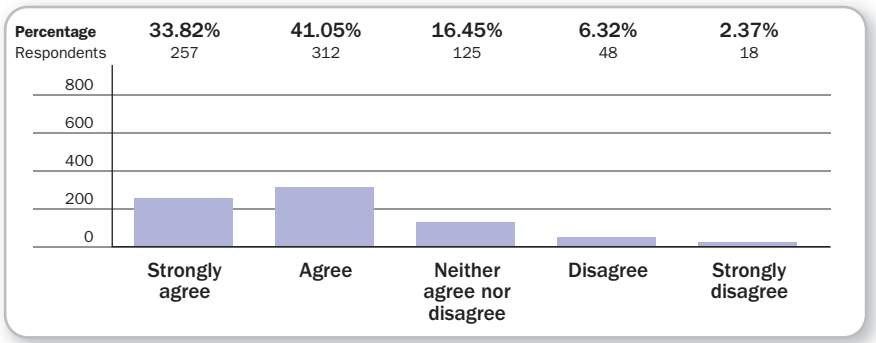
Clinical lecturer posts in England will normally be coincident with higher specialist training (ST3 and beyond).



(Interim Recommendation 43 is considered in the next section)

Interim 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.



COMMENT

Although the structural proposals above were generally welcomed, respondents warned against the dangers of over planning and being over prescriptive as to when academic experience should occur. Some individuals are stimulated to pursue a research pathway relatively late in their training and opportunities should exist to accommodate those with the relevant attributes at that point, subject to the usual competitive criteria. In practical terms this requires that some ACFs should be available at ST3 equivalent, although In England it is assumed that the majority of ACFs or their equivalent will map onto Core. Such flexibility could be further encouraged if ACFs and other research training awards were managed by Medical Schools in conjunction with the local Deanery/Graduate School to assure the most appropriate integrated academic training for the individual. In the same spirit of flexibility valuable academic FY2 programmes should be interpretable within the new Core training proposals, leading to ACFs and research fellowships where appropriate. In Scotland a different integrated structure with competitive selection into a 'run-through' academic pathway at the equivalent of ST1 (second year 'Core') is underway. Different models will provide a variety of opportunities from which those responsible for the organisation of clinical academic activity can learn.

In the Interim Report concerns were raised about the creation of a 'binary divide' – doctors who pursued an academic career path and those who had no research involvement. Consultation comments reinforce the need to enhance research awareness amongst all doctors and offer research experience for those who may facilitate research in future rather than necessarily becoming principal investigators. There is no enthusiasm for research becoming a necessary hurdle between Core and higher specialist training however, but a clear desire that trainees can move seamlessly and without stigma between integrated academic training and a conventional clinical training track. In this respect the distinction between NTN and NTN(A) is unhelpful.

FINAL RECOMMENDATIONS

FINAL 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 facilitated. The current Academic Clinical Fellowships in England allowing *c*25% 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.

FINAL RECOMMENDATION 42

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

FINAL 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.

IMPLICATIONS FOR ACTION

In England the future disposition of ACFs is under discussion. Future arrangements need to facilitate flexibility of interpretation allowing better mapping on to local academic strengths and service need.

8.6 Post CCT Careers

In the Interim Report it was concluded that the lack of clarity regarding the future role of fully trained doctors, be they consultants or GP specialists, and how this relates to CCT acquisition creates career planning tensions for the individual as well as between service and the profession, risking further professional disengagement.

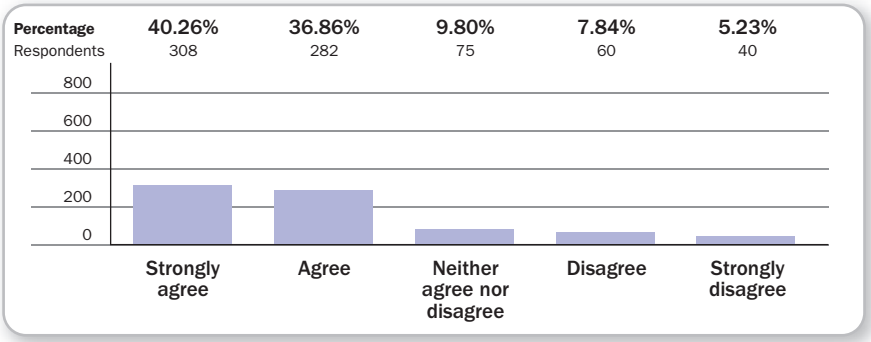
Career paths for enhanced roles for consultants (e.g. researcher, educator, manager) need suitable preparation during the postgraduate training years.

CONSULTATION RESPONSE

77% of respondents agreed or strongly agreed with the relevant Recommendation (43).

Interim Recommendation 43

Successful completion of Higher Specialty Training as confirmed by assessments of knowledge, skills and behaviours will lead to a CCT. 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 gained post CCT and aid selection to consultant positions.



COMMENT

This issue provoked strong responses, as indeed it did in the wake of *Unfinished Business,* some interpreting the box diagram separating 'specialist' and 'consultant' as a proposal to create a 'sub consultant' grade. In contrast a significant minority believes that a distinction between specialist/senior specialist is inevitable and cite the Senior Lecturer – Reader – Professor pyramid in clinical academia, or the Australian experience.

The issue is more fully discussed in Section 2. The Panel maintains that CCT holders should be competent specialists capable of independent practice in their specialty. We anticipate that in some specialties/localities CCT holders will be recruited directly into consultant positions, the acquisition of which will be enhanced by having additional skills developed during training. In some specialties/localities competition for consultant posts may promote the acquisition of further experience or subspecialty expertise.

FINAL RECOMMENDATIONS

FINAL RECOMMENDATION 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.

8.7 General Practice

In the Interim Report it was concluded that the integration of workforce policy and postgraduate training and the length of training in General Practice are currently inadequate to meet the demands of shifts in care to the primary sector, a demand that will grow further as the age profile of the population rises. The location and nature of such extended specialist training in General Practice is an issue for resolution between the relevant Royal Colleges.

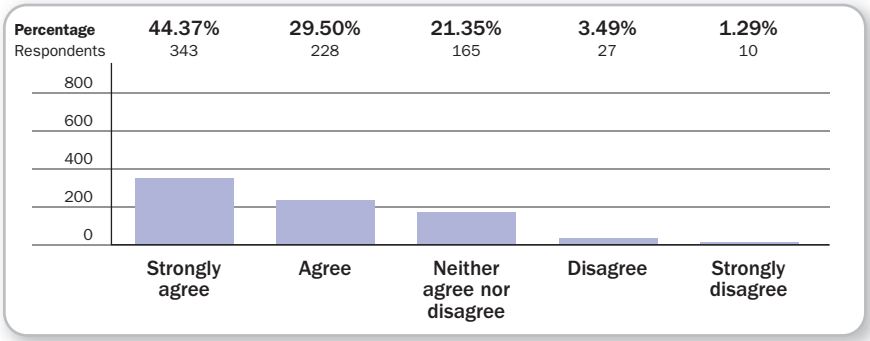
The related ideal that all doctors practising in the UK should have experience of the nature of general practice during their Foundation Years has not been met.

CONSULTATION RESPONSE

75% of respondents agreed or strongly agreed with Interim Recommendation 45.

Interim Recommendation 45

The length of training in General Practice should be extended to five years, bringing it in line with specialty training and the other developed European countries.



COMMENT

The Panel anticipates that 3 years of 'Core' in General Practice/Community medicine embracing relevant disciplines and including 4–6 months in General Practice would be followed by 2 years of practice based training. We intimated that location and nature of such extended specialist training in General Practice is an issue for resolution between the relevant Royal Colleges. Consultation feedback has been positive regarding the length of training but from some quarters there has been insistence that such training should be 'integrated', i.e. possess a dedicated element throughout Core. This might be desirable for those who know from the start that they want a General Practitioner role (and such a track could be accommodated much as we propose research, education and public/global health interests are integrated). However in the interests of flexibility, of accommodating 'late deciders', and a projected need for doctors with roles intermediary between the hospital specialist and the current General Practitioner role, the Panel suggests a mix of potential training routes should be considered.

It is important, too, that new arrangements enhance rather than detract from the development of academic strengths in this discipline given the major contribution General Practitioners make to undergraduate medical education and training and the need for a stronger evidence base for primary care. In England ACFs are currently four years for Primary Care and thought should be given as to how such a scheme maps on to the proposed five year training scheme.

FINAL RECOMMENDATIONS

FINAL RECOMMENDATION 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.

IMPLICATIONS FOR ACTION

An extended programme has resource implications although as intimated in the Interim Report, Higher Specialty Trainees In General Practice are contributing cost effectively to patient care. The move to more care in the community in the face of increasing chronic disease complexity and rising public expectation demands more sophisticated 'front end' services, of which the GP will be a crucial part. The Panel is concerned that SHA derived local workforce plans will not universally accept this analysis. Central clarity on professional roles and the skill mix required to meet projected demands is therefore crucial and it is hoped will stem from the NHS Next Stage Review.

9 NEW RECOMMENDATIONS

9.1 European Working Time Directive (EWTD)

In deliberating further on the future structure of Postgraduate Medical Training, the Panel has reflected on the impact of EWTD. The effect of the current interpretation in UK legislation impedes the acquisition of experience, of confidence and the ability to shoulder responsibility. This promotes further the 'trainee mentality' over and above a recognition of the trainee's service contribution. In the interest of patient safety, no one would wish to see a return to hours of duty that impact on adequate rest and relaxation, but few other professions in the UK, nor medical career structures in Europe embrace the Directive in the same way that it has been embraced in the UK. Given that it is a critical part of the regulatory environment and thus legitimately falls under the Terms of Reference of the Inquiry the issue does need to be addressed as suggested in Recommendation 46.

NEW RECOMMENDATION 46

The Panel recommends that urgent attention should address whether there are 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) could offset any reduction in clinical experience. DH should explore the potential for contractual solutions. The profession, service, Medical Schools and Deaneries should come together to define compensatory approaches.

9.2 National Coordination: England

The Panel believes that a coordinated response in England to the many issues itemised by the Inquiry requires the establishment of a national body. The scale and complexity of the situation in England demands such a solution, mirroring the arrangements in the Devolved Administrations.

NEW RECOMMENDATION 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 [Rec 23]
- Define the principles underpinning PGMET [Rec 1, 2]
- Act as the professional interface between policy development and implementation on matters relating to PGMET [Rec 3, 18]
- Develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery [Rec 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 [Rec 14]

- Coordinate coherent advice to Government on matters relating to medical education [Rec 18]
- Promote the national cohesion of Postgraduate Deanery activities [Rec 24, 25]
- Scrutinise SHA medical education and training commissioning functions, facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained [Rec 22]
- Commission certain subspecialty medical training [Rec 12]
- Act as the governance body for MMC and future changes in PGMET [Rec 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 [Rec 21] and be advised by an Advisory Board with professional, service, academic, employer, BMA and trainee representation [Rec 7]

FINAL RECOMMENDATIONS

RECOMMENDATION 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.

RECOMMENDATION 2

Policy development should be evidence led where such evidence exists and evidence must be sought where it does not.

RECOMMENDATION 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.

RECOMMENDATION 4

Changes to the structure of postgraduate medical education and training should be consistent with the policy objectives and conform to agreed guiding principles.

RECOMMENDATION 5

There needs to be a common 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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, a 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 26

Reflecting the fact that Postgraduate Medical Education and Training involves service, academic and workforce dimensions, it is proposed that the Foundation/Specialty 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.

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 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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'.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

RECOMMENDATION 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 specialities including general practice, will be known as Specialist Registrars.

RECOMMENDATION 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 Post-graduate 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.

RECOMMENDATION 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.

RECOMMENDATION 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.

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 facilitated. The current Academic Clinical Fellowships in England allowing *c*25% 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.

RECOMMENDATION 42

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

RECOMMENDATION 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.

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.

RECOMMENDATION 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.

RECOMMENDATION 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), and 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.

RECOMMENDATION 47

The Panel recommends the formation of a new body, NHS Medical Education England (NHS:MEE). This body would fulfil the following functions

- Hold the ring-fenced budget for medical education and training for England
- Define the principles underpinning PGMET
- Act as the professional interface between policy development and implementation on matters relating to PGMET
- Develop a national perspective on training numbers for medicine working within the revised medical workforce advisory machinery
- Ensure that policy and professional and service perspectives are integrated in the construct of PGMET curricula and advise the Regulator on the resultant synthesis
- Coordinate coherent advice to Government on matters relating to medical education
- Promote the national cohesion of Postgraduate Deanery activities
- Scrutinise SHA medical education and training commissioning functions, facilitating demand led solutions whilst ensuring maintenance of a national perspective is maintained
- Commission certain subspecialty medical training
- Act as the governance body for MMC and future changes in PGMET
- 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 and be advised by an Advisory Board with professional, service, academic, employer, BMA and trainee representation.

TERMS OF REFERENCE

The Independent Inquiry was appointed by the Secretary of State for Health. It was not charged with resolving the appointment to training posts in the 2007 round. This fell to the Review team chaired by Professor Neil Douglas whose report is included as Appendix 9. The Terms of Reference for the Independent Inquiry are as follows:

'The independent review will examine the framework and processes underlying Modernising Medical Careers (MMC) and make recommendations to inform any improvements for 2008 and beyond.

The review will examine:

- The extent to which MMC has engaged the medical profession and to make recommendations to ensure that it has the support of the profession in the future
- The extent to which implementation to date has met the needs of doctors in training, patients, the service and employers
- The governance structures across the UK that underpin MMC and the inter-governmental working arrangements of the four home countries
- The implementation processes underlying MMC and the methods used in selection and recruitment
- Factors relating to the wider professional, regulatory, workforce and service environment which may have impacted on the programme.

Specific issues that have been the subject of stakeholder concern, including:

- The extent and quality of stakeholder engagement with the programme
- The effective engagement of doctors in training and the profession as a whole in MMC and the development of a proper understanding of its aims and benefits
- The appropriate relationship between the acquisition of competence and the pursuit of excellence
- The assessment methodologies used in the selection process including the relative merits of competency-based and more traditional methods of selection and recruitment
- The use of assessment centres in selection and recruitment
- The level of choice on offer at application
- The lack of flexibility available to trainees on run-through programmes
- The role of fixed-term training posts alongside run-through posts
- The relative roles of the Deaneries and the Medical Royal Colleges in delivering components of the programme
- The need for flexibility in implementation across the UK.

The review will be conducted independently of the four Health Departments and will have its own independent secretariat.'

MMC Inquiry
c/o 4th floor
Universities UK
Woburn House
20 Tavistock Square
London WC1H 9HD

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