ASPIRING TO EXCELLENCE

FINDINGS AND FINAL RECOMMENDATIONS OF THE

INDEPENDENT INQUIRY INTO MODERNISING MEDICAL CAREERS

LED BY

PROFESSOR SIR JOHN TOOKE

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FOREWORD

The greatly acclaimed physician and educator, Sir William Osler, wrote of the 'unbroken continuity of methods and of ideals' that characterises the profession of medicine. According to Osler, the methods the doctor employs are to 'carefully observe the phenomena of life in all its stages, … to cultivate the reasoning faculty so as to be able to know the true from the false.' In so doing the doctor seeks 'to prevent disease, to relieve suffering and to heal the sick.'[1]

As Osler himself would have acknowledged the capacity to undertake such methods and assume such roles is fundamentally dependent on both the education and training the doctor receives, together with an accumulated experience of the various expressions of illness and its interplay with the human condition.

Modernising Medical Careers (MMC) was an honest attempt to accelerate training and assure the fundamental abilities of the next generation of doctors. Such ambitions are understandable given the changing nature of our society (e.g. increasing longevity, rising expectations associated with increasing wealth, a rise in consumerism in relation to health coupled with lifestyle-driven disease), and an increased emphasis on safety and accountability. However in making a system fit for contemporary purpose we need very good reason to depart from fundamentals of professional practice which have guided medicine for millennia, even if they too need reinterpreting for the modern era.[2]

There are historical commentators who maintain that we are seeing closure of medicine's finest hour and 'the dawn of its dilemmas.'[3] As Roy Porter further maintains, medicine 'has led to inflated expectations … yet as those expectations become unlimited, they are unfulfillable: medicine will have to redefine its limits even as it extends its capacities.'

Whether or not this analysis is correct, time will tell. But despite the predictions of some, scientific discovery and our knowledge of the interplay between nature and nurture continue to burgeon. What is clear is that postgraduate medical education and training in the UK is at a crossroads. Having been regarded as being one of the best systems in the world, we have to ask ourselves whether the aspirations of MMC will assure a similar high reputation in the future.

In reflecting on the evidence it received and formulating its Recommendations, the Independent Inquiry Panel was clear: mechanisms that smacked of an aspiration to mediocrity were inadmissible. Put simply 'good enough' is not good enough. Rather, in the interests of the health and wealth of the nation, we should aspire to excellence.

Sir John Tooke

September 2007

1 Sir William Osler, quoted in Horder 'Whither Medicine?', 2 April 1949, pp 557-560
2 Doctors in society: Medical professionalism in a changing world; Royal College of Physicians Report of a Working Party, December 2005
3 Roy Porter, The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present, 1999, Fontana Press, London

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 SUMMARIES

1

OVERVIEW

1 Final Report

2 Interim Report

EXECUTIVE SUMMARY FINAL REPORT – JANUARY 2008

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

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.

EXECUTIVE SUMMARY INTERIM REPORT – OCTOBER 2007

INTRODUCTION

The crisis precipitated by the perceived failure and abandonment of the online Medical Training Application Service {MTAS} in Spring 2007 has revealed profound concerns about the new system of medical postgraduate training known as Modernising Medical Careers (MMC).

An Independent Inquiry into MMC was established by the Secretary of State for Health in April 2007. In fulfilling the Terms of Reference the Panel explored the background and context – in medical terms the predisposing or aetiological factors – that may have contributed to the perceived problems with MMC, rather than simply focusing on MTAS.

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 expressed their views and preferred solutions to a range of critical issues.

Whatever else this Inquiry achieves, the distress caused to the next generation of specialists and senior doctors must never be repeated. We should also acknowledge the exceptional efforts of consultant clinicians, postgraduate deaneries, Trust HR Departments and the Review Team in their attempts to handle the crisis and ensure that the impact on service was contained. It is a testament to their commitment that this was indeed the case and that most specialist training posts were filled.

From the experience of the implementation of MMC to date the Panel has reached a number of conclusions. The introduction of Foundation training (the first two years post graduation FY1 and FY2) has gone reasonably well in contrast to specialist training although there are concerns as to whether FY1, the first year, builds effectively on undergraduate experience. However competency assessment is largely non standardised, staff have been inadequately prepared and a ‘tick box’ perception prevails. The experience offered by FY2 placements has been very variable and for many trainees did not provide experience that matched their career aspiration. For the majority the need to select a specialty track six months into FY2 was premature and constraining.

The process used for selection into specialty training whilst promoted as theoretically sound was lacking in face validity, was rushed in implementation and was technically deficient. The nature of the process denied the value of experience (and the commitment required to acquire it) and underplayed aspiration to excellence and academic achievement. It was perceived as insensitive to the trainees as people and their domestic circumstances, a perception aggravated further by the inadmissibility of historical information, the electronic portal and inadequate personal communication. These system weaknesses were exposed on a massive scale because of the great excess of applications over training places. This was occasioned by failure to anticipate the behaviour of international medical graduates and resolve their status in advance. There was also

inadequate provision for the many experienced and talented SHOs already in the system.

Notwithstanding the inadequacy of the selection system, the experience triggered concerns about the broader interpretation of MMC. Although the initial educational principles underlying the initiative endure in the opinion of many clinicians, the emerging reality is characterised by inflexibility and concerns regarding the preparedness of someone certified as trained under the new system for the consultant role. The stability and certainty of 'run-through' training, a concept that emerged without clear consultation, is in the minds of most trainees more than offset by the lack of a broad base of clinical experience and premature selection of a narrow field of endeavour.

From the analysis of evidence from all sources, issues that demand resolution have been identified in eight key areas:

- Policy objectives
- The Doctor's role
- Policy development, implementation and governance
- Workforce planning
- Medical professional engagement
- Management of postgraduate medical education and training
- Regulation
- The structure of postgraduate medical education and training.

1 POLICY OBJECTIVES

There was no definitive description of MMC and what it embraced. The original, sustainable educational principles which argued for broad-based beginnings and flexibility were eroded and over time subsumed by workforce objectives. Changes to postgraduate training in the future and the bodies that enact the changes need to be informed by clear policy objectives and guiding principles, co-developed with the medical profession. Recommendations 1–4 address these issues.

2 THE DOCTOR'S ROLE

It is impracticable to pursue outcome focused medical education or attempt to plan the medical workforce unless there is a clear understanding of the role the doctor plays in the healthcare team at each career stage, including doctors in training and certificated specialists.

Resolution of this fundamental issue is urgently required as expressed in Recommendation 5.

3 POLICY DEVELOPMENT AND GOVERNANCE

There were clear DH deficiencies in policy making with complex and ambiguous accountability structures for policy development and very weak governance and risk management processes. Responsibility for MTAS and the HSMP issue lay outside the MMC management framework. Coherent development was also hampered by the erosion of the health:education sector partnership in England in recent years. Recommendations 6–10 address these issues, the resolution of which is a prerequisite for further change.

4 WORKFORCE PLANNING

Medical workforce planning, too, left much to be desired with little attempt made to integrate the impact of changing patterns of healthcare on future

medical workforce size and structure. The very rigidity of 'run-through' as currently configured militates against workforce redesign in the future as health needs and therapeutic advances evolve. Conflicting policies on overseas doctors remain unreconciled. The fate of those in Fixed Term Specialist Training Appointments (FTSTAs) remains uncertain. Devolving an under-resourced, sub-optimal workforce planning function, together with training commissioning, to SHA level is not without risk. Recommendations 11–17 address these issues, calling in particular for revised and enhanced medical workforce advisory machinery, as a means to meet national imperatives whilst remaining locally responsive, and oversight of SHA workforce planning and commissioning. In addition policy uncertainties with regard to the current bulge in trainees, and international medical graduates should be urgently resolved.

5 MEDICAL PROFESSIONAL ENGAGEMENT

Although quick to criticise MMC in the wake of the MTAS failings the profession was engaged in the development of MMC, although the extent to which concerns raised were accommodated was limited. This was particularly true for calls for delay and more extensive piloting. On other matters individual medical constituencies all too often responded as such rather than exhibiting the professional leadership required to resolve issues of importance to the service as a whole. Recommendations 18-20 stress the need for coherent medical advice on key matters of principle and the importance of doctors being more involved in the management of the health service.

6 MANAGEMENT OF POSTGRADUATE MEDICAL EDUCATION AND TRAINING

The funding structure and incentivisation of Trust involvement in postgraduate medical education and training in England is flawed. The management and governance of the Postgraduate Deanery function in England is complex with little relationship to medical schools. This contrasts with the situation in the devolved administrations and many other developed countries. Employer and service links are suboptimal and there is a lack of national cohesion. Recommendations 21–29 call for a review of the medical Postgraduate Deanery function in England and postgraduate training contracts. Accountabilities should be better defined and Trusts incentivised to engage in postgraduate training. A new graduate school construct should be trialled in England where locally applicable, drawing together key stakeholders to common purpose. Links with medical schools and service should be enhanced.

7 REGULATION

The regulation of the continuum of medical education currently involves two bodies, GMC and PMETB, creating diseconomies both in terms of finance and expertise. Recommendation 30 calls for the swift merger of PMETB within GMC, facilitating economies of scale, a common approach across the continuum, the linkage of accreditation with registration and the sharing of quality enhancement expertise.

8 THE STRUCTURE OF POSTGRADUATE MEDICAL EDUCATION AND TRAINING

Changes to the structure of postgraduate training need to be guided by clear, shared principles referred to in 1 above, that embrace broad based early years, flexibility and the pursuit of excellence. In harmonising the new with the current arrangements, opportunities to trial approaches should be maximised and the circumstances of the 'bulge' of trainees currently in the system should receive particular attention.

In summary the Panel proposes that the link between FY1 and FY2 is broken. This would allow universities to fulfil their defined obligations to their graduates and allow FY2 to become the first of a three-year Core training programme. Core specialty training would replace FY2/ST1/ST2, be broad based and involve six, six-month attachments. The Panel envisages that there would be a small number of defined types of core programme that would serve as stems for subsequent specialty training. Entry to Core specialty training will involve computer adaptive tests towards the end of FY1, whereas entry into higher specialist training at ST3 level will be based on marks obtained in national assessment centres for the specialty in question together with structured CVs and interviews for short-listed candidates at Deanery level. Recruitment would thus occur more locally, supported by a nationally co-ordinated application system three times a year.

The Panel anticipates that it will take two to three years to develop relevant core curricula and owned and trialled assessment methodologies, requirements that will demand an unprecedented degree of co-operation between the Colleges and the regulator. Such detailed work will need to be sensitive to legitimate demands for special case status from particular specialties without abandoning the key principle of competitive entry into higher specialist training. It must acknowledge that detailed interpretation may vary in the devolved administrations if they are to be responsive to local need, another dimension of flexibility.

General practice training must be extended to five years to assure the skill base of that part of the medical workforce that is going to become increasingly important with rising longevity, increasing co-morbidity and shifts of care to the community.

The future of the non consultant career grade contract must be resolved urgently to include a new nomenclature (Trust Registrar), job description clarity and opportunities for re-entry into higher specialist training via the conventional route. The role should be de-stigmatised and made more attractive.

The future of those clinicians currently in FTSTAs should receive particular attention in harmonising new structures with the present to avoid the creation of another ‘lost tribe’.

All postgraduate training programmes should involve the capacity and flexibility to allow the trainee to compete to pursue interests in research, education and management, and should encourage appropriate overseas, public health and out of programme activity deemed to add value to the UK experience. Relevant training tracks should be integrated with clinical programmes for all these domains. It is particularly important that the research track is enhanced not only to increase UK competitiveness in this field but because of the added value research awareness brings to the quality of care.

The training implications in terms of protected time, staff development and the understanding of contemporary methods of assessment, must be grasped as must be the financial, service and employment implications for Trusts. Recommendations 31–45 cover these issues in detail.

CONCLUSION

In conclusion, although a deeply damaging episode for British Medicine, from this experience must come a recommitment to optimal standards of postgraduate medical education and training. This can only occur if a new partnership is struck between the profession and the DH, and between Health and Education. Each constituency, has been found wanting thus far. In future, each must play its part. An aspiration to clinical excellence in the interests of the health of the population must be paramount.

INTRODUCTION 2

OVERVIEW

1 Rationale for an inquiry

2 Terms of reference

3 Modes of working

2.1 RATIONALE FOR AN INQUIRY

The origins of Modernising Medical Careers (MMC) can be traced back to 1988 and the publication *Achieving a Balance* which sought a better balance between the numbers of doctors in training and definitive career posts. But it was the Chief Medical Officer's (CMO) publication *Unfinished Business* in August 2002 that pointed out the excess of Senior House Officers (SHOs) in the system many of whom were not in structured training and were required repeatedly to apply for jobs. A set of educational principles was espoused which largely endure but the initiative prompted a more far reaching reform of postgraduate training. MMC was born. The first phase, the replacement of the Pre Registration House Officer (PRHO) year with Foundation Training began with Foundation Year 1 (FY1) in August 2005, setting the clock ticking for entry into new style Specialist Training on 1 August 2007 after the end of the second Foundation Year. As a result of largely unsubstantiated claims that previous systems of selection into specialist training had been riven with patronage, and favourable experiences with the second round of FY1 recruitment and with NHS Careers, a computerised centralised admission system, Medical Training Application Service (MTAS) was chosen for recruitment into Specialist Training Year 1 (ST1). The system went live in January 2007. From early in the process there were reports of technical problems and evidence of unacceptable variation in the individuals selected for interview.

There was also mounting evidence that doctors who in prior selection processes would have been regarded as first class candidates were not being shortlisted. In response to these concerns in mid March the Department of Health (DH) announced a review into round 1 of MTAS.

Not only had MTAS appeared to fail but the experience unleashed a range of views on the perceived deficiencies of MMC in general. On 24 April 2007, the then Secretary of State for Health, Patricia Hewitt, announced the Independent Inquiry into MMC of which this document is the Final Report.

2.2 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 were 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.'

2.3 MODES OF WORKING

Given the central involvement of DH in the development and implementation of MMC it was important that a truly Independent Inquiry was established. The Panel members selected to support the Chair were chosen by the Chair and no member had had day to day involvement with MMC. Panel biographies appear in Appendix 10. The Chair also appointed an Independent Secretariat to support the work of the Panel and all reports and forensic analyses were commissioned by the Chair.

The Panel was deliberately chosen to be non-representative, the views of particular constituencies e.g. service and trainees, being sought through specific groups formed for the purpose.

A number of workstreams was conducted:

2.3.1 FORENSIC ANALYSIS OF RECORDS OF MEETINGS AND RELEVANT PUBLICATIONS

The Panel acquired from the DH, from the MMC team, from the Royal Colleges and other stakeholders all formal documentation relating to MMC. Email evidence was not considered to avoid the risk of bias introduced by selectivity. The formal papers were subject to independent forensic analysis, the results of which are found throughout the report. Where appropriate, clarification on specific issues was sought at oral evidence sessions.

2.3.2 ORAL AND WRITTEN EVIDENCE

The Panel invited those organisations most closely involved with MMC to provide both oral and written evidence. Solicited written evidence was received from 130 sources. All submissions were read by a resource investigator and at least two panel members and key themes noted. 45 oral evidence sessions allowed panel members to explore written evidence further.

Unsolicited written evidence was also provided by 226 organisations and individuals and was catalogued and themed, a summary of which appears in Appendix 8.

2.3.3 E-CONSULTATION

In order to broaden further the spectrum of views received a website was set up – www.mmcinquiry.org.uk – to keep people informed about progress and through it to invite people to contribute to an e-consultation, the results of which are provided in Appendix 1. Concern was raised that there was insufficient space in the consultation to provide feedback – and so a web forum was created to allow views to be shared. The forum was monitored by the Panel and the views expressed consolidated within the unsolicited evidence received. The interim findings were subject to consultation from 8 October to 20 November 2007.

2.3.4 TRAINEE WORKSHOPS

The Panel was keen to engage with trainees across the UK and to hear their views, rather than simply those of organisations representing them. Eight workshops were arranged: two in London and others in Edinburgh, Cardiff,

Belfast, Birmingham, Cambridge and Leeds. Letters were sent to Trusts throughout the UK inviting them to select three trainees to attend the meetings, one of whom was to be drawn from the staff or associate specialist grade.

The format of each workshop was identical. Trainees were invited to express their views about MMC, which were recorded. In small groups they then considered four issues and were asked to feed back. Collective written views from each small group were recorded as were individual submissions. The data obtained were then subjected to formal analysis. The questions posed were:

- What are the pros and cons of 'run-through' training? Please list them. In the light of this analysis, what amendments, if any, would you wish to see?
- How far do you believe Foundation Year 2 (FY2) has: a) built on FY1, b) given you the opportunity to sample the specialty you are interested in; c) been a valuable clinical experience
- The health service does not envisage every medical graduate operating at the level of consultant, or principal in General Practice. How could the status and attractiveness of 'non-training' grades be improved? What should be the principles that underpin such other roles?
- More medical graduates want to undertake higher specialist training, particularly in some specialties, than service requires. What should be the principles guiding selection into specialist training recognising this reality?

A summary of the responses is given in Appendix 2.

2.3.5 SERVICE PERSPECTIVE

A recurring theme to emerge throughout the Inquiry was that service had been insufficiently involved in the development and implementation of MMC. A sub-group, Chaired by Dr Allan Cole, Panel member, and Medical Director of the University Hospitals of Leicester NHS Trust was therefore set up. Its Terms of Reference and membership are shown at the end of the Report which is given in full in Appendix 6. The issues raised by the Sub Group informed the recommendations made by the Panel.

2.3.6 EXPERT INDEPENDENT EDUCATIONAL PERSPECTIVE ON BEST PRACTICE FOR SELECTION AND ASSESSING PROGRESSION OF POSTGRADUATE MEDICAL TRAINEES

To advise on best practice in selection and assessment a team of international medical experts was assembled. The team's Terms of Reference, membership and report appear in Appendix 4.

2.3.7 INTERNATIONAL COMPARISONS

A comparison of the structure and management of medical specialist education and training programmes in a range of developed nations was conducted and is provided in Appendix 7.

2.3.8 PANEL WORKING

The Panel worked both electronically through email contact and met as a group at monthly intervals from May to December. This Report represents the collective view of the Panel.

BACKGROUND AND CONTEXT

3

BACKGROUND AND CONTEXT FOR REFORM OF POSTGRADUATE TRAINING

3.1 INTRODUCTION

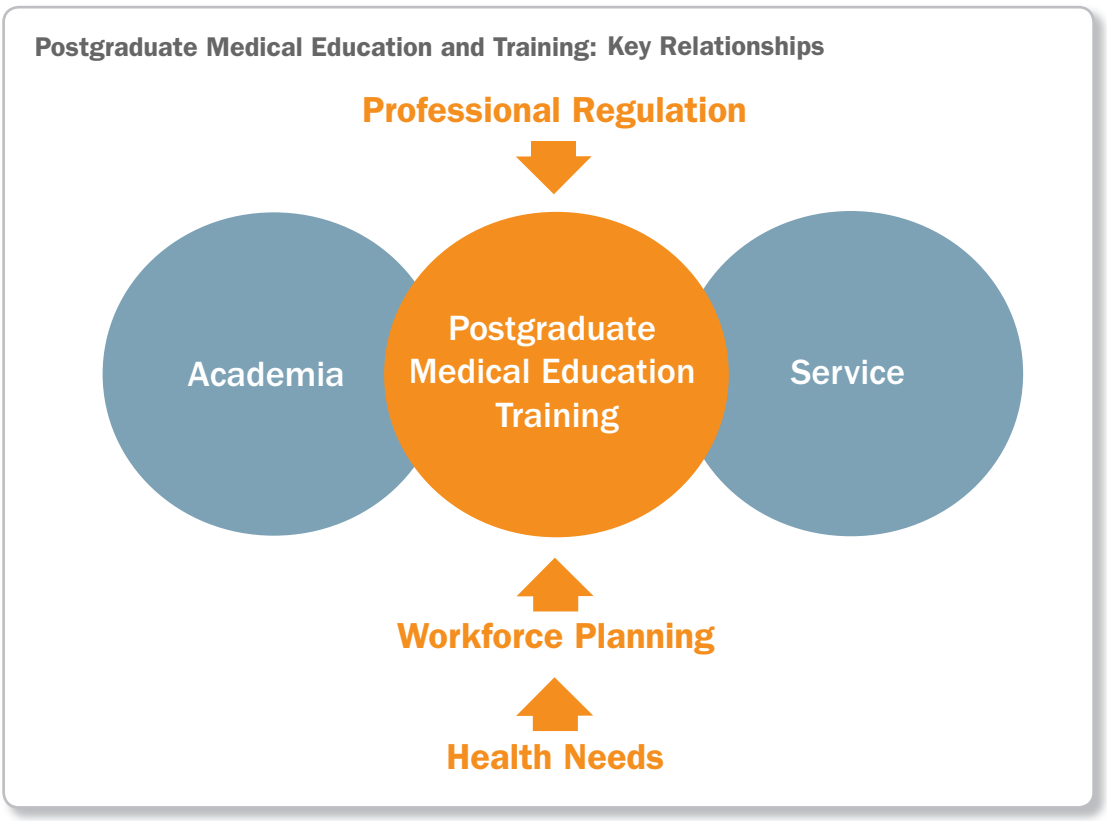
Postgraduate Medical Education and Training is an activity that is intimately interwoven with health service delivery and medical workforce planning considerations. To protect the interests of the public it is subject to stringent regulatory requirements. The academic dimension, the training itself, is largely hosted by the NHS and conducted by NHS staff, in conjunction with clinical academics in larger centres.

All of these critical interfaces which have a bearing on postgraduate training – the Health Service, the NHS as an organisation, workforce planning, the regulatory environment and clinical academia (Fig 3.1) – have been in a state of considerable flux over the period covering MMC development.

This section describes recent developments in each domain to provide a contextual backdrop against which MMC needs to be considered; such consideration is in line with Term of Reference 5:

'To examine factors relating to the wider professional, regulatory, workforce and service environment which may have impacted on the programme'.

Figure 3.1



3.2 SERVICE ENVIRONMENT

3.2.1 INVESTMENT, DEVOLUTION AND DECENTRALISATION

The educational journey which started in 1993 with the report by the then Chief Medical Officer, Sir Kenneth Calman *Hospital Doctors: Training for the future*[1] and culminated in the implementation of MMC has been paralleled by a period of major investment in the NHS and in the way that it is organised and services arranged. Spurred on by the NHS Plan 2000 and the Wanless Report, the NHS budget increased from £63bn in 2001-2 to £107bn in 2006-7 to increase capacity and attain doctor:population ratios comparable with OECD averages. During this development period the educational and service paths have not always been aligned and the implications of implementing changes in one area not clearly assessed or understood. At a national level there was devolution with responsibility for the delivery of the health service passing to the individual administrations of the four home countries. Each country chose to deliver its version of the NHS in a slightly different way. Thus, a centralised approach to the reform of postgraduate medical training had to be implemented across four increasingly diverse health systems.

Whilst some of the devolved administrations reverted to more integrated healthcare systems, England persisted with a policy of separation of the health needs assessment/commissioning functions from the provision of services by hospitals. This purchaser: provider split led to the development of a more commercial style of relationship and increasing decentralisation. Thus, the large centrally funded and centrally managed National Health system across the United Kingdom was becoming more of a virtual organisation, abiding by the fundamental principles of the NHS, but being delivered in different ways in different parts of the Nation with increasing variation of approach due to local autonomy.

3.2.2 ADMINISTRATIVE REORGANISATION AND MANAGEMENT CULTURE OF THE NHS IN ENGLAND

Throughout the period 1993 – 2005 there were regular re-organisations of the structure and relationships between constituent parts of what had previously been an integrated service. Within England a clear strategy was developed, which saw the introduction of market and commercial disciplines within a publicly funded health system. This approach survived a change of government but was subsequently partially reversed in the devolved administrations. The market discipline introduced across the English NHS was accompanied by the introduction of a management culture based on the identification of numerous national targets and service specifications. This in turn required a tight performance management structure encompassing clinical standards, operational service delivery and financial performance. There were no similar performance or quality targets covering education and training.

Co-incident with a tighter performance management approach new contracts were negotiated for consultants in 2003 reflecting time committed, and for General Practitioners in 2006 reflecting performance against the *Quality and Outcomes Framework 2006* or QOF.

[1] Department of Health Hospital Doctors: Training for the Future. The Report of the Working Group on Specialist Medical Training (1993)

NHS regional management underwent progressive change with the previous Regional Health Authorities being replaced by Regional Offices, then the establishment of 28 Strategic Health Authorities covering England. Within 3 years 28 had been reduced to 10 by another round of restructuring, effected in 2006. These SHAs have progressively taken responsibility for running and funding activities that were previously managed from the centre. This transfer of responsibility included that for the funding and supervision of education and training of the workforce, with the funding derived from the historic allocation model through the system of centrally funded levies.

The NHS saw the progressive introduction of new funding systems for clinical activity. The funding for 'service' progressively moved from a lump sum allocation based on adjusted prior year activity, to a more commercial approach of funding for units of care based on agreed contracts for activity and cost. The system evolved into one known as 'Payments by Results' whereby units of activity were given a price (Tariff) against which contracts between purchasers and providers could be set up.

A more contractual approach to the funding of NHS Research and Development was also introduced as part of the new strategy announced in 2006 *Best Research for Best Health*.

In 2004 the NHS in England saw the introduction of a new more autonomous provider organisation, the NHS Foundation Trust. These Trusts were effectively public benefit organisations, and were legally autonomous organisations which, whilst remaining part of the wider NHS, were no longer part of the core line management infrastructure of the NHS. Foundation Trusts are accountable to their members (local community, patients and staff), to an independent regulator (Monitor) and to Parliament but no longer to the Department of Health or to local or national NHS management.

Thus, those parts of the NHS across England which were responsible for the strategic development, commissioning and supervision of postgraduate medical education and the organisations in which much of the training had to be undertaken were in a constant state of reorganisation. The implementation of a strategy for postgraduate medical education that was highly centralised both in conception and delivery, across an increasingly decentralised NHS was bound to be challenging. Regional variation in priority, historic levels of educational resource and in overall financial health resulted in differing approaches to the delivery of postgraduate medical education. In the 2006-7 financial year significant reductions in education and training budgets that had been devolved to SHAs were experienced across much of the NHS, to help restore the service to overall financial balance.

3.2.3 EUROPEAN WORKING TIME DIRECTIVE

Another policy which had, and continues to have, a major impact on the education and training of postgraduate doctors is the implementation across the NHS of the restrictions in working hours and patterns required of the NHS by the European Working Time Directive (EWTD). The continuing impact of this policy can be seen in a number of ways:

- In a profession which requires a large experiential component to training, anything that reduces the opportunity of exposure to clinical activity runs the risk of having a negative impact on the quality of training. This is particularly so for activity which is not amenable to forward scheduling or may be experienced infrequently. Thus, for example, exposure to unplanned emergency activity is particularly at risk.
- The required move to a service pattern based more on shift working to ensure that trainee doctors did not exceed the allowed hours, and indeed the same shift in working pattern for

many consultants, resulted in the disruption of the traditional 'clinical firm structure' which has underpinned postgraduate medical training over the decades. Trainee doctors no longer had the same relationship with a senior doctor who could act as trainer, role model (both good and bad) and mentor for that particular component of the training. Trainees were also much less likely to have the opportunity to follow through with patients in a way that allowed them to participate in, and understand, the end to end sequence of a disease or a patient's care.

- In many hospitals the only way to meet the requirements of the EWTD has been to introduce multi-disciplinary teams covering clinical problems arising out of normal working hours (The Hospital at Night Team). Whilst there are many benefits that come from such an approach, there is a risk that the reduction of exposure to clinical problems arising out of hours further reduces the experience and ultimately the competence and capacity to assume responsibility of postgraduate doctors in training as well as the continuity of both care and training.

3.2.4 CUMULATIVE IMPACT OF DIFFERING POLICIES ON POSTGRADUATE MEDICAL TRAINING

In a policy context of building greater capacity and getting more trained doctors into service earlier, MMC aimed to reduce the time that junior doctors spent in their postgraduate training. This plan was based on the premise that with a more focused and structured training programme, competency could be achieved in a shorter period. EWTD reduced the total time that an employee could be at work, including time spent on structured training away from the clinical environment. There was thus a cumulative reduction in time available to contribute to the service needs of the patient and organisation or to obtain the experience that is such an essential part of training.

Reducing the service contribution of postgraduate doctors in training, whilst continuing to remunerate them on the basis of full time employees, would inevitably produce financial and service pressures for organisations which faced strict performance management against service and financial targets. Trust Chief Executives were becoming increasingly concerned that the financial and service implications of the implementation of MMC were not being effectively modelled or understood by the DH or NHS.

A centrally conceived change in the number, training and working patterns of qualified doctors who were employees as well as trainees was implemented in the context of increasing devolution and decentralisation of the NHS and related accountabilities. Service recognised the increasing challenge of designing and delivering high quality medical training in this context.

3.3 MEDICAL WORKFORCE PLANNING

A number of major reviews beginning with the Goodenough Committee in 1944 attempted to assess the likely supply of doctors under certain assumptions and compare it with measures of prospective NHS demand.

In 1991 the Medical Workforce Standing Advisory Committee (MWSAC) chaired by Sir Colin Campbell was set up to advise on the future balance of medical workforce supply and demand, taking account of government advice including resource limits. The MWSAC was charged specifically with making recommendations about medical school intake, including the balance between overseas and home students. The committee commissioned research, gathered evidence and took account of national policy developments and took a longer term (20 year) view, accepting the necessary uncertainty that goes with this. In its 3rd Report, after which it was disbanded, the Committee recommended an increased annual medical student intake of 1,000 and improved workforce analysis and information. In fact 1129 new places were created to which were added a further 1000 as a result of public consultation on the NHS Plan. A survey of 152,000 members of the public and 58,000 NHS staff had placed more NHS staff as the top priority, providing the rationale for this decision.

In 1999 the House of Commons Select Committee recommended that there should be a major review of workforce planning in the NHS. The subsequent publication *A Health Service of all the Talents: Developing the NHS workforce* recommended greater integration and flexibility with the establishment of a National Workforce Development Board supported by sub-regional Workforce Development Confederations (WDCs) which subsequently mapped on to Strategic Health Authority Boundaries. In addition the merger of education and training levies across all professional groups was proposed. At this point the responsibilty for the management of medical education and training policy moved to the DH's Directorate of Human Resources. A Deputy Director of Human Resources was appointed to lead education and training policy development and implementation across the entire NHS workforce. This person also ensured that the policy direction for the Postgraduate Deans, set by the CMO, was implemented.

Medical workforce needs were integrated within the requirements of the health service as a whole. A Workforce Review Team (WRT) was formed to work on behalf of the NHS throughout the UK to co-ordinate and synthesise workforce supply and demand and intelligence and is currently hosted by the South Central Strategic Health Authority (SHA). The WRT informs the Workforce Numbers Advisory Board which in turn makes recommendations on national training numbers to the DH National Workforce Development Board. In parallel with the activities of the WRT other initiatives were being driven by the Sector Skills Council and Skills for Health.

In 2007 the House of Commons Health Select Committee Workforce Planning 4th Report of Session 2006-07 praised the *NHS Plan 2000* which promoted the development of local WDCs and the full involvement of education providers in developing workforce plans in local health economies. The Report however pointed out that staff increases had exceeded those proposed by the Plan, concluding there had been a perceived 'failure in workforce planning'. It was particularly critical of the merging of the WDCs with the new SHAs in 2004. The Report nonetheless concluded that SHAs were the appropriate bodies to lead workforce planning and commissioning in the future, yet would require greatly increased capacity to undertake these roles.

3.4 THE ACADEMIC ENVIRONMENT

In the context of this Inquiry, the last decade in the Higher Education Sector has been characterised by an increasing University focus on the quality of research performance and the need to diversify funding streams thereby reducing reliance on Higher Education Funding Council's money. A step function in this regard occurred following the publication of the White Paper in 2003 *The Future of Higher Education* heralding greater mission differentiation of Universities with the promotion of the concept of a cadre of research intensive organisations, (many of which hosted medical schools). Given this context it is not surprising that biomedical research evolved as a major preoccupation of medical schools, driven by the imperative of strong performance in periodic national Research Assessment Exercises.

In parallel the emphasis on multidisciplinary research and the opportunities afforded by the 'new biology' eroded the traditional clinical academic departments, compounded by a marked fall in clinical academic posts over the same period, despite major medical school expansion. Undergraduate teaching has increasingly been delivered by NHS clinical staff rather than clinical academics, as has postgraduate supervision. The vulnerability of the clinical teaching function of Universities in England was seriously exposed in 2006-07 with the cutbacks made by SHAs to MPET, the Multi-Professional Education and Training Levy. MPET consists of MADEL (the Medical and Dental Education Levy, which meets the salary costs of doctors and dentists in specialist training); SIFT, (the Service Increment for Teaching supporting clinical placements for Undergraduate Medical Students); and NMET (the Non Medical Education and Training budget covering undergraduate, postgraduate and CPD costs for nursing and other health professions). Formerly ringfenced, in year cuts of 15% to MPET made to restore the NHS to financial balance impacted seriously on Universities and their healthcare partners. Although SHAs are now subject to a Service Level Agreement (SLA) with DH over the use of these funds the Higher Education Sector regards the vulnerability of health education funding as one of the greatest risks it faces (HEFCE Board Paper July 2007).

Although it could be argued that teaching, and in particular the development of medical education expertise may have been influenced by these shifts in emphasis, there can be no doubting that biomedical research is a UK success story, and one that is crucial to the country's economy. The performance of the UK biomedical science base, in global terms, is second only to the United States and even then more productive per dollar spent. Following Sir John Pattison's Working Party Report, *Research for Patient Benefit* a major programme of work has been initiated under the aegis of the UK Clinical Research Collaboration (UKCRC) involving funders, academia, NHS R&D and industry. The principle aim of this activity is to enhance and harness the power of the clinical research base for the ultimate benefit of patients. The new NHS R&D Strategy *Best Research for Best Health* quickly took this initiative forward. Rapid progress has been made since its inception in 2006, including the formation of the National Institute for Health Research, the establishment of Biomedical Research Centres, the creation of new research programmes and regionally responsive schemes, and a web of local and comprehensive Research Networks in England. The creation of these new arrangements has inevitably involved significant redistribution of resource, compounding

funding changes associated with MPET and the introduction of PbR. There have been similar initiatives to develop clinical research in Scotland and Wales, and related measures are also being developed in Northern Ireland. In parallel with these developments schemes have been established to regenerate waning clinical academic capacity. In England the 'Walport Scheme' is supporting Academic Clinical Fellowships and Clinical Lectureships. A HEFCE funded intiative is creating 200 new blood Clinical Senior Lecturers over five years.

In Scotland the Scottish Clinical Research Excellence Scheme already supports new clinical research training fellowships (funded by the Chief Scientist's Office), and additional clinical lectureships (funded by NHS Education Scotland). The outcome of an application to the Scottish Funding Council to support Senior Clinical Fellowships will be known shortly.

These developments are being built on in a major way following the report of Sir David Cooksey, *A Review of UK Health Research Funding* in 2006, proposing the development of a unified, ringfenced fund to support UK government funded health related research. A key rationale behind the unified fund is the desire to drive the translation of research findings into benefits for patients through, amongst others, the rapid development and adoption of new treatments. This Report is now being implemented with the creation of the Office of Strategic Co-ordination of Health Research and increased funding to support the entirety of health research.

Thus the R&D strategy is now clear and a ring-fenced fund, the distribution of which is informed by the quality of research outputs, has been created. In contrast education funding is no longer ring-fenced and the link between education funding and high quality education outputs from Trusts and Universities is less clear.

3.5 THE REGULATORY ENVIRONMENT

The role of the regulator is to protect the public. Medical education and training need to conform to clear standards and reflect the needs of patients and the health service. The regulator determines, monitors and enforces the standards to be met.

The General Medical Council (GMC) was established under the Medical Act of 1858. This gives it powers to protect, promote and maintain the health and safety of the public.

As far as undergraduate education is concerned, the GMC works with UK medical schools that issue UK primary medical degrees, to set standards for the knowledge, skills, attitudes and behaviours that medical students should acquire. These are laid out in a document called Tomorrow's Doctors. The GMC also produces joint guidance with the Medical Schools Council (MSC) on professional behaviour and fitness to practise.

The GMC runs a highly regarded quality assurance programme for UK medical schools to ensure they maintain a good standard of medical education.

In 1975 the *Merrison Report* concluded that postgraduate medical education and training required a regulatory framework and suggested that the GMC undertook this role and hold a register of specialists and GPs. This recommendation was not heeded.

The *Calman Report* of 1993[1] recommended that legislation should be enacted introducing the UK Certificate of Completion of Specialist Training (CCST) – awarded by the GMC to trained specialists on the advice from the appropriate Medical Royal College – thus ensuring consistency with European Commission (EC) law. Holders of CCSTs or European Union (EU) equivalents could then have this reflected in the Medical Register. The Report also recommended that Medical Royal Colleges and Faculties should set standards in medical education, but that greater cooperation between bodies was required. It also argued that the NHS management and Postgraduate Deans had a legitimate interest in training.

The European Specialist Medical Qualifications Order (1995)[2] created the Specialist Training Authority (STA) of the Medical Royal Colleges (and the Specialist Register held by the GMC). The legislation gave the Authority the statutory responsibility for specialist training, and defined a predominantly profession-based membership. General Practice training was overseen by the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

Historically the medical profession has been self regulated. This arrangement is crucially dependent upon the public trusting the profession to maintain high standards.

A series of medical failings, such as Bristol, Alder Hey and Shipman around the turn of the century increased the pace of regulatory reform and led to calls for more public involvement in all healthcare regulatory functions. The Bristol Inquiry[3] recommended that postgraduate medical education should be regulated by the GMC, as undergraduate medical education had been since 1858.

Rather than adopt this recommendation, the government consulted on the creation of an independent Medical Education Standards Board to replace

[2] The European Specialist Medical Qualifications Order Statutory Instrument No. 3208 (1995)
[3] The Stationery Office The Bristol Royal Infirmary Inquiry Final Report (2001)

the STA. It was argued that this body would better reflect the views of the NHS and patients working alongside the medical profession. The new Board, renamed the Postgraduate Medical Education and Training Board (PMETB), was created in 2003.

The Board's statutory remit is to oversee the content and standards of postgraduate medical education and training (PMET) across the UK. The Order sets out the legal framework for its operation.

The principal statutory functions of the Board are:

- To establish standards of, and requirements relating to, postgraduate medical education and training
- To secure the maintenance of the standards and requirements established
- To develop and promote postgraduate medical education and training in the United Kingdom.

The main statutory objectives of the Board in exercising its functions are to:

- safeguard service users
- ensure that the needs of those undertaking education and training are met
- ensure that the needs of the employers are met.

PMETB's remit does not extend to:

- undergraduate education
- recruitment and selection into postgraduate medical education and training (including the application process and scoring system) other than determining the standards to be reached by doctors to enter specialist training
- workforce planning
- determining or setting the number of training posts
- continuing professional development and recertification

In response to the consultation following the Chief Medical Officer for England's report *Good Doctors, Safer Patients*[4], the CMO accepted the GMC's proposal for a three Board model, covering undergraduate education, specialist training and continuing professional development. It was further proposed that consideration be given to merging all three activities in due course.

[4] Department of Health, Good Doctors, Safer Patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients (2006)

3.6 POSTGRADUATE MEDICAL EDUCATION AND TRAINING

The origins of MMC can be traced back to 1988. The DH paper of that year, *Hospital Medical Staff: Achieving a Balance – Plan for Action* revealed that reports over the preceding 20 years had called for an increase in the ratio of consultants to training posts. *Achieving a Balance* proposed a 2.8% pa increase in the number of consultants with central pump priming for 100 new posts. Registrar posts were to be linked to future opportunities and consultant need with the average time in registrar posts reducing to 3 years. An inevitable consequence of this policy would be that consultants would need to be more directly involved in direct patient care and supervising trainees and there would need to be new opportunities for doctors unable to progress to consultant posts. As well as new national medical workforce advisory machinery, Regional Manpower Committees with representatives from Districts and Medical Schools would provide a regional perspective including, for example, on the 'safety net' of necessary staffing levels.

In 1993 The Calman Report *Hospital Doctors – Training for the Future* responded to the perceived need for both the shortening of British training and for a defined endpoint marked by the award of a certificate by a body responsible for regulating training. The report recommended:

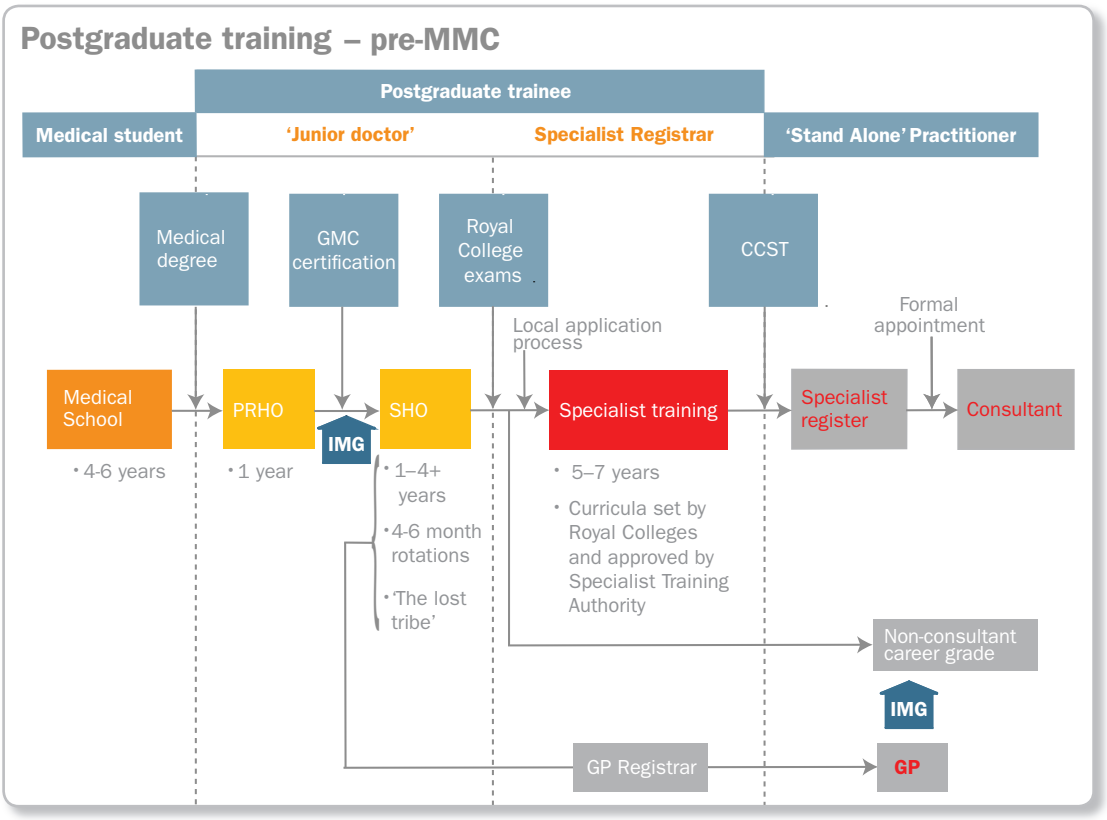
- A reduction in the minimum length of specialist training to 7 years.
- The introduction of more explicit training curricula and a certificate of completion of specialist training (awarded by the General Medical Council [GMC]).
- The merging of registrar and senior registrar grades, phased in gradually from 1 April 1996, completed in April 1997

The resulting structure of postgraduate training that prevailed until MMC is summarised in Figure 3.2.

Despite the creation of 'Vanguard specialties' that were 'Calmanised' a year early the timetable proved tight. It proved harder for some smaller District General Hospitals (DGH) to attract posts and the mismatch between educational priorities and service need became more apparent in some areas. Perhaps more relevant to contemporary concerns was the sense that a shorter training period and the academic focus of training might create doctors who were not ready to assume the consultant role.

Against this background, the consultation paper, *Unfinished Business*, produced by the CMO in August 2002, is rightly regarded as the seminal publication that led to MMC. *Unfinished Business* exposed clear deficiencies in the nature of the Senior House Officer (SHO) grade, a grade that comprised almost 50% of doctors in service. Just under half were not part of a training programme thus necessitating frequent reapplication and change of job. Yet by definition just over half were, and for this constituency the experience was more positive – and more likely to have a successful outcome. Furthermore *Unfinished Business* acknowledged that not all trainees could or indeed wished to make definitive career choices early in their postgraduate training and should not be pressed or expected to make premature career decisions. Data were cited revealing 24% of doctors entering the SHO grade changed their career preference at least once within the three year period following entry to the grade.

Figure 3.2



The principles expounded for the reform of SHO training endure in the minds of most doctors, namely training should:

- Be programme-based
- Be broadly based to begin with for all trainees
- Provide individually tailored programmes to meet specific needs (i.e. trainee sensitive)
- Be time-capped
- Provide opportunities to leave and re-enter

Furthermore the report's suggestions that following Foundation there should be eight (or so) broad-based, time capped, basic specialist training programmes, which should be flexible in design and operation are also frequently quoted as aspirations for any revision of the present arrangements. Although it was suggested that moving to a single training grade encompassing foundation; basic specialist; general practice; higher specialist; and individual training programmes should be urgently explored it was nonetheless acknowledged that some element of competition might still be retained to meet the needs of service and acknowledge the availability of training places.

Although focused on reform of the SHO grade, *Unfinished Business* had implications for other aspects of the medical workforce. These included the earlier completion of specialist training as a 'generalist consultant' implying a need for further specialist training beyond certification, and the need to destigmatise, restructure and enhance the Non Consultant Career Grade (NCCG) with greater opportunities to enter (and re-enter) higher specialist training. The four UK Health Minsters responded in February 2003 to the ensuing consultation on *Unfinished Business* which generated 370 responses.

Although the proposals were broadly welcomed, many issues were raised. Would, for example, a seamless training grade hinder competition and flexibility? Would sufficient resources be committed? The lack of detailed implementation plans also provoked concern. On the question of 'run-through' training 42 of 90 respondents agreed. From the remainder concerns were expressed including the need to create a hurdle between basic and higher specialist training, the necessary, arguably premature, choice of specialty, and the sense that such an approach might hinder competition, drive and aspirations for excellence and therefore downgrade standards.

Most controversial however was the proposal for early award of the Certificate of Completion of Training (CCT), on the basis that it would endanger patient safety as doctors would be less well prepared and it would devalue the consultant grade.

To facilitate implementation, a phased transition was suggested, informed by evaluation of early pilots. Concern was also expressed that implementation should be delayed until the impact of the European Working Time Directive (EWTD) was known and adequate assessment tools were available.

The implications with regard to NCCGs were reported in a document *Choice and Opportunity* in July 2003 proposing a series of principles and recommendations that doctors at the start of their careers would still wish to see.

Following the Ministerial Report the future shape of foundation, specialist and general training programmes was enshrined in the document *Modernising Medical Careers – The Next Steps*, published in April 2004, produced by the UK Strategy Group involving the GMC, DH, Medical Royal College representation and the Postgraduate Medical Education and Training Board (PMETB).

Of note is the fact the specific plans for specialist training reported that 'thinking had moved beyond the basic specialist programmes foreseen in *Unfinished Business*' towards a single, 'run-through approach', although whose thinking and with what authority is not entirely clear. The MMC Delivery Board Paper of October 2003 rationalised the decision on the basis of:

- Perceived support expressed during the consultation on Unfinished Business for the more rapid introduction of 'run-through'.
- The establishment of PMETB 'allowing doctors to count all relevant training after full registration towards their CCT'.
- Competency based training rendering the division between basic and specialist training 'meaningless'.
- Emerging thinking encapsulated in the STA conference in 2003 which 'grasped the possibilities of new, more streamlined specialist training programmes'.

It was thereafter assumed there would be progressive acquisition of basic and higher specialist competencies in a single time limited programme. Consequently, it was anticipated that a greater proportion of more advanced training would occur following the acquisition of a CCT.

As regards entry into specialist training, experience in a particular specialty at Foundation level would not be a criterion for entry to a specialist programme. Furthermore a route to entry for doctors without UK primary, specialist or general practice training or experience would be created.

The anticipated structure of postgraduate training following full implementation of MMC is illustrated in Fig 3.3.

Figure 3.3

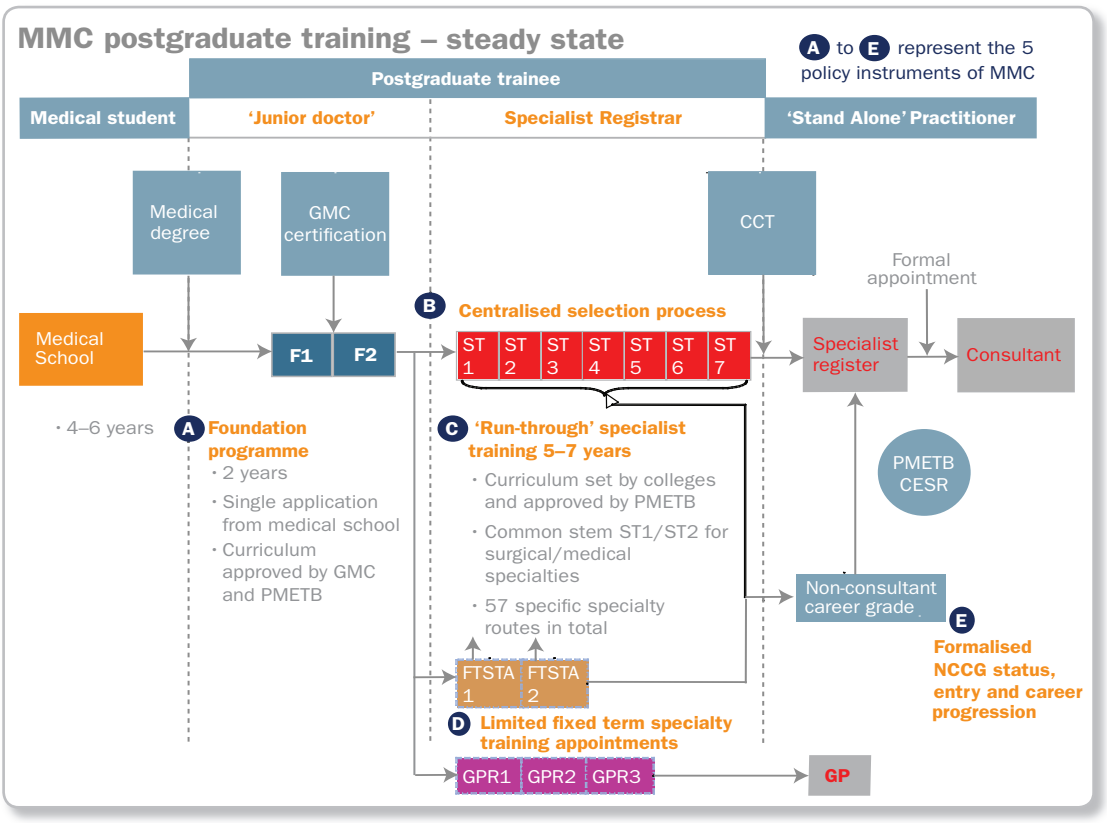
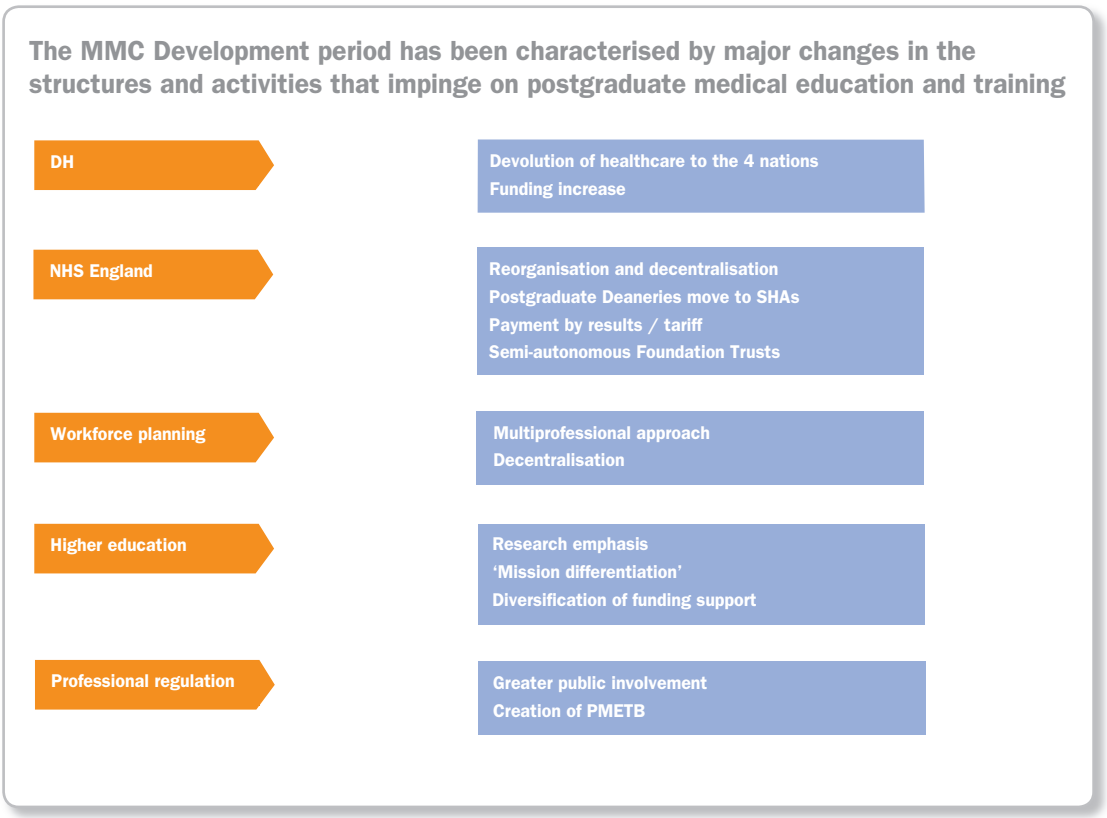


Figure 3.4



3.7 CONCLUDING COMMENT

As the preceding Sections make clear, the MMC development period has been characterised by major flux in those structures and activities that have a crucial bearing on postgraduate medical education and training. (Fig 3.4). Many of these changes reflect the Reform Strategy for the English NHS, the origins and nature of which are well described in Simon Stevens' Health Affairs article[5]. Funding streams in England relating to service contracts, education and research have also been subject to considerable change.

Given such flux, it is likely that coherence of an activity that relies on close alignment of purpose across the domains involved, will be adversely affected unless there are robust mechanisms to ensure close collaboration. The need for such close collaboration between the Universities and the healthcare sector through explicit commitment to education and research, was one of the founding principles of the NHS in 1948. In 1981 Sir Fred Dainton's reflections on the National Health Service considered the interface between Universities and the NHS to be 'the place where the future confronts the past' and the challenge was 'to make this confrontation productive rather than the cause of sterile and unproductive tensions'

In 1987 the Steering Group for Undergraduate Medical and Dental Education and Research (SGUMDER) was set up to improve co-ordination between the sectors. The Steering Group's fourth report in 1996 concluded that 'close collaboration between Universities with Medical Schools and the NHS is essential (and) the successful outcome of this co-operation is a key factor in determining the quality of the nation's healthcare.' It issued 10 Key Principles to guide the working relationship between medical schools and the health service. These 10 Key Principles were updated as recently as 2004 and accepted by Sir Nigel Crisp as Chief Executive at the NHS and Permanent Secretary at the DH and by Sir David Normington as Permanent Secretary at the DfES.

In practice, in England, the MMC development period has been characterised by fracturing of many of the linkages between the health service and academia in the wake of health service reorganisation. (Fig 3.5)

The high level body, StLaR, charged with taking an overview of activity at the interface between DH and DfES appears to have been disbanded; the new SHAs are no longer required to have medical school or academic representation; and health education sector partnerships (HESPs) proposed as means to ensure collaboration at a local and regional level have disappeared. The detachment of most postgraduate Deans and Deaneries from Universities has undermined further the health:education sector partnership. Medical Schools have played a decreasing role in postgraduate training reflecting in part their emphasis on undergraduate education and research. Furthermore despite being one of the priorities of the UKCRC little progress has been made on creating incentives to promote health: education sector partnership through the mechanism of the Healthcare Commission Trust inspection regime.

Devolution provides the UK with a 'natural experiment' however. The strength of the health:education sector partnership appears to vary across the four countries, as judged by an analysis conducted for the UK Health Education Advisory Committee (UKHEAC), (Fig 3.6) with Scotland and N. Ireland faring better than England and Wales.

[5] Reform Strategies for the English NHS: Health Affairs Vol. 23 No. 3

Figure 3.5

Factors eroding Health:Education Sector Partnership during the MMC development period

- Abandonment of the Strategic Learning and Research Advisory Group (StLaR)
- Loss of academic representation on SHA Boards
- Abandonment of Health Education Sector Partnerships
- Abandonment of Workforce Development Confederations with academic representation
- Postgraduate Deaneries links with Universities reduced
- Raiding of education and training budgets to meet service financial pressures in 2006–07
- Lack of hospital incentives for education and research in a strongly target driven environment

Figure 3.6

JMAC[1] Questionnaire on degree of joint working between government health and education departments: Question 5

Relative effectiveness of the relationship for the following domains of activity (1 least – 5 most)	England	Scotland	Northern Ireland	Wales
Workforce Planning	2	4	4	2
Funding of undergraduate clinical placements	5	2	5	5
Commissioning non-medical education and training	2	5	3	3
Hosting clinical research	3	5	4	2

Reference JMAC minutes 17 November 2006
[1]JMAC Joint Medical Advisory Committee (now UK Health Education Advisory Committee

INQUIRY FINDINGS

4

OVERVIEW

The Inquiry focused on seven areas of concern:

1 MMC policy objectives, their development, implementation and governance

2 Professional engagement

3 Regulation: PMETB

4 Workforce analysis

5 Education and selection analysis

6 Management postgraduate training

7 Service perspective

4.1 MMC POLICY OBJECTIVES, THEIR DEVELOPMENT, IMPLEMENTATION AND GOVERNANCE

In this first section we consider:

- Were policy objectives clear?
- Were the components or policy instruments of MMC (i.e. Foundation Programme, centralised selection, 'run-through' specialist training, fixed term specialist training appointments (FTSTAs), and formalised NCCG status in line with objectives and fit for purpose?
- Was the policy development process coherent and properly managed?
- Was policy implementation appropriate and effectively governed and 'risk-managed'?

4.1.1 MMC POLICY OBJECTIVES

Although precipitated by specific concerns about the SHO grade addressed in the CMO's report, *Unfinished Business* in 2002, the scope of MMC began to address the 'wider challenge of introducing reform across the whole medical training and career structure…'. Despite this broad ranging remit the precise policy objectives of MMC do not appear to have been definitively stated at any point nor agreed by key stakeholders. In the absence of such a definitive statement or clear consensus a wide range of educational and workforce objectives was ascribed to MMC by both stakeholders and MMC's own management.

Given this lack of clarity it is perhaps not surprising that the Inquiry's e-consultation found that nearly half of respondents erroneously attributed certain functions, namely standard setting and the determination of the number of training places, to MMC.

This lack of clear objectives left MMC open to the risk of scope drift:

'The scope is seen to have changed from a programme to update training and careers into a major workforce redesign. Some key stakeholders will sign up to the former but not the latter.'[1]

MMC's senior leadership team recognised the issue of multiple competing objectives:

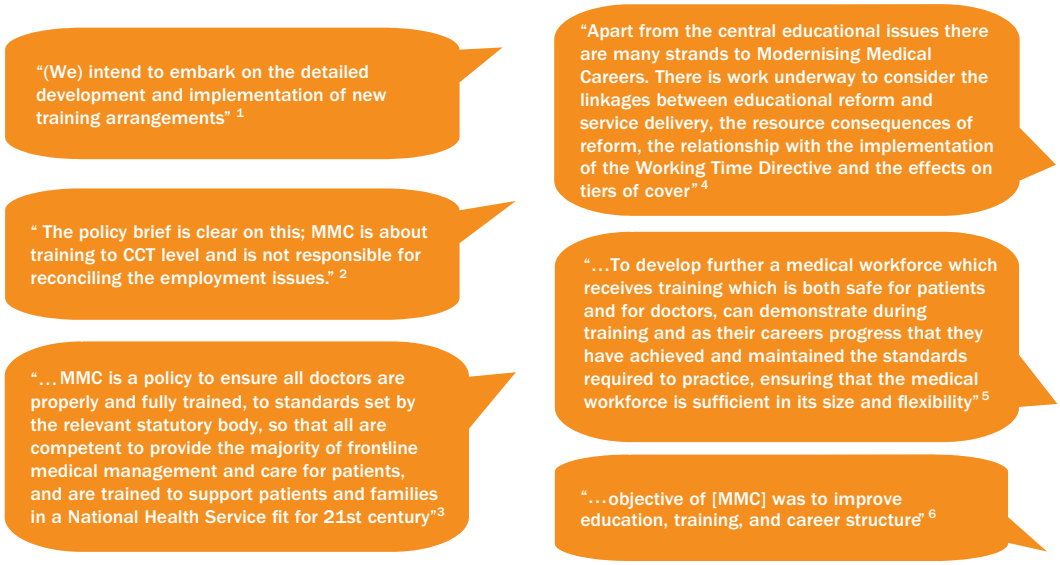
'There are currently at least three inconsistent 'objectives' required of MMC by different, but key, stakeholders.

- Royal Colleges/BMA etc want run-through training programmes designed to deliver more consultants in every specialty that also deals with and eliminates the bulge, gives every doctor a job and provides excellent educational opportunities for all.
- Trusts/service/DH workforce policy want a service-driven, large, low-cost pool of doctors at SHO or 'trust doctor' level. This runs completely counter to the NHS plan, MMC policy documents and the existing 2008 target.
- CMO/PMETB want a training programme that delivers safe accredited doctors providing a high standard of service to national standards of care.'[1]

[1] DH Healthcheck Report, MMC Programme, 10.08.05

Figure 4.1

Educational and workforce-related objectives were ascribed to MMC



1 MMC: response of the four UK Health Ministers to the consultation on Unfinished Business report, February 2003
2 Policy Rationale for MMC (undated)
3 Policy context for MMC (undated)
4 Modernising Medical Careers – The Next Steps – 4 Home Countries Report, April 2004
5 Training Tomorrow's Doctors: Delivering Excellence, June 2006
6 Minutes of Delivery Board, 28 October 2003

Despite this recognition of inconsistencies, MMC's objectives do not appear to have been redefined and agreed, nor at any point do value for money considerations seem to have been explicitly considered. In particular the necessary integration of career structure, workforce and service implications, does not appear to have been addressed in policy objective terms. Rather the emphasis remained on streamlined, structured competency based training.

With hindsight it is easy to see how the achievement of such limited training objectives was bound to be complicated by a number of compounding workforce issues. Not only was the nature of the post CCT specialist in relation to the existing concept of a consultant unresolved, so too was the NCCG contract. Synchronous NHS reforms and service redesign necessity were prompting Trusts to review their skill mix to achieve cost effective quality care. But arguably the most significant confounding factors relate to the structure and growth trajectory of the medical workforce comprising two major components, considered further in Section 4.4.

Objectives

MMC will endeavour to achieve its visions and aims by

- Ensuring that the standards of competence required for doctors are explicit and met
- Streamlining postgraduate medical training so that doctors are trained in the minimum appropriate time
- Championing effective approaches to safe training and further career development using skills, drills and rehearsals so that doctors always have the safe care of patients uppermost in their practice.

Vision statement, Workforce Development (ERP), May 2006

Aim

The aim of MMC is to improve the quality and safety of patient care by the introduction of more structured, competency-based training, focusing on both clinical and generic skills designed to meet the needs of service.

NHS Management Board paper by Head of Education Training and Development (DH) Oct 2006

- The large bulge in trainees at the FY2/SHO level
- The massive increase in the medical student cohort since the late '90s that will drive demand for postgraduate training posts, and the overall size in the medical workforce. (Fig 4.2)

4.1.2 DELIVERY OF TRAINING POLICY OBJECTIVES

The training policy objectives articulated in *MMC – the Next Steps* comprise:

- Structured, time limited training
- Competence based selection, training and evaluation
- Flexible training opportunities
- Competition-based selection

The Inquiry considered the extent to which the key components of MMC reform – the MMC policy instruments – delivered, or had the capacity to deliver, the training policy objectives.

As pointed out above, training and workforce issues are intertwined and so it is instructive to examine the extent to which the same MMC policy instruments contribute or not to workforce objectives as reported to the DH Workforce Programme Board, namely:

- Consultant delivered service
- 'Safe' doctor delivered service
- Cheaper, more flexible medical workforce
- Non reliance on International Medical Graduates.

Fig 4.3 summarises the degree to which MMC structural reforms align with these policy objectives.

Although the five policy instruments – the Foundation Programme, centralised selection, 'run-through' training, FTSTAs and formalised NCCG structures – do address some pre-MMC concerns and exhibit particular strengths, a number of weaknesses are also evident, which are considered in detail below.

4.1.2.1 The Foundation Programme

The Foundation Programme, representing the first stage of MMC reform, possessed inherent strengths designed to address perceived deficiencies in the PRHO and first year SHO experience. Foundation for the first time comprised a formal programme with a national curriculum and structured assessment of clinical competences. There was a single application to a fixed two year programme, avoiding the need to apply for one or more SHO posts for the second year.

In practice selection into the reformed PRHO year, Foundation Year 1 (FY1) generated adverse publicity in the first round (2005 for August 2006 entry) with claims by some that undergraduate academic performance was given insufficient weight and yet reluctance on behalf of some student individuals and groups to acknowledge that such information could legitimately be considered.

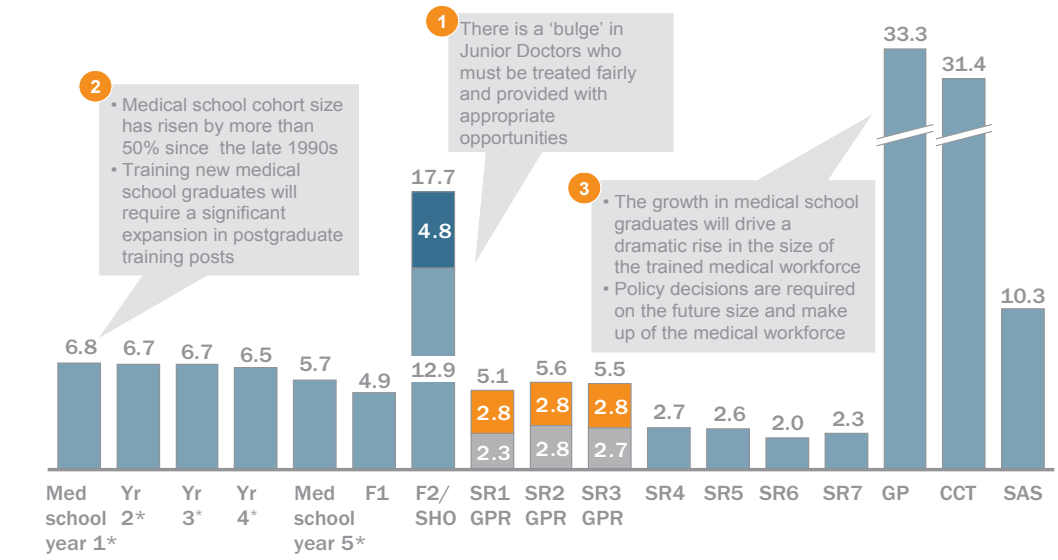
The e-consultation view on the 2006 selection round revealed that few (10%) favoured the system employed over previous systems for selecting PRHO jobs. In contrast the view from the Centre in Northern Ireland was that Foundation recruitment had benefited those sites that had had recurrent recruitment difficulties in the past. E-consultation opinion was equally divided as to whether FY1 links effectively with undergraduate education and training but the majority of those expressing a judgement felt that the FY1 experience could be improved by greater integration with undergraduate programmes.

Figure 4.2

Challenges for MMC/postgraduate training resulting from medical workforce policies

NHS England medical population by grade as of 2006/07

000s in role



* Medical school entry – graduation rates are likely to be 4-7% lower

Source: MMC – PDB 06 – 21 model; team analysis

Figure 4.3

The degree to which MMC policy instruments deliver against training and workforce goals

\+ Contributes to policy goal

– Detracts from policy goal

MMC policy instruments	Training objectives: Structured, time limited training[1]	Training objectives: Competence-based selection, training and evaluation[1]	Training objectives: Flexible training opportunities[1]	Training objectives: Competition-based selection[1]	Workforce objectives: Consultant delivered service[2]	Workforce objectives: 'Safe' doctor delivered service[2]	Workforce objectives: Cheaper, more flexible medical workforce[2]	Workforce objectives: Non-reliance on IMGs[3]
Foundation programme	+	+	+	+		+		
Centralised selection process		+/–		+/–				
Run-through specialist training	+	+	–	+/–	+	+/–	?	+
Fixed term specialist training	+	+	?	+/–		+/–	?	
Formalised NCCG status, entry and progression	+		+		?	+	+	+

1 'Modernising Medical Careers – the next steps' statement by the 4 UK health departments, April 2004

2 Workforce Programme Board Paper 05-084 November 2005

3 Workforce Programme Board Report July 2006

Trainee workshops revealed scepticism regarding the competency assessments employed, the 'tick box' mentality involved, and worse, the sense of replicating skills familiar pre-graduation, perpetuating the student role. Most nonetheless affirmed the FY1 year as a useful introduction to supervised clinical practice.

Formal evaluation of the Foundation Programme in the Postgraduate Medical Deanery for Kent, Surrey and Sussex[2] reaffirmed such positive sentiments, trainees particularly appreciating being in one place for the whole year, having a broad range of experience, and being given greater responsibility for their development. However, the majority of respondents felt the curriculum had been too hastily introduced and opportunities to link with undergraduate education had not been taken. Criticism of the assessment process was common.

Clearly the experience of Foundation Year 2 (FY2) is more limited with only one cohort having completed the year and their experience inevitably coloured by application for specialist training, a process that began six months into the year. The e-consultation revealed that whereas a slight majority regarded FY2 as a valuable educational experience that built effectively on FY1, 69% of respondents disagreed with the concept that it was an advance on the first year SHO experience that it replaced.

The trainee workshops revealed FY2 experience was very variable, broadly split between those who had enjoyed coherent rotations that were relevant to their future career intentions, to those who felt no connection with the specialty to which they had been allocated.

The four month attachments were generally perceived as too short. This added to the lack of sense of worth in the role, particularly for those who experienced little increase in responsibility over that encountered as an FY1 doctor.

But the clearest view expressed was that, for the majority, half way through FY2 was too early to be deciding on a specialty, particularly as was often the case, experience relevant to that specialty, if available, would not be had until after the choice had to be made. Polls at the trainee workshops confirmed that fewer than a third of trainees thought they knew which specialty they wished to pursue at the end of FY1, and of these approximately half subsequently changed their minds. This contrasts with a survey undertaken of medical students prior to entry into FY1 where 98% of whom were able to name 3 specialties they were considering, suggesting decision making is very fluid at this phase[3] . A recently published monograph[4] on the Foundation Programme supported by the Association or the Study of Medical Education (ASME) concludes with a 'Balance Sheet' assessment of the new arrangements. In addition to the points made above concerns are raised about the following issues:

- The greater centralisation of the management of training programmes with resultant loss of choice for trainees of the Trust in which they work, and an erosion of their relationship with their employer and the relationship between selectors and selected.
- The impact of travelling to rotations.
- Potential erosion of opportunistic learning.
- A lack of emphasis on the management of chronic disease, (and the treatment of sepsis).
- An emphasis on the number of hours per week that trainees should have for protected teaching, rather than an emphasis on the requirement for that most important of clinical educational commodities, regular feedback. This is ironic given the rejection in the clinical training programmes of the value of 'served time'.

[2] Final report of an evaluation of the Foundation Programme in the Postgraduate Medical Deanery for Kent Surrey and Sussex
[3] J Malawana et al Hosp.Med. 2004; 65 No7pp 431-433
[4] Monograph on the Foundation Programme, Association for the Study of Medical Education 2007

In conclusion although conforming reasonably well to MMC training objectives, and having been relatively well managed into place, there are residual concerns about the Foundation Programme. Prominent amongst these are the integration of FY1 with the final undergraduate year, the validity and robustness of the competency assessments, the length of FY2 placements and in many cases their relevance, and the premature choice of specialty half way through FY2.

4.1.2.2 Centralised Selection: MTAS

A more comprehensive critique of MTAS appears in Appendix 5. In Section 4.5.1 we examine the MTAS experience from an educational perspective. Here we consider its fitness as a policy instrument to deliver MMC's policy objectives and the personal impact of its introduction.

The attractions of a single centralised application system for specialist training are several including the avoidance of the need for multiple applications and the opportunity of consistency of process. The perceived weaknesses of the MTAS system employed, notwithstanding the technical failings and rushed implementation, related to the fact that experience and exam performance were not part of the explicit selection criteria. Furthermore acceptance of the approach employed required a culture shift as well as significant training of evaluators in the new methods.

As the catalyst that precipitated the Inquiry it is no surprise that the commentary surrounding the selection process for specialist training has been the most extensive, and emotive. The overwhelming view of the profession (93%) refutes the effectiveness of the selection processes used, and supports greater weight being placed on undergraduate academic achievement, postgraduate academic achievement and experience obtained in the particular specialty applied for.

At trainee workshops the need for competitive entry was acknowledged as long as tests with professional face validity were used and candidates were made better aware of the prospects for success in particular specialties.

The MTAS process for many was viewed as dehumanising through i) operating as an electronic portal, ii) deficient communication, iii) anonymisation with no reference information utilised, and iv) appointments being made to wide geographical areas potentially separate from partner/family.

But it is perhaps the experience of those SHOs in 2nd year and beyond who were 'ahead of the curve' that is the most poignant, particularly in the case of those who had committed to acquiring what they perceived to be valuable extra clinical or research experience or postgraduate qualifications. In scoring the application forms the academic achievements for this group did receive greater weight than those seeking ST1 entry, but the denial of employment history or references provoked understandable resentment.

As the personal accounts illustrate the impact of MTAS in particular on some at least has been profound. Surveys of doctors' morale have always tended to be conducted at potential low points but recent analyses are difficult to dismiss. With the 'high stakes' nature of this year's round, a psychological impact would be anticipated. An on-line survey published in the BMJ involving 790 anonymous respondents revealed 94% admitted to higher stress levels over the past six months, in the vast majority of cases attributed to MTAS/MMC[5]. A traditional means of monitoring morale is in terms of sickness absence rates. To that end NHS Employers submitted evidence examining sickness levels for Doctors employed at Foundation, SHO or Trust grade levels for training year August 2005 to July 2006 compared with August 2006 to July 2007. A survey of 30 Trusts did not support the hypothesis of increased sickness absence in the last year although it was felt that goodwill had been stretched all round. Most

[5] Mental health of applicants seems to be deteriorating, Lydall et al, BMJ 334 (7608) 1335, 2007

absences and pressures for locum cover related to interview requirements rather than sickness. A survey of 174 UK Trust HR/Medical Personnel Departments revealed very high levels of staff stress over this period (mean score 7.2 $\pm$ SD 2.0, where 10 = extreme stress on staff and 1 = no greater pressure than usual). Stress levels were noticeably less marked in N Ireland (mean score 2.5 $\pm$ 2.5).

Much has been made of the fact that our best junior doctors may be emigrating in droves as a result of this process. No hard data exist, but a surrogate for emigration intent is the seeking of a 'Certificate of Good Standing' (CGSs) for GMC registered doctors, who are considering registering outwith the UK. For UK graduates numbers of CGSs issued for the first 7 months of 2007 were down at a total of 2003 applications, compared with 2265 in 2006 and 2042 in 2005. There are no data on the make-up of those seeking such experience. It is perhaps reasonable to speculate that the reason for the slight fall this year is that recently qualified UK doctors would have considered very carefully the wisdom of absenting themselves from the UK without the guarantee of a training post on their return.

In conclusion, MTAS conformed to the competence based selection training objective but the competition was perceived as unfair and paid insufficient regard to experience and academic achievement. Rushed implementation, poor communication, overloaded Deaneries and technical deficiencies contributed to a system that caused profound distress and demoralisation.

4.1.2.3 'Run-through' Specialist Training

The development of the 'run-through' concept – progression subject to satisfactory competency assessment from the start of specialist training through to completion, emerged in the *Next Steps* as an 'advance' on the original MMC concepts envisaged in *Unfinished Business* but without thorough rationalisation. There is however evidence that Junior Doctors at the time supported the concept, no doubt attracted by the clear pathway to specialist certification and the promise of more certainty on geographic location. It also appears that they were under the misapprehension that specialty places would be available for all those desiring them. (JDC minutes June 2003 and January 2004). More streamlined training with a structured curriculum and assessment process is a potential strength if trainees are certain of their career aspiration. These positive features were reiterated at the trainee workshops the Inquiry conducted. Another advantage could be the focus on clinical abilities rather than examinations.

However, at all workshops perceived disadvantages outweighed the advantages with forced prematurity of choice of final specialty and perceived rigidity being the dominant themes. In this regard 'run-through' has singularly failed to provide the training objective of flexible training opportunities. The initial attraction of a clear path to CCT had been offset in many instances by uncertainty as to what such status equipped the doctor to do. Clinical confidence was further threatened by the prospect of shorter training, and the compounding impact of EWTD. Were such a system to prevail it would be highly dependent on effective forecasting of specialty workforce needs to avoid under or over supply. It would also necessitate potentially expensive retraining given the limited generalist foundation from which the specialty trainees are differentiated. Thus an earlier commitment to specialist training reduces the capacity to achieve the workforce objective of a more flexible medical workforce.

The e-consultation confirms the perception gained at the trainee workshops. Only 21% agreed or strongly agreed with the notion that there should be 'run-through' specialist training after the Foundation Programme. 75% believed 'run-through' would have a negative impact on clinical service delivery – and 95% wanted the flexibility to take more than seven years from graduation to obtain a CCT.

4.1.2.4 Fixed-Term Specialist Training

At one level a FTSTA can be perceived as an opportunity further to develop skills and broaden experience prior to entering specialist training or taking an NCCG post. One year appointments are however inconsistent with the latter route which requires four years postgraduate experience. FTSTA post holders nonetheless benefit from the same structured curriculum and assessment methodologies as Specialist Training positions. The major concern regarding the role is that it risks becoming the new 'milling ground' for those hoping to enter specialist training or a stigmatised direct route to NCCG.

4.1.2.5 Formalised NCCG status, entry and progression.

An integral part of the MMC spectrum was modernising medical careers for non-consultant career grade doctors. Four years on the views of doctors in such grades expressed at the trainee workshops echo the recommendations of the July 2003 publication, *Choice and Opportunity*, the need for a new nomenclature, capacity for some independent work, education and development opportunities with CPD and study leave access, re-entry into specialist training programmes and revised terms and conditions.

The workshops also emphasised the need to destigmatise the roles, and rejected the concept that any doctor could be in a 'non-training grade'. The positives – the consolidation of experience as part of a consistent team – could be better acknowledged, as could the contribution such doctors make to education, research and development.

Unfortunately to date there has been no approval of the Staff Grade and Associate Specialist (SAS) contract agreement that might lead to a parallel attractive career route. Without this resolution the grade runs the risk of remaining in the perception of many a diversion into a cul de sac, with trainees and policy developers harbouring different expectations of the likelihood of entering and exiting the role either as a specialist trainee or an Article 14 Certified specialist.

4.1.3 MMC POLICY DEVELOPMENT PROCESS

Notwithstanding the uncertainties regarding the policy goals and the confounding workforce objectives, in the Inquiry's view the accountability structure chosen for policy development appears inappropriate for a programme of this complexity, involving four nations, in a health service in a state of considerable flux. (Figure 4.4). In particular the ambiguity resulting from split accountability of senior leadership and Senior Responsible Officer roles, with significant rotation of individuals in the DCMO role and on the UK Strategy Group contributed to a lack of clarity/resolution of key issues. (Figure 4.5). In Scotland it was felt that the lack of consistency of Chairmanship of the UK Strategy Group allowed the development of an educational structure and philosophy, which although broadly consistent with *Unfinished Business* impeded the ability to absorb SHOs into the training grades. Furthermore the MMC Programme Board was an English device despite the four nation roll out and contributed to a sense in Wales, Scotland and N. Ireland that the process was 'English-centric'. Lines of accountability within the Devolved Administrations appear to have been shorter and clearer with resultant greater coherence, although all three Devolved Administrations were between CMOs at some point during the development period

Despite the complexity of the accountability structures MMC policy development appears to have adhered in theory to a standard process (i.e. problem description, accountability assignment, option development, consultation, decision and implementation).

Figure 4.4

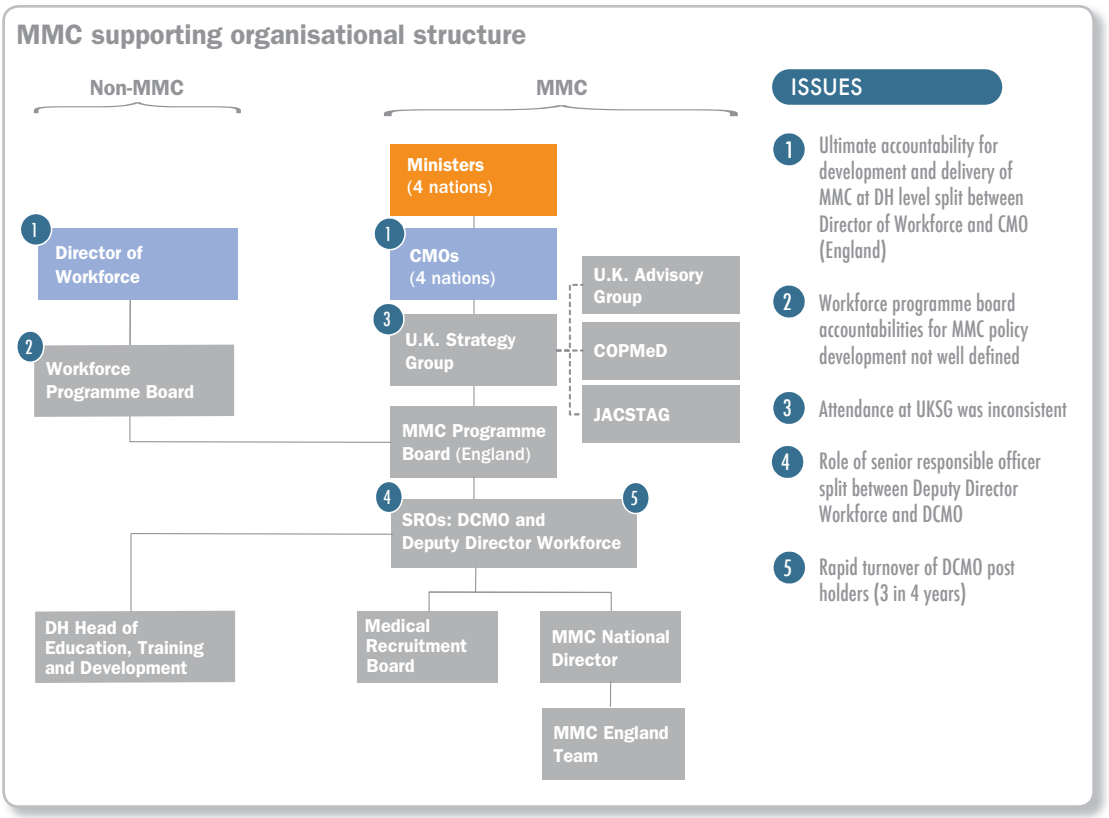


Figure 4.5

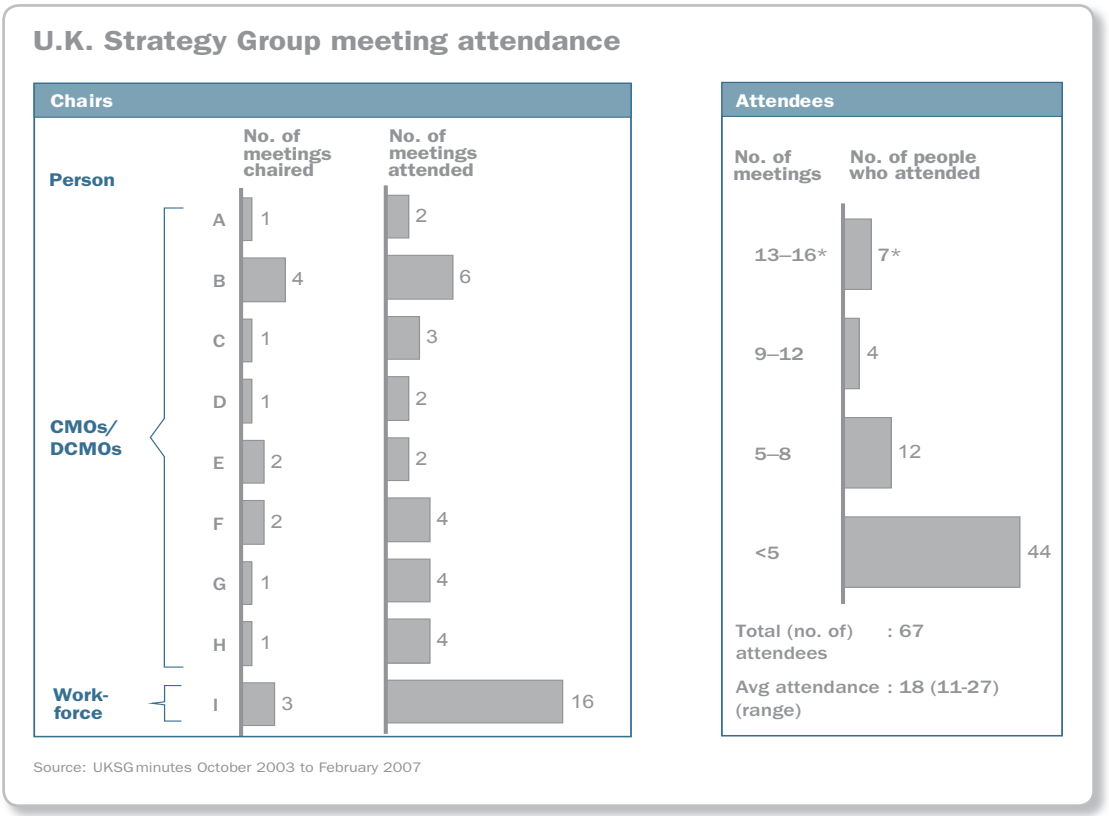


Figure 4.6

Foundation programme transition: Decision making process over time

	Decision maker	Description	Timing	Source
Problem described	CMO	• CMO describes problems with poor training and career progression for junior doctors	Aug 2002	• 'Unfinished business' August 2002
Accountability assigned	UKSG	• COPMED is given responsibility for driving a national recruitment process accountable to UKSG for F1/F2	Jan 2005	• UKSG minutes 20 January 2005
Options developed	UKSG	• 2 options presented for Foundation training – Number of predetermined places over 2 years or – Generalist F1, 'specialist' F2	Oct 2003	• MMC S/G 03/03, 05/03, 28 October 2003
	UKSG	• Consideration given to changing all SHO 1 to F2	Jan 2004	• UKSG minutes 28 January 2004
	UKSG	• Competency based draft curriculum developed with intercollege input from 20 specialties	Apr 2004	• UKSG minutes 27 April 2004
	UKSG	• Options of local vs national recruitment procedures examined	Jan 2005	• MMC S/G 20 January 2005
Consultation	UKSG	• CHMS agrees on general principles of recruitment	Mar 2005	• UKSG minutes 18 March 2005
Options and final decision	UKSG	• Decision made to implement F1/F2 years starting August 2005		• UKSG minutes 28 January 2004
	UKSG	• Agreement reached on single U.K. curriculum	Jan 2004	• UKSG minutes 20 January 2005
	UKSG	• PMETB agrees on curriculum and entry into ST from F1/F2	May 2006	• MMC/SG 11/06 18 May 2006
Policy implementation	UKSG	• First F1 cohort starts	Aug 2005	
		• Entry into SHO grade to be closed	Aug 2007	• MMC/SG 11/06 18 May 2006

Figure 4.7

Centralised selection introduction: decision making process over time, was compressed into 2 years

	Decision maker	Description	Timing	Source
Problem described	CMO	• CMO describes how appointment procedures for registrar training not always standardised and competency based	Aug 2002	• 'Unfinished business' August 2002
Accountability assigned	PMETB	• Independent statutory body set up to and ensure post graduate medical education and training standards are met	Sep 2005	• www.pmetb.org.uk
	COPMED	• COPMED agrees to take forward centralised selection process	Mar 2006	• MMC S/G 03/06 1 March 2006
Options developed	UKSG	• Draft selection framework put before UKSG	Mar 2005	• MMC S/G 07/05 18 March 2005
	COPMED	• COPMED selection steering group believes selection should not be based on purely online methods and should involve a 'range of activities'	Aug 2005	• COPMED selection steering group minutes 22 August 2005
	PMETB	• PMETB published guidelines suggest experience of a particular post should not be a selection criterion	Jan 2006	• PMETB Principles for entry to specialist training
	–	• BMA disagrees with use of 'knowledge testing'	Apr 2006	• COPMED selection steering group minutes 21 April 2006
Consultation	UKSG	• All 65 specialties asked for views on selection	Mar 2005	• UKSG minutes 18 March 2005
	–	• WPP held 23 workshops with Deanaries to review selection methodology	Sep / Dec 2006	• Evidence presented by WPP to inquiry
Options and final decision	UKSG	• Examinations would not be entry requirement for specialty training	Nov 2005	• UKSG minutes 16 November 2005
	UKSG	• UKSG endorses selection methodologies	July 2006	• UKSG minutes 25 July 2006
	COPMED	• Interview panels will refer to application form, not CV	Nov 2006	• COPMED selection steering groups minutes 15 November 2006
	UKSG	• UKSG agrees on final rules for specialty selection	Nov 2006	• UKSG minutes 3 November 2006
Policy implementation	DH	• Awards tender for implementing selection methodologies to WPP	Jun 2006	• Evidence presented by WPP to inquiry
		• MTAS goes live using MMC agreed selection methodology	Jan 2007	• www.mmc.nhs.uk

Figure 4.8

Problematic MMC implementation decisions

	Decision	Comments
A	'Nationwide' implementation of new selection process across all geographies and all specialties	• There was no opportunity to test the robustness of new selection procedures prior to national roll out • Significant problems with the new selection procedures occurred on roll out
B	All SHOs and NCCGs allowed to participate in selection process	• The large number of applications as a consequence of SHO 'bulge' was worsened by large numbers of NCCG applications
C	Implementation of MTAS	• There was no opportunity to test the robustness of MTAS prior to national roll out • Significant problems with MTAS occurred on roll out undermining the credibility of MMC
D	IMGs allowed to participate in selection process	• The pool of potential and actual applicants was significantly expanded

In the case of the Foundation Programme policy development appeared to follow such a pattern over five years with key decisions made by the UK Strategy Group.

In contrast the development process for the complex move to centralised selection was over a much shorter two year period, with decision making resting with a variety of bodies including COPMeD and PMETB as well as the UK Strategy Group.

4.1.4 POLICY IMPLEMENTATION, GOVERNANCE AND RISK MANAGEMENT

In the Inquiry's view, successful implementation of the specialist training element of MMC was compromised by four key decisions (See Figure 4.8):

- Nationwide implementation of new selection processes across all geographies and specialties
- Concurrent participation of all SHOs and potentially all NCCGs in selection to specialist posts at the same time as FY2 doctors
- Nationwide implementation of MTAS that was largely unpiloted and subject to last minute changes
- The eligibility of IMGs to participate in the selection processes.

Just as policy development was hampered by ambiguities and inconsistencies in accountability so too was implementation. In addition accountability for mission critical workstreams (the IMG issue and MTAS) lay outside the MMC team and within the DH Workforce Directorate.

Figure 4.9

Effective policy implementation was hampered by ambiguities and inconsistencies in supporting organisational structure

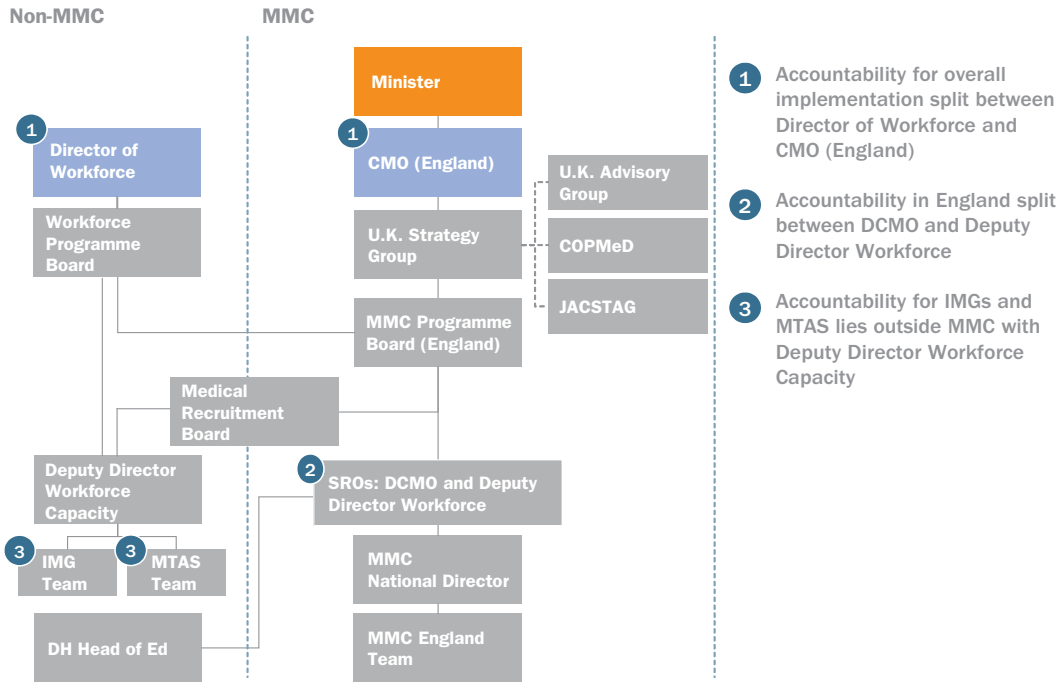


Figure 4.10

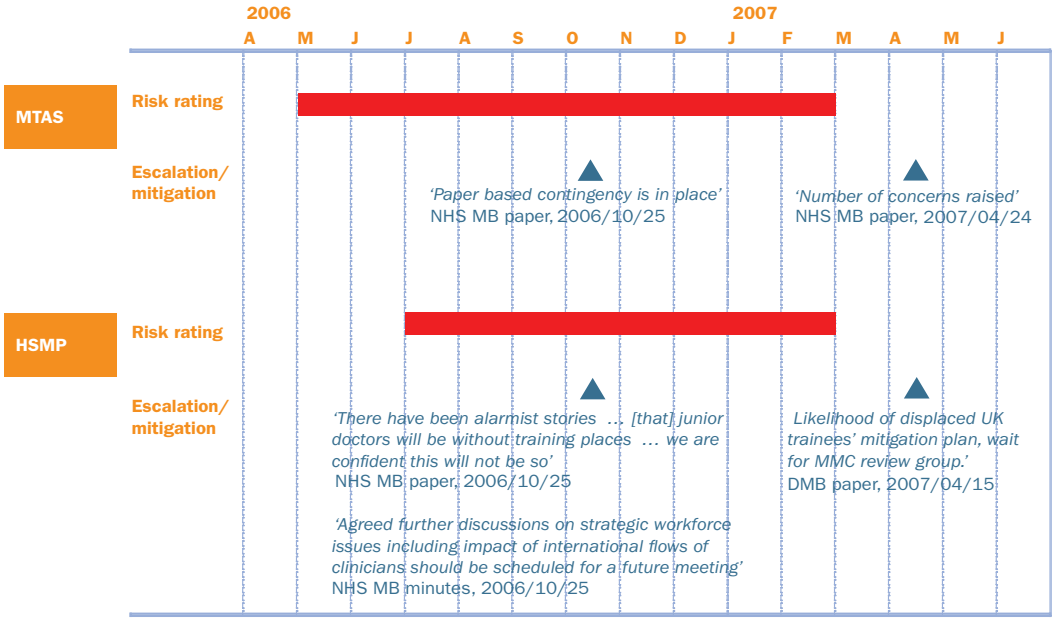
MTAS and HSMP: The flagging of problems, and contrary views

	Problems flagged…	… and alternative views
MTAS	• "The major internal risk (to MMC) lies with the online application system MTAS where the schedule is too close for comfort and would not normally be regarded as acceptable for an IT project"[1]	• "MTAS is currently on schedule and deliverable"[3]
	• "It may not be possible to accommodate change on such a grand scale"[2]	• "Although timescales were tight they were on target to deliver"[4]
		• "The MTAS Project Board remain confident that the specialty training functionality will be delivered on time"[5]
HSMP	• "There are conflicting objectives between Treasury and DH on this issue, the outcome could undermine training and standards in the UK and precipitate UK graduate unemployment if migration is not managed appropriately"[6]	• With respect to BAPIO case regarding HSMP entry: "The Judicial Review is scheduled to be heard on 7 and 8 December. DH will be drawing up an action plan taking into account both possible outcomes."[8]
	• In September 2006 the need for a contingency plan is raised in the Gateway report: "There are two major external risks to do with funding and the status of IMGs. These are outside the control of the programme team but contingency action needs to be developed further"[7]	• "Work is continuing with the Treasury to consider whether changes should be made to the HSMP … to bar people from working as junior doctors whilst on the programme."[9]

1 Gateway Programme Review 21 September 2006
2 MMC Programme Risk Log May 2006
3 Workforce Programme Board Report June 2006
4 MMC UKSG Minutes November 2006. Refers to Methods Consulting and the presentation given by them to the UKSG at their meeting
5 Medical Recruitment Board minutes 19 October 2006
6 MMC Update January 2007
7 Health Gateway Programme Review 21 September 2006
8 Medical Recruitment Board minutes 19 October 2006
9 Medical Recruitment Board minutes 20 December 2006

Figure 4.11

MTAS and HSMP, risk ratings were red for at least six months, with little evidence of contingency planning or escalation



Source: Based on review of DH MB and NHS MB meetings from May '06 to April '07 in which MMC was an agenda item

Although relating to the MMC Programme Board through the Medical Recruitment Board these two fundamental MMC deliverables lay outside the line management of the MMC team's Senior Responsible Officers.

Governance and risk management also appears to have been weak. In the case of MTAS and IMGs in particular, risks were recognised as early as 2005 and formally flagged in 2006. However, there were repeated assurances that MTAS was on schedule and deliverable, and that contingencies were being drawn up for the different possible outcomes of the IMG/HSMP issue.

4.2 PROFESSIONAL ENGAGEMENT

In the wake of the crisis surrounding the 2007 specialist training selection round many professional bodies and individuals criticised not only MTAS but MMC more generally. This raises the question as to the degree to which the medical profession supported MMC during its development and implementation, notwithstanding the less than transparent policy objectives alluded to in Section 4.1.1

4.2.1 INVOLVEMENT IN MANAGEMENT MEETINGS

It is clear that the medical profession had broad representation on key MMC bodies, (Figure 4.12), including the UK Steering Group and the MMC Programme Delivery Board (Figure 4.13).

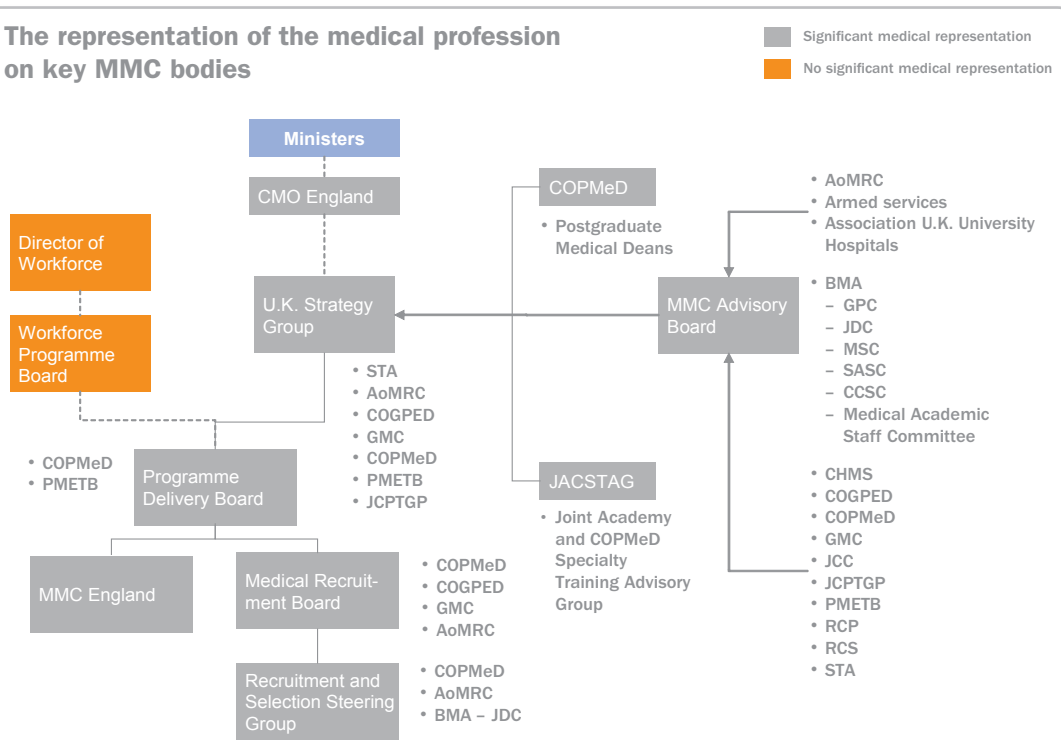
Medical professionals also held key roles in the MMC England Team (Figure 4.14).

Furthermore not only was the medical profession represented in principle but their attendance at the MMC's key decision making body, the UK Steering Group from 2003, is well documented (Figure 4.15).

Similarly attendance at the MMC's key advisory body by medical professional representatives was also comprehensive (Figure 4.16).

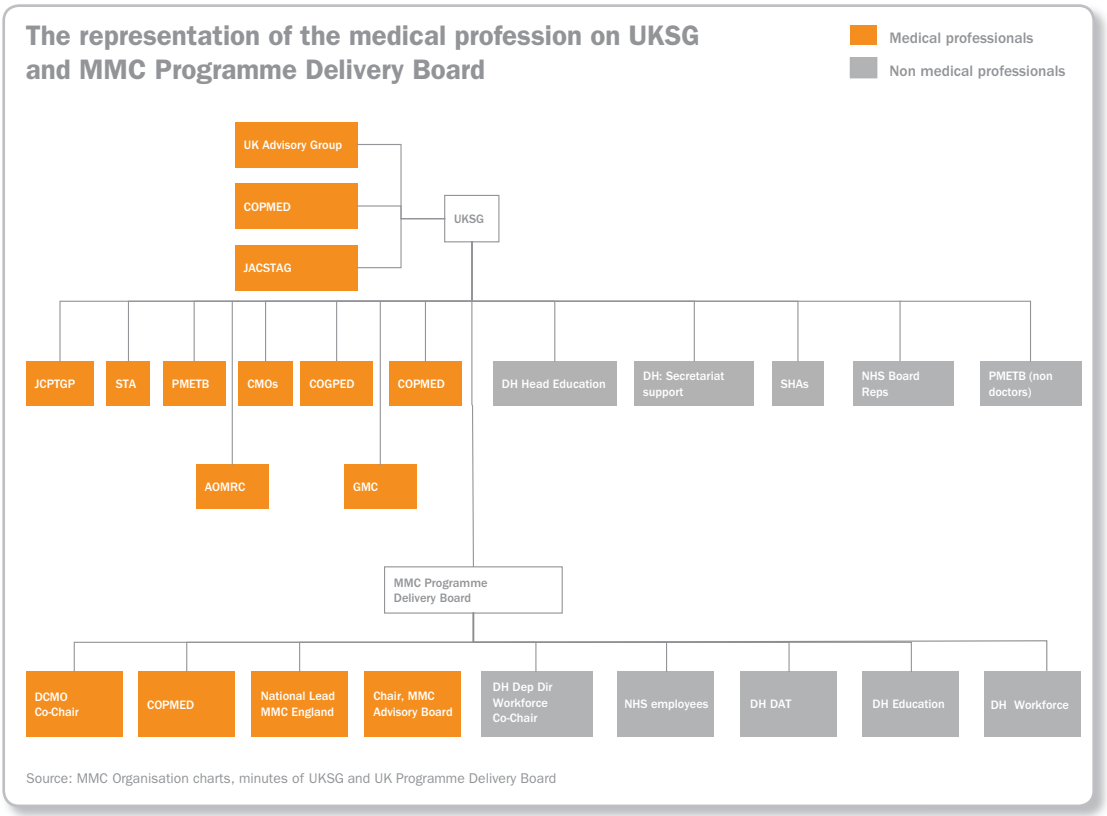
Figure 4.12

The representation of the medical profession on key MMC bodies



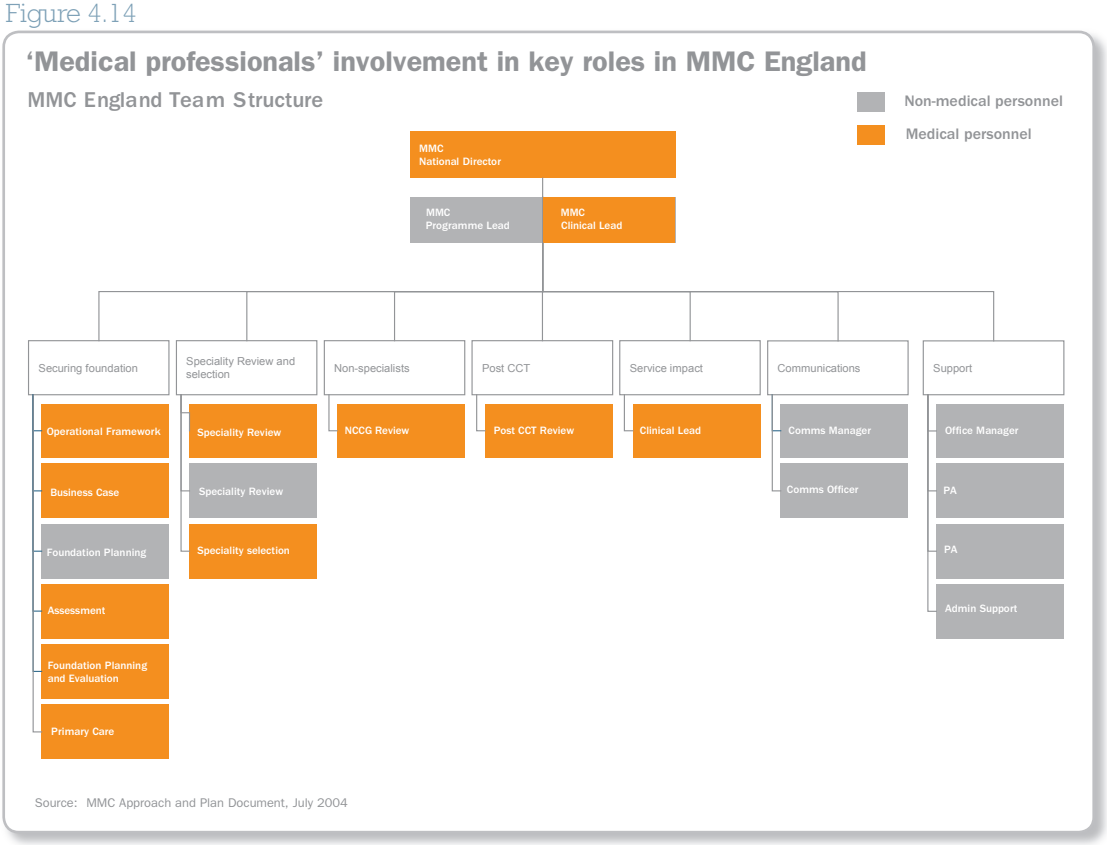
Source: MMC Board minutes

Figure 4.13



Source: MMC Organisation charts, minutes of UKSG and UK Programme Delivery Board

Figure 4.14



Source: MMC Approach and Plan Document, July 2004

Figure 4.15

The medical profession representatives' attendance at UKSG, 2003–07

• Indicates attendance by at least one representative

Body	Year / Month	2003 Oct	2004 Jan	Apr	July	Nov	2005 Jan	Mar	Jun	Sep	Nov	2006 Mar	May	July	Sept	Nov	2007 Feb
STA		•	•	•	•	•	•	•	•	•							
AoMRC											•	•	•	•	•	•	•
COGPED		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
GMC		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
COPMeD		•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PMETB		•	•			•				•	•	•	•	•	•	•	•
JCPTGP		•	•	•	•	•	•	•	•	•							

Source: MMC UKSG minutes

Figure 4.16

The medical profession representatives' attendance at MMC Delivery/Advisory Boards, 2003–07

• Indicates attendance by at least one representative of body

Body	Sub group	Year / Month	2003 Oct	2004 Jan	Mar	May	Jun	Jul	Sep	Oct	Dec	2005 Feb	Apr	Jun	Sep	Nov	2006 Mar	Jun	Nov	2007 Mar
AoMRC			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	(No minutes available)	•	•
Armed services					•	•	•	•	•	•	•	•		•	•	•	•			•
Association U.K. University Hospitals											•		•		•		•		•	
BMA	GPC		•	•	•		•	•	•	•	•	•	•	•	•				•	•
	JDC		•	•	•	•	•	•	•	•	•	•	•		•	•	•		•	•
	MSC		•	•	•	•	•	•	•	•	•		•			•	•		•	
	SASC		•	•	•	•			•	•				•		•	•		•	
	CCSC				•			•	•		•	•	•	•		•	•		•	•
	Medical Academic Staff Committee							•	•			•								
CHMS			•	•		•	•		•		•	•	•	•	•	•	•			•
COGPED			•	•	•		•	•	•	•	•		•	•	•		•			
COPMeD			•	•	•	•	•	•	•	•	•	•	•	•	•	•	•		•	•
GMC			•	•	•	•	•	•				•	•	•	•	•			•	•
JCC			•	•			•		•	•	•	•	•	•	•	•	•			•
JCPTGP			•	•	•	•	•	•		•	•	•	•	•						
PMETB			•			•						•	•	•	•	•	•		•	•
RCP				•	•		•	•			•	•	•		•	•	•		•	•
RCS				•			•	•	•	•	•	•	•	•	•	•	•			•
STA			•	•			•		•	•				•						

Source: MMC Delivery/ Advisory Board minutes

The complexity of the management structures and the large numbers of meetings presented challenges for the smaller devolved administrations, although their local engagement networks were well developed. In Northern Ireland, for example, there was regular communication and consultation with the local professional bodies as well as Trust Medical Directors, throughout the development period.

Review of minutes reveals that key policy issues were discussed throughout the life of MMC. For example, review of MMC minutes suggests that the question of selection into specialty training was discussed 17 times between 2004 and 2007 in at least three different MMC bodies (Figure 4.17).

Although the Academy of Medical Royal Colleges was involved in key MMC bodies (UK Strategy Group, MMC Advisory Board) and individual Colleges contributed detailed curricula for the new specialist training programmes, on one critical issue in particular, the nature of the MTAS questions and the scoring system employed, Colleges were inadequately consulted. This was despite the Academy raising concerns over MTAS and in particular the weighting given to academic criteria.

A review of MMC minutes reveals evidence of concerns over the implications of policy implementation but little evidence that these concerns influenced decisions made by UK Strategy Group. Indeed it is clear that UKSG did not regularly receive or note minutes from the other key committees, calling into question the rigour with which professional concerns may have been considered by the group setting strategy and policy. Furthermore the Inquiry also received evidence that on occasion questioning policy was actively discouraged.

It is also surprising that some aspects of the policy were not probed more thoroughly by the profession. The BMA's publication *Selection for specialty training* states that 'With the outcome of foundation training being that all successful trainees will have gained the same competencies, selection processes will have the dilemma of selecting trainees for specialties who are already deemed to have reached the same level of competence'. Whilst trainees might all have achieved threshold levels, it is inconceivable that all would have the same knowledge, skills, attitudes and behaviours.

One area in which the profession did voice consistent concerns was in relation to the implementation timescales. This culminated in the publication in July 2006 by the BMA JDC of the *Case for Delay*. Originally supported by the Academy of Medical Royal Colleges such support was later withdrawn by the Academy's Trainee Doctors Group, raising issues about the consistency of medical professional advice on matters of key importance (Figure 4.18). Indeed the advice derived from individual medical professional constituencies frequently reflected the particular interests of that grouping rather than the interests of medicine and medical care as a whole.

Figure 4.17

The medical profession's involvement in key MMC policy decisions, e.g. selection to specialty training

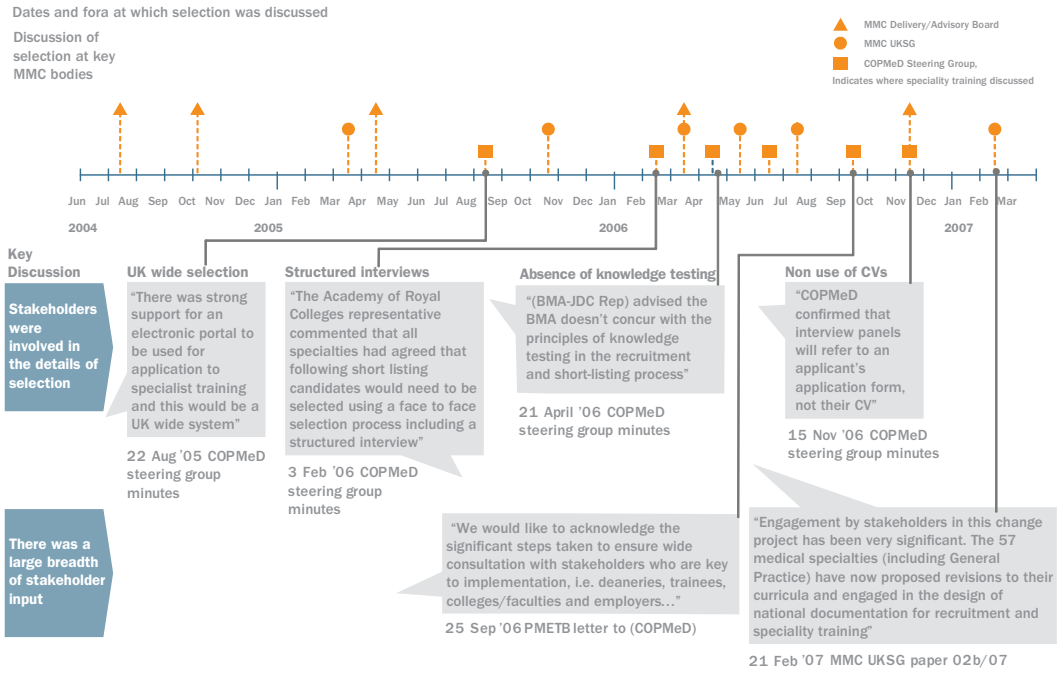


Figure 4.18

The medical profession was broadly supportive of MMC policy but was concerned with implementation timescales

"It was understood that the JCC had been supportive of the original proposals to reform SHO training... However with the introduction of certain timescales along with the lack of clarity in particular areas there was real concern that the high expectations of the profession would not be met"

20 April 2004 JCC meeting minutes

"Prof. W. (JACSTAG) tabled papers summarising work on this (selection) to date. He highlighted the tension of both addressing the difficulties inherent in devising criteria as part of such radical change, and the need for urgent action to inform trainees of what awaited them and to ensure systems were in place on time"

1 Mar '06 MMC UKSG minutes

"There are concerns that the timescale is short and that we are not adequately resourced to do it ... in addition we need the relevant experts to inform the design"

7 Mar '06 MMC AB Minutes

"Although a timetable exists for this project, JDC believes it to be too ambitious and likely to fail"

July '06 BMA JDC 'Case for Delay'

Figure 4.19

Sessions organised by MMC in the second half of 2006 to inform the medical profession: Calendar of MMC team

July

- 10th • Director for Patient Experience and Public Involvement
- 10th • Welsh CMO
- 11th • BMA chair
- 11th • JCC
- 12th • PMETB Academy Foundation Curriculum Committee
- 18th • SW London SHA
- 24th • DCMO, PMETB chair
- 25th • UKSG meeting
- 26th • Academy Speciality Training Subcommittee
- 31st • JACSTAG meeting

August

- 8th • Foundation Programme Standing Committee
- 10th • Radiology Integrated Training Initiative

September

- 6th • Deans Workforce Group
- 6th • JASME Meeting
- 7th • Academy Specialty Training Subcommittee

October

- 4th • BAMM
- 5th • RAF Medical Branch
- 6th • AoMRC Foundation Committee
- 10th • JACSTAG meeting
- 18th • Academy Specialty Training Subcommittee
- 19th • Controversies in Neurosurgery Symposium

November

- 6th • JACSTAG meeting
- 8th • GMC Transitional Group
- 16th • Deans Workforce Group
- 29th • RCP Postgraduates Medical Education and Training Conference

December

- 6th • Academy Specialty Training Subcommittee
- 13th • AoMRC Foundation Committee
- 14th • JACSTAG meeting

Source: MMC stakeholder calendar

4.2.2 GENERAL COMMUNICATION

It is clear that attempts were made by MMC to inform the medical profession of policy decisions, organising at least 30 sessions in the last half of 2006 (Figure 4.19)

However prompted by a perceived lack of communication with employers from other sources, NHS Employers (NHSE) began a programme of work in 2006 to ensure that Trusts were informed about recruitment to specialty training.

Roadshows were subsequently held jointly with MMC in September 2006 and again in January 2007. The body also acted as an information resource, updating service via its websites, e-bulletins and published material. Nonetheless, and perhaps not surprisingly given the complexity of the process and policy objectives, misconceptions flourished as evidenced by the Inquiry's e-consultation.

4.3 REGULATION: PMETB

4.3.1 PMETB'S ROLE

As pointed out in Section 3.5, The Postgraduate Medical Education and Training Board (PMETB) is an independent statutory body established by Parliament in 2003. It assumed its statutory powers on 30 September 2005, taking over the responsibilities of the Specialist Training Authority of the Medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

Those responsibilities embrace:

- Establishing standards and requirements for postgraduate medical education and training
- Making sure these standards and requirements are met through Quality Assurance
- Developing and promoting medical education and training across the UK

4.3.2 RATIONALE FOR CONSIDERING PMETB

Although PMETB had no direct part in the design of MMC its role as the standard setter, approver of the new curricula and quality assurer, and its synchronous emergence with the new arrangements for specialist training link it closely in the minds of many clinicians with MMC. There is clear evidence that the roles and responsibilities of PMETB and MMC are frequently confused. It is therefore not surprising that PMETB has been subject to public criticism in the wake of the 2007 specialty training selection crisis.

The purpose of the Inquiry deliberating on this parallel regulatory function is to learn from experience to date to help define the ideal characteristics of the regulatory authority to oversee Postgraduate Training in the future. This is particularly relevant given PMETB's stated agenda of considering:

- What should the future of specialty medicine look like?
- Should we adopt a core and options model of training?
- How do we achieve coherence in a changing health service?
- What is the relationship between specialties and subspecialties?

All of the above are legitimate questions and rigorous professional engagement in their resolution will be crucial.

4.3.3 PMETB: PROGRESS TO DATE

Although PMETB got off to a slow start, since assuming its statutory powers two years ago it has undertaken a great deal of work including:

- Publishing the first ever generic standards for training (April 2006) covering all postgraduate specialist programmes after the end of the Foundation Years, including General Practice.
- Reviewing all medical specialty training curricula which lead to an award of a CCT so they adhere to the above standards.

- Considering proposed curriculum assessment systems.
- Visiting all 21 Deaneries across the UK as part of its quality assurance role and undertaking additional triggered visits to deal with specific concerns.
- Conducting the first National Trainee Survey.
- Consulting on a new quality assurance framework.
- Issuing 5000 CCTs in 2006 and by March 2007 having processed 950 CESR and CEGPR applications.

4.3.4 ROYAL COLLEGE CONCERNS

The establishment of PMETB resulting in assumption of the responsibilities of the STA inevitably impacted on the influence of the Royal Colleges over Postgraduate Medical Education and Training. PMETB's more formalised and rigorous requirements for College examinations that were reproducible, valid and robust has proved challenging for some. It also had implications for Colleges' financial positions in relation to the cessation of funded College inspection visits and in some cases the reduced requirement for College exams as determinants of a trainee's progress. Such a background would have tested the relationship between any new and old regulatory authority. Nonetheless a consistent pattern of concerns has emerged through Colleges' written evidence to the Inquiry. Principal concerns revolve around:

- A sense of marginalisation on the part of the Royal Colleges
- Suboptimal communication
- The handling of certification work of CESR (Article 14)
- Insufficient involvement in quality assurance
- The contractual basis of work undertaken by the Colleges on behalf of PMETB.

The Colleges have met PMETB to consider these issues and a way forward has been defined that will hopefully forge better relationships.

4.3.5 THE VIEWS OF DEANERIES

Postgraduate Deaneries are responsible for the local quality management of postgraduate medical education and training, a function which is quality assured by PMETB. PMETB visits to Postgraduate Deaneries for QA purposes are therefore not strictly analogous to previous Royal College visits which concentrated on the local education providers rather than the deaneries. Nevertheless a comparison between Postgraduate Deanery experience of PMETB versus College visits is instructive if viewed in this light. The Inquiry surveyed all deaneries achieving a 57% response rate.

The collated results confirmed that the PMETB approach focused on Deanery quality control processes, was generally a positive experience but one that involved considerable bureaucracy, preparation and documentation. Nonetheless the majority of Deaneries felt they had improved their processes as a result compared with previous College visits, which could be onerous and uncoordinated for provider organisations. The 'microsampling' of specialties by PMETB inspection was felt to be too small to back up some conclusions. Useful suggestions for improvement included better mechanisms to assure quality interaction between trainer and trainee and effective formative workplace assessment.

4.3.6 IMPLICATIONS FOR AN 'IDEAL' REGULATORY AUTHORITY

In the light of these observations and the necessary timescale to which PMETB has had to work to confirm the curricula standards for all 57 subspecialties in advance of 1 August 2007 it is perhaps not surprising that the new regulator has been perceived as contributing to the inflexibility many regard as a negative feature of 'run-through' training.

It is clear from the evidence received that the profession perceives the need for a regulatory authority that is external to government, has strong lay representation and works in close partnership with the profession, drawing fully on relevant specialist expertise.

In the view of the Inquiry, the ideal Regulatory Authority would also facilitate flexible training and ideally embrace the essential continuum of medical education from undergraduate studies through to revalidation and continuing professional development. Co-location of such regulatory functions in a single regulatory body is perceived as offering the potential for shared expertise and philosophy as well as value for money derived from economies of scale. The ideal regulatory authority would also report direct to Parliament rather than through the Department of Health, given the fact that c 25% of UK doctors do not work for the NHS[6] and thus the authority should be independent of the monopoly employer. The financial burden of regulation falls heavily on the trainee under PMETB and many feel it more appropriate that such costs should be borne by the profession as a whole.

[6] Loss of British-trained doctors from the medical workforce in Great Britain; Michael J Goldacre et al, *Medical Education* 2001, 35: 337-344

4.4 WORKFORCE ANALYSIS

In this Section we consider the workforce issues raised by MMC. These include:

- Clarity about doctors' roles and those of the trainee.
- MMC Workforce Review Team's projections and the impact of the SHO bulge (and how it was to be accommodated), and the expansion of medical school intake.
- The underestimated size of the applicant pool resulting in large part from failure to anticipate the actions of IMGs.
- Special cases: Clinical academia; General Practice; contributions to global health.
- In the light of the above whether current workforce planning machinery is appropriate, adequately resourced and sited.

4.4.1 ROLE DEFINITION

The Inquiry acknowledges the assertion made by the Workforce Review Team in its submission to the Inquiry:

'workforce planning needs to be at the core of any changes to a medical career structure (and that) in general this should be demand, not supply, led and in particular this should be focused on the needs of the service for the skills of doctors and not on the career aspirations of those in training'.

These principles immediately demand an acknowledgement of the particular skills exhibited by a doctor and in the context of the overall structure of the medical workforce, explicit acknowledgement of the role of the consultant, the general practitioner, those in the NCCG roles and the service contribution of those in training. In all of these areas acknowledgement is lacking in key documentation defining MMC, and indeed in the case of trainees the assertion that 'they will become increasingly supernumerary'[7] diminishes the role they play.

The public in contrast has a clear view of the role of the doctor as evidenced by recent YouGov surveys for the Medical Schools Council (MSC). Society views the doctor as key to diagnosis, prognostication and interpretation of information and more often than not the leader of the healthcare team. The process of diagnosis can be complex, clinical reasoning demanding the capacity to appraise evidence and parallel process competing hypotheses. These demands in turn require a profound educational and training experience grossly underestimated in any 'Skills Escalator' representation of role acquisition.

'The logical conclusion is that a hospital porter could become a consultant. We have a long way to go towards unjamming the regulatory systems that would allow that to happen, but it is an exciting message'[8].

Whilst we celebrate any mechanism that widens access to medical careers, any proposed system must acknowledge the academic hurdle presented by a demanding but necessary five year Higher Education programme. The need to ensure appropriate educational foundations for all health care professional groups and to encourage aspiration in each has recently been emphasised[9].

[7] Andrew Foster: *Medical Workforce Growth: Pressing ahead with SpR expansion* January 2003
[8] Andrew Foster – speaking at the NHS Confederation quoted in *The Guardian*, 5 July 2000
[9] HSJ On line, 13 September 2007

Concerns regarding the capabilities (and status) of CCT holders surfaced during the consultation on *Unfinished Business* and the issue remains unresolved although one of considerable concern for trainees at the workshops conducted as part of the Inquiry and one considered 'fudged' by MMC according to the Welsh submission. Lack of experience (compounded by the impact of the EWTD) occasioned by shortened training periods in narrower domains of practice has fuelled anxiety regarding the preparedness of CCT holders for the consultant practice of old.

Despite the joint accountability of the MMC process there appears to have been no overt connection between workforce planning and other service policy objectives e.g. a shift to more care to the community. The demands this would place on the specialty of general practice have thus far been insufficiently acknowledged with training for General Practice at three years being well below the requirements of other developed health economies. Furthermore with increased longevity and co-morbidity in elderly populations the clinical demands on general practice are set to rise still further.

In one particular regard the structure of 'run-through' training as currently envisaged by MMC runs completely counter to the needs of an adaptable medical workforce, able to respond to changing technical capacity and clinical need. The difficulties of accurate medical workforce planning with the long lead time from student to certificated specialist are well acknowledged. Such difficulties can be mitigated by shortened training times (with the risk of inadequate experience alluded to above) or the acquisition of broadly based clinical competencies (as originally envisaged by *Unfinished Business*) before differentiation into subspecialty expertise. The latter system allows subsequent 're-differentiation' as clinical demand evolves, without the necessity to return to the beginning of training. It is also arguably more consistent with an holistic approach to medicine and the need for the clinician to acknowledge competing clinical priorities in the context of the elderly patient with significant co-morbidity.

4.4.2 MMC WORKFORCE REVIEW TEAM'S ANALYSES

The Inquiry reviewed the Workforce analyses conducted by the MMC Workforce Review Team.

The MMC Workforce Review Team estimated there would be 12,940 trainees in the SHO grade in 2006/7. In this period SHO grade trainees would be required either to take one of the new posts proposed under MMC reforms or face unemployment. The team assumed that 5,203 trainees would take ST1-3 spots, 2,800 would take GP training posts and 4,665 would take Fixed Term Specialist Training Appointment (FTSTA) posts (Fig 4.20; the remaining 272 were assumed to leave the profession). Former SHOs were then assumed to hold FTSTA posts for a single year before all taking NCCG posts (Fig 4.21; with the exception of a small number leaving the profession).

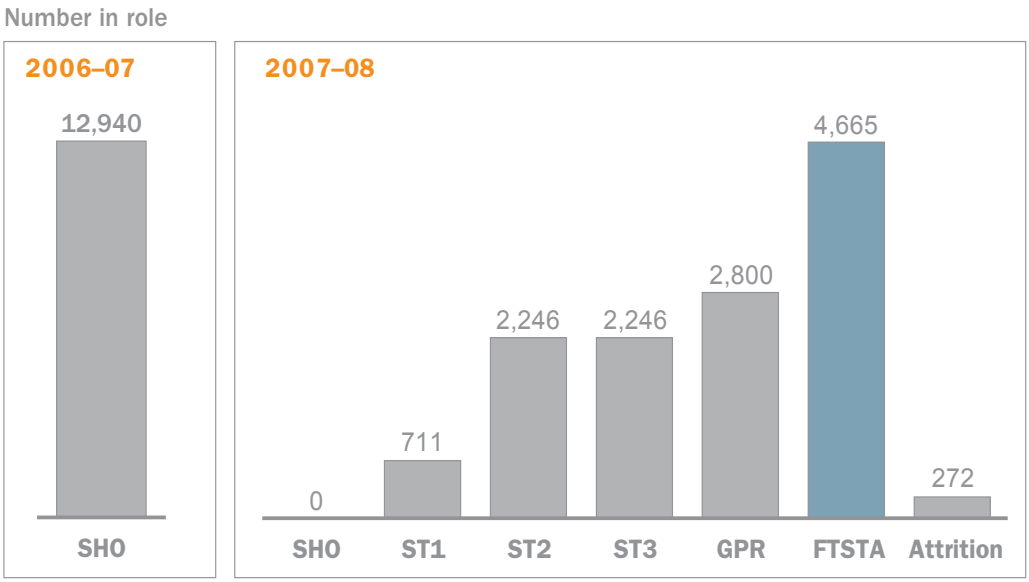
The modelling was inconsistent with MMC policy which required a two-year FTSTA posting before transition to an NCCG post and also provided two career alternatives for FTSTA post-holders, which were not modelled (applying for GP/specialist run-through programmes or applying for a further FTSTA position in another specialty). Further, it is questionable whether requiring close to 5,000 SHOs to take NCCG posts would be viewed as an equitable or acceptable outcome by SHOs or the profession more broadly.

4.4.3 DEMAND FOR POSTGRADUATE TRAINING POSTS

The dramatic increase in medical school cohort size from 1999/2000 (Fig 4.22) means that the demand from domestic students for GP and specialist training spots will also increase dramatically, albeit with some lag as the cohorts take a number of years to move through the system (Fig 4.23).

Figure 4.20

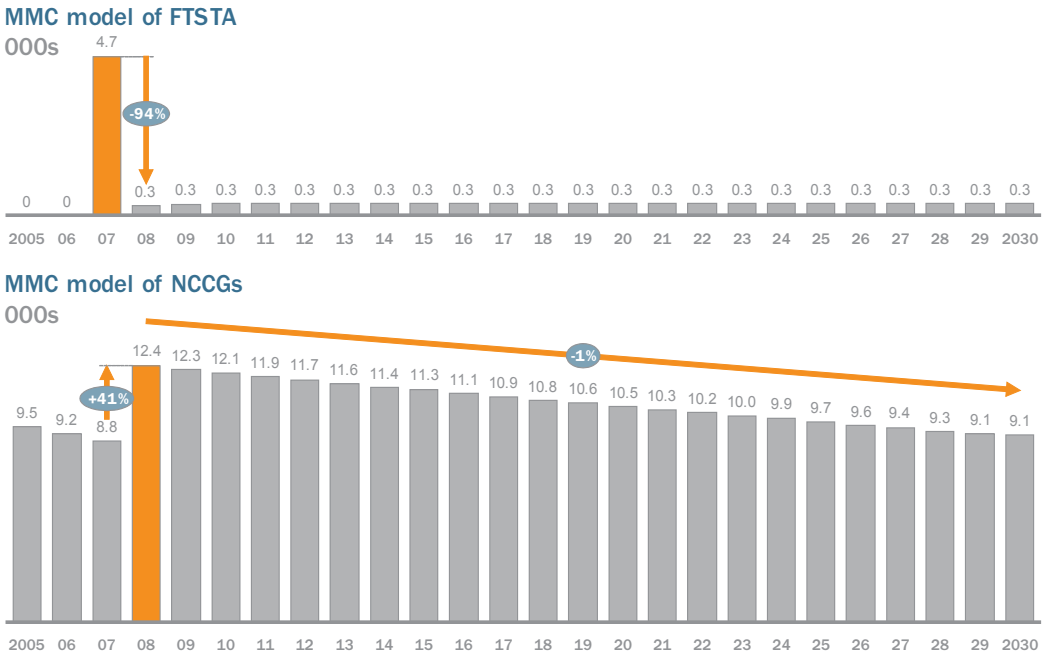
MMC assumptions on the future of those in SHO roles in 2006/7



Source: MMC Workforce Review Team 06/21 Model

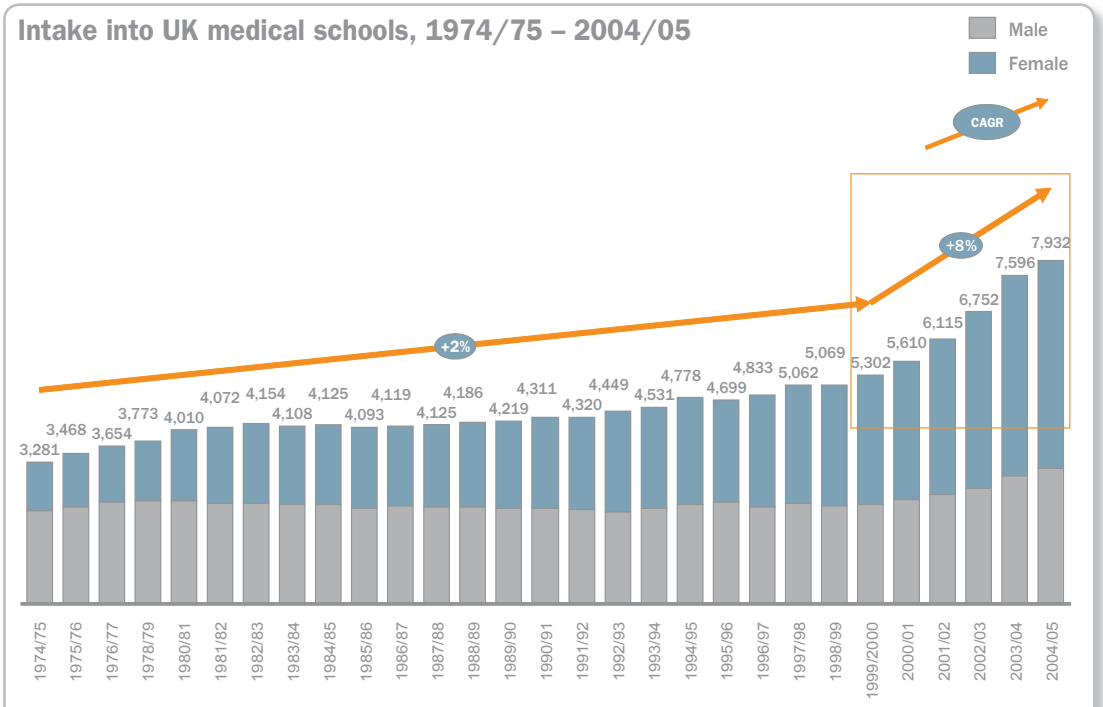
Figure 4.21

The SHO bulge was assumed to feed into a single year bulge in FTSTAs and then a surge in the number of NCCGs



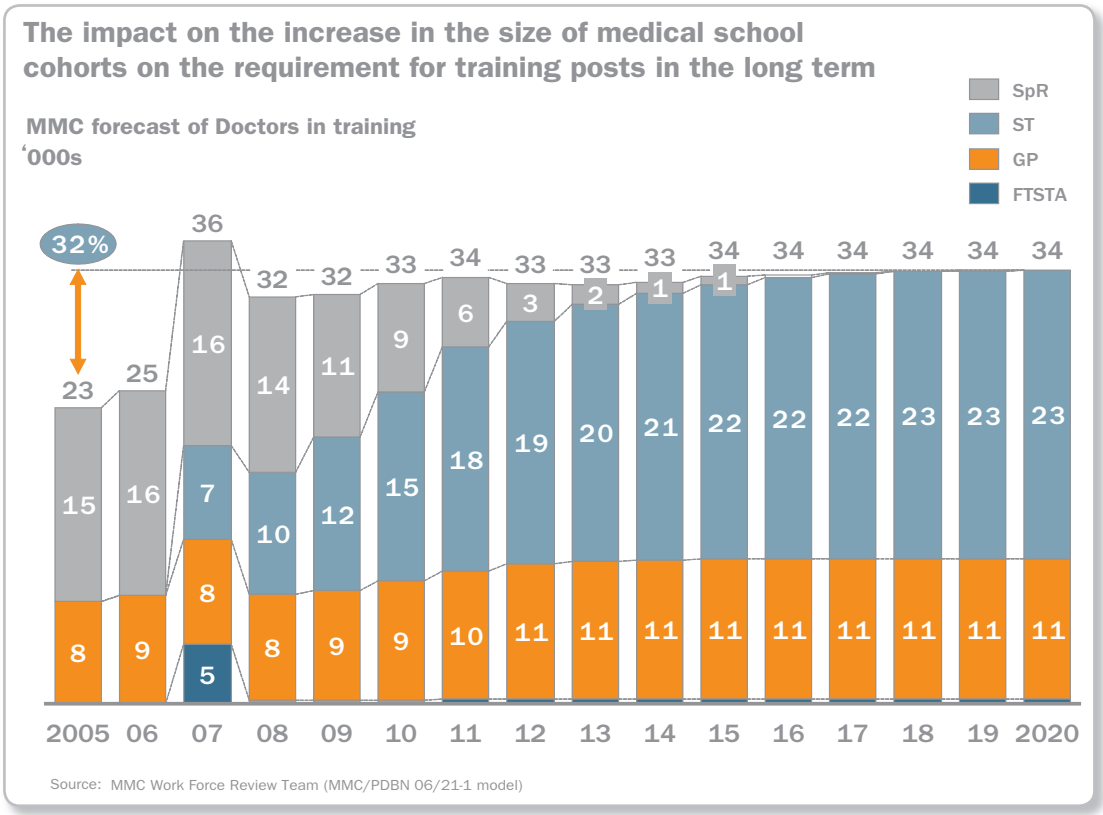
Source: MMC Workforce Review Team 06/21 Model

Figure 4.22



1 'NHS Plan' Secretary of State for Health, July 2000
2 Webster R, Mellor D, Spavin B. *Who are the doctors of tomorrow and what will they do?* 9th Conference of The International Medical Workforce Collaborative, Melbourne, November 2005 [http://www.health.nsw. gov.au/amwac/amwac/pdf/9_tomdocs_uk.pdf]
3 CAGR: Cumulative Annual Growth Rate

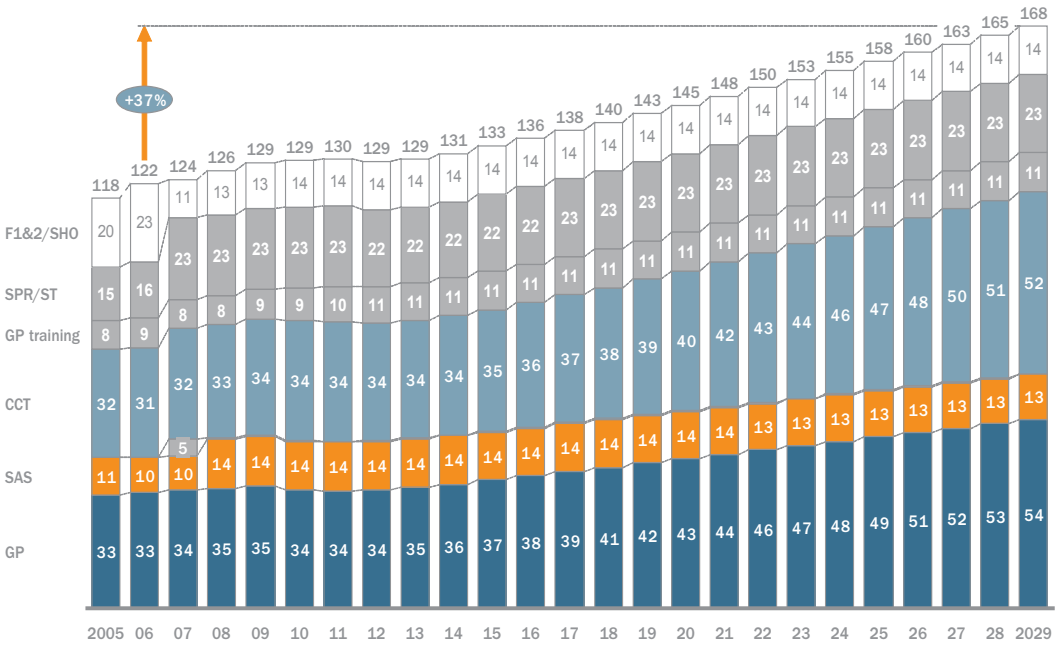
Figure 4.23



Source: MMC Work Force Review Team (MMC/PDBN 06/21-1 model)

Figure 4.24

MMC model of NHS Doctor workforce 2005–2029



Source: MMC Workforce Review Team 06/21 model

The MMC team's workforce modelling suggests that demand for specialist and GP training posts in England will rise from approximately 25,000 in 2006/7 to close to 34,000 in 2016 (Figure 4.24). However, most of increase in demand will occur in 2007/8 and 2008/9 (distorted somewhat by the need to find places for those in the SHO bulge). It is important to note that this modelling assumes 5,000 SHOs take FTSTA posts then exit training programmes to take posts as NCCGs, as described above.

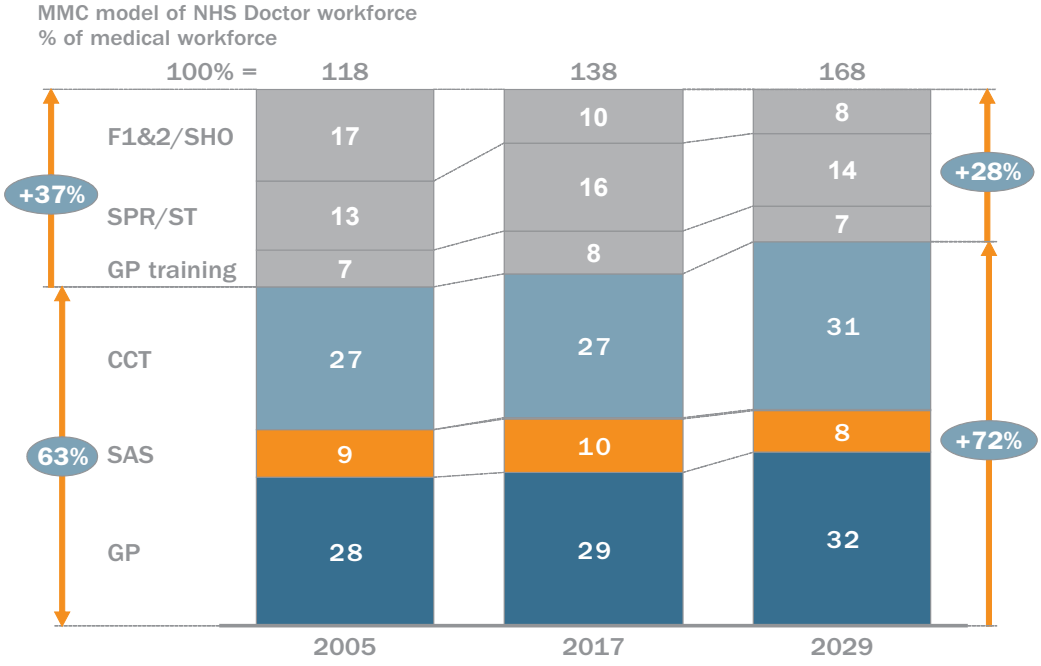
4.4.4 FUTURE WORKFORCE STRUCTURE

The medical school cohort size increases have substantial implications for the future structure and size of the medical workforce. Assuming cohort sizes stabilise at current levels, the MMC Workforce Review team projected that the medical workforce headcount would increase from approximately 120,000 in 2006 to 168,000 in 2029 (Figure 4.25). A paper for the MMC Board using similar assumptions projected an increase from 116,000 in 2007 to 235,000 in 2050. While the implications of these increases for the cost of funding the medical workforce depend heavily on remuneration levels and participation assumptions, modelling based on MMC/PDB 06/03 makes clear the increased cost will be substantial (Figure 4.26).

The paper for the MMC board also highlighted a second long-term implication of the increase in medical school graduates: a change in structure of the medical workforce. As the overall workforce increases, the proportion that is doctors-in-training will fall, from 36% to 18% by 2050 according to the MMC/PDB 06/03 paper (Figure 4.27). The change in the structure of the medical workforce, in particular the growth in the number and proportion of trained doctors, has profound implications for the way in

Figure 4.25

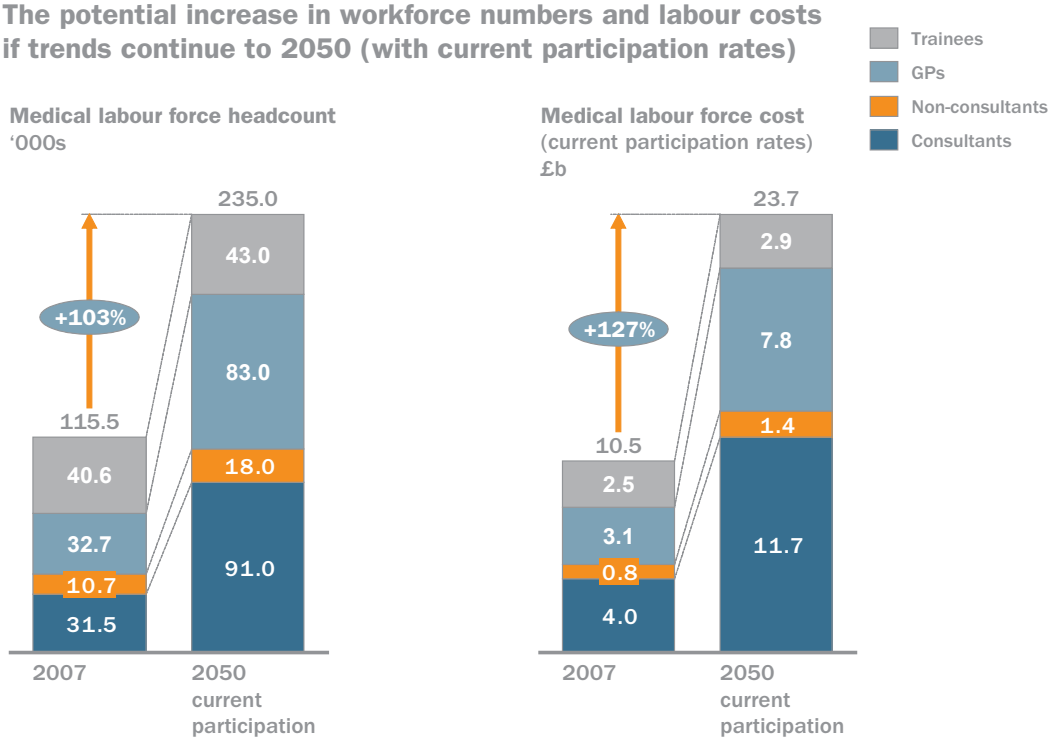
The implications of MMC policies for the proportion of trainees in the medical workforce



Source: MMC Workforce Review Team 06/21 model

Figure 4.26

The potential increase in workforce numbers and labour costs if trends continue to 2050 (with current participation rates)



Source: MMC Workforce Review Team 06/21 model: MMC/PDB 06/03; team analysis

which service is delivered and consequently for the role trained doctors will be expected to play in the future, highlighting the role definition issues raised at the beginning of this section.

The increase in medical school cohort size in the late 1990s was not the result of MMC policies, but the policy implications of that increase should have been taken into account by MMC in designing postgraduate medical careers. The issues of the increased medical school cohort size were raised in MMC fora. It is not clear, however, from the evidence presented to the Inquiry that MMC ever received clear guidance on the associated DH policy or that this was ever resolved by DH and MMC senior leadership.

It is clear from written submissions and trainee workshops that the perception of planned overproduction of the medical workforce such estimates portray is contributing to professional disengagement in some quarters.

4.4.5 THE SIZE OF THE APPLICANT POOL

There were 32,649 applicants for 23,247 posts: 18,670 for 'run-through' training, 4,392 FTSTAs and 185 academic posts. In other words there were 9,402 more applicants than posts. 19,056 applicants were from the UK and other EU countries. 3,511 applicants were from those on HSMP visas already holding FY2 or SHO posts. 10,082 were from overseas doctors or from those on HSMP visas but not in educationally approved training posts (Fig 4.27).

MMC identified the potential implications of divergent Government views on the IMG/HSMP issue as early as February 2006. The Home Office changed the Immigration rules, such that postgraduate doctors would need work permits and hospitals must prove posts could not be filled by UK/EEA doctors. However by May 2006 it had become clear to the UK Strategy Group that the Highly Skilled Migrant Programme (HSMP) would effectively by-pass the Home Office ruling. Although the risk log for IMG was subsequently rated red from July 2006 to February 2007 there is little evidence of risk management, escalation or contingency planning as a result.

As pointed out in Section 4.1.4 accountability for the IMG workstream was within DH Workforce, separate from MMC and the CMOs. By November 2006 DH was alerted to the potential impact of doctors applying through the HSMP route. A forecast of the scale of the problem projected by Workforce was that around 1,000 UK graduates could be displaced each year and this could rise to 1,500 as medial school expansion works through.

It is clear that this was a material underassessment of the impact the simplicity of the online application process would have on trainee doctors from overseas who might wish to benefit from the HSMP.

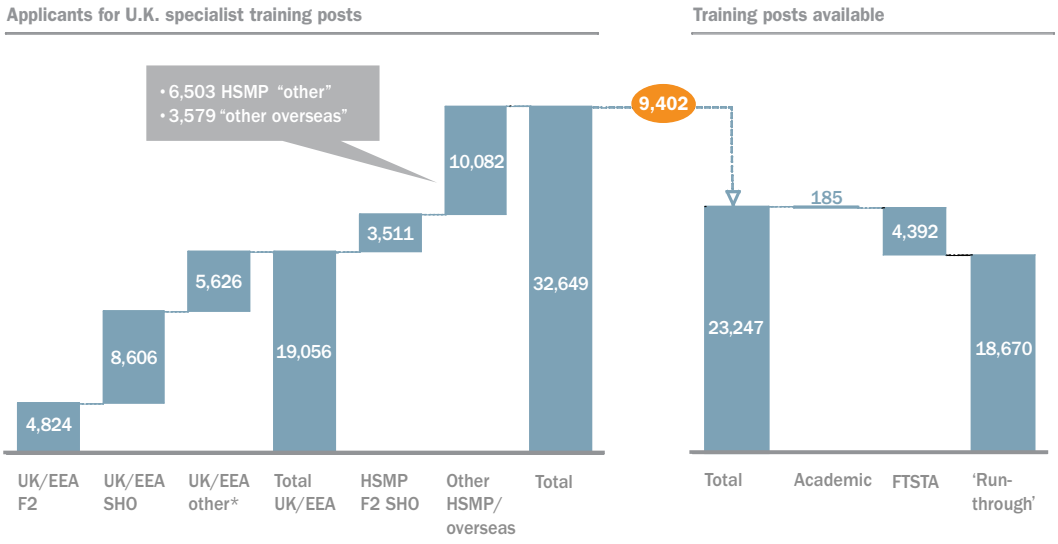
Once the applications came through in March 2007 it was clear that the numbers of IMG had been seriously underestimated. 'Large numbers of doctors applied to the HSMP – rarely used prior to this for postgraduate training. There are 10,817 applicants with limited leave to remain …. Most of these likely to be HSMPs. They are in the recruitment system but in planning terms this was not the intended outcome'. (Applicants and Posts NHSE 21 March 2007[10]).

The HSMP route remains available for IMGs and is likely to impact further on UK graduates' prospects in subsequent rounds of recruitment to specialist training, especially if, in future years, the number of training positions is less than it was in 2007.

[10] Applicants and Posts NHSE 21 March 2007

Figure 4.27

Breakdown of applicants for specialist training in 2007 compared to the training posts available

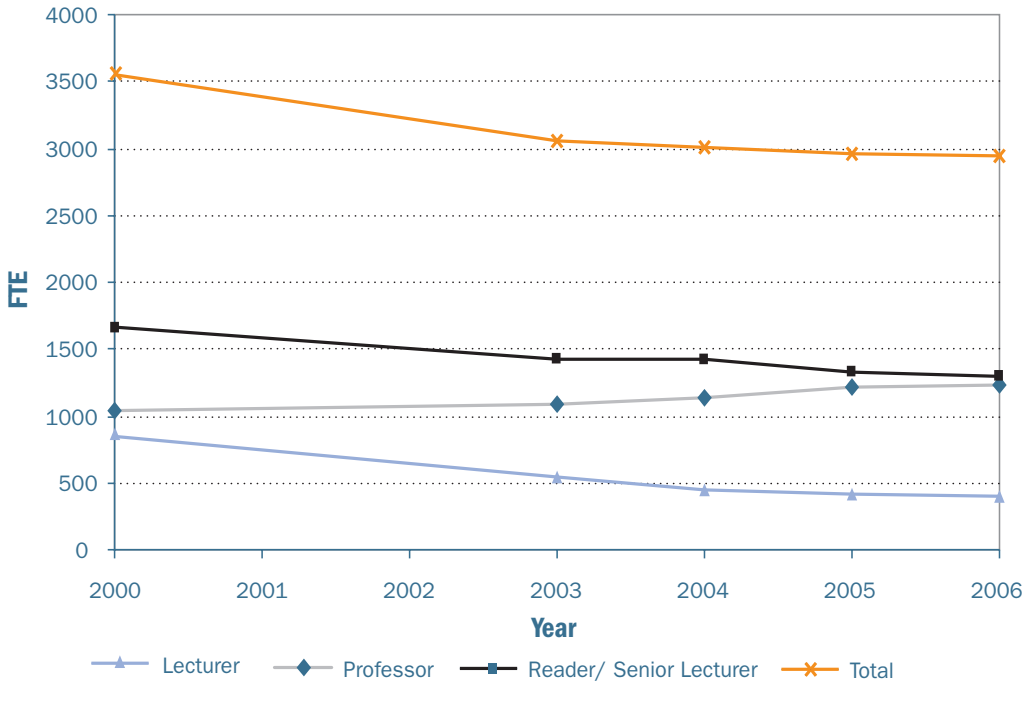


* 'Other' = staff/trust grade doctors and SHOs not on educationally approved training posts

Source: WDAT analysis of MTAS applications, 19/06/07

Figure 4.28

Change in number of Clinical Academics (FTE) in medicine, by grade, since 2000



4.4.5.1 Concluding Comment

The inadequacies of MTAS were exposed in large part by the great excess of applicants over trainee places. As the MMC Workforce Review Team's analysis makes clear, the integration of a large number of 'milling around' SHOs was anticipated, as was the future spectre of an increased demand for trainee places reflecting medical school expansion. The difficulty of integrating the SHOs was compounded by gross underestimates of the IMGs that would apply via the HSMP route, for which little mitigating action was planned.

4.4.6 SPECIAL CASE: CLINICAL ACADEMIA

Against this background of increasing medical student and trainee numbers and the increasing education and training demands of more intensive professionalised training regimes it is concerning to see the static numbers of clinical academic staff revealed by regular surveys by the Medical Schools Council (formerly CHMS) (Figure 4.28).

Recognising the seriousness of this situation, the UKCRC proposed investment in new Academic Clinical Fellowships (ACF) and Clinical Lecturer posts. The profession has welcomed this recent English investment in clinical academic careers replicated in Scotland. It is essential to drive both the research and educational agendas but it is too early to see the impact of such investment on survey data.

Of acute concern however is the way the MTAS selection process diminished the relevance of academic achievement. Such a message coupled with a reluctance to commit to out of programme activity threatens the attractiveness of the clinical academic career and hence the impact of this increased investment. The rigid interpretation of 'run-through' also presents challenges for clinical academia, potentially discouraging would be academics from taking time out of a tightly regulated programme.

Further concerns expressed regarding the clinical academic workforce by the Academy of Medical Sciences' submission to the Inquiry include:

- The additional time that may be needed for clinical academics to complete training may act as a disincentive for such careers.
- There is a risk of creating a 'binary divide' between the academic and non academic clinician and a failure to recognise the great value of exposing all trainees to academia.
- The distinction between academic and non-academic NTNs, has the potential to diminish flexibility and make for difficult transition between the two career pathways.

In addition the Academy emphasised the desirability of research for a higher degree contributing to clinical training, subject of course to the acquisition of clinical competence.

Evidence presented to the Inquiry suggests that outside the larger centres implementation of the ACFs in England is proving problematic in practice. Difficulties relate particularly to smaller specialty units and the construction of practical rotas.

4.4.7 SPECIAL CASE: GENERAL PRACTICE

General Practice is a specialty in its own right with more general practitioners than consultants in all hospital specialties combined. Further, 95% of patient contacts in the NHS take place in Primary Care[11]. In the context of an ageing population GPs see patients in the 85 – 89 age group on average 12.9 times a year[12]. Given these statistics and the health policy of shifting more care closer to home the lack of emphasis of MMC on general practitioner training is inconsistent. Furthermore given this shift it

[11] Burnham, A. 2006. http://www.nihr.ac.uk/files/pdfs/PressRelease_NIHR_new_Primary_Care_Research_School_launches_17052006.pdf
[12] Hippisley-Cox, J., Fenty, J., Heaps, M. 2007. Trends in Consultation Rates in General Practice 1995-2006: Analysis of the QRESEARCH Database. The Information Centre.

becomes more important for all doctors to experience training in (as opposed to for) General Practice as favourably experienced by 55% of doctors in their Foundation Years.

Evidence from a number of sources to the Inquiry strongly supports the extension of GP training to at least 5 years[13] to bring GP training in line with Specialist Training in other medical disciplines.

Although such an extension carries a cost implication it is argued that this is partly offset by potentially fewer referrals to secondary care and more older people being looked after effectively in the community. In addition the extra years in GP training would be on a salaried basis which would be less expensive than GP principal posts. There would also be the possibility of siting senior trainees in areas where recruitment and retention is poor. It is time to acknowledge that to be a skilled generalist possibly takes longer than being a narrowly confined specialist. Academic development too, must catch up with hospital specialties, to provide the evidence base to drive up quality of patient care.

4.4.8 SPECIAL CASE: CONTRIBUTIONS TO GLOBAL HEALTH

The recent reports by the CMO, *Health is Global: Proposals for a UK Government-wide Strategy, March 2007* and by Lord Crisp, *Global Health Partnerships: the UK contribution to health in developing countries, February 2007* emphasise the important part the UK has to play in global health, and the essential nature of such involvement for our own health status. Indeed Lord Crisp's Report maintains:

'The introduction of Modernising Medical Careers could provide the opportunity to reconsider how international medical training and overseas work might be included in the higher medical training programmes – both in the Foundation Years and within Specialist and General Practice training'.

Given these imperatives it has been particularly discouraging to learn of difficulties encountered by trainees wishing to pursue opportunities overseas and the negative implications for their career progression on return from abroad. Numerous examples of inflexibility have been reported to the Inquiry one of which is highlighted below and overleaf.

I would like to express my concern regarding the flexibility of MMC and the problematic nature MMC has had on junior doctors' potential to work abroad and gain further useful clinical experience whilst also contributing to the field of International Medicine.

I understand that this issue has been raised with you before, but hope that by briefly outlining my experience of MMC I will be able to demonstrate how this impact has been a reality for junior doctors.

Having always been keen on the potential of a flexible career, enabling me to work abroad in the future as much as possible, I decided to apply to MTAS for an ST2 training GP position. This involved a written exam, and an assessment day. There was very little consistent information pre-application as to whether deferral of my post would be an option.

Happily, I was offered an ST2 post and furthermore, where I live.

Unhappily, the GP Deanery then refused to even consider the option of letting me defer my post for one year so I could fulfil my long term plans to work in Zambia at the University Hospital in Lusaka as a medical SHO. I tried hard to contact the Heads of the Deanery to discuss this decision, and see if there was any flexibility in the system. It proved extremely difficult to get beyond the bureaucracy to speak to anyone with decision making potential, and when I did, they simply confirmed that I was unable to defer. They declined to see me in person to discuss the reasons for this.

I was then offered a core medicine ST2 post. I asked the same questions, with the same conclusion.

Frustrated, after considerable soul searching I decided that I had made a commitment to Lusaka, and could not turn down my post simply because the British training system is showing such gross inflexibility,

[13] *Royal Commission on Medical Education*. 1968. Chairman,Lord Todd. 119-121. London, HMSO.

and terrifying its trainees into considering they will never achieve training posts. As such I have turned down my training posts to go abroad. There is not a single one of my medical colleagues who does not think I am insane – but it was done on the acknowledgment that I have to do what truly excites me, and stay true to why I studied medicine in the first place.

It does mean that I have to fly back home (twice, minimum) for a repeat of the GP exam, and then interview process. During my time in Lusaka I am being paid a local wage, as I have chosen to try and work in the local system to truly understand it, rather than for an NGO, and so this expenditure threatens to be ominous. Needless to say, as the GP recruitment system at no point includes a look at your CV, neither this foreign experience, nor my MRCP membership will count in helping to try and secure me another training post so close to home.

The Deanery also assures me that there are unlikely to be ST2 posts available soon in the future, so I will have to apply for an ST1 position.

I am very excited about my impending experience abroad, but saddened that I have had to give up so much to do this. I cannot but help think that were the Deanery confident in their selection process, they would have been keen to keep the candidates they had selected as being suitable for their first choice posts, especially when they are showing some initiative in their career choices and keen to broaden their experiences.

I hope that this gives you some insight into how MMC has impacted on potential experience in International Medicine.

4.4.9 WORKFORCE PLANNING CAPACITY

The challenge of medical workforce planning in the context of changes in the NHS, service delivery patterns and training programmes alluded to in Section 3 is formidable. The Panel agrees with Sir Derek Wanless's recent assessment that

'The Department of Health has not yet been able to find effective ways of linking forecasts of service development with the education and training of health professionals'[14].

That challenge is compounded by longevity and evolving health need and burgeoning technological capacity as well as social trends reflecting career aspirations and work:life balance issues. Such an analysis calls into question whether the resources available for this complex task are either adequate or appropriately sited.

Staff costs in England were £34 billion in 2005/6 yet the resource dedicated to the workforce planning function is miniscule in comparison. Drug costs in England were £10 billion in the same period. The resource (appropriately) committed to the National Institute for Health and Clinical Excellence, (NICE), the agency charged with evaluating new drugs is £23 million pa, many times the sum dedicated to workforce planning.

Medical workforce planning is now integrated within the Workforce Review Team (WRT) alongside planning for other healthcare professions. Such an integrated function is rational in view of the contemporary nature of healthcare delivery involving an array of skills and an emphasis on teamwork. Nonetheless concerns have been expressed to the Inquiry that this endangers diluting the resource available for medical workforce planning. Further, it is felt that there is a reluctance to acknowledge openly that the doctor is often the leader of the healthcare team and as such the commander of considerable clinical resource. Given this reality it is crucially important that sufficient emphasis is placed on the medical workforce planning component.

It is clearly important that workforce considerations embrace supply side and demand side issues and their necessary integration. Demand side

[14] *Our Future Health Secured?* Sir Derek Wanless, King's Fund, 2007

analysis argues for close involvement with service and service performance managers, providing a rationale for SHAs assuming a key role in England. However aspects of medical workforce planning must retain a national dimension to accommodate for example suitable numbers of doctors with particular subspecialty expertise that cannot be developed in every locality. Transferability of doctors between regions and the home countries requires a degree of national oversight and consistency of roles.

Local responsiveness is however important. Concerns have been expressed to the Inquiry that the particular workforce needs of the devolved administrations may not be best served by a WRT based in an English SHA with limited resource for medical workforce planning.

Given the challenge presented by medical workforce planning (and the consequences of getting it wrong) a clear view presented to the Inquiry is that the medical profession must be fully engaged in this inevitably inexact science, so that projections and their underlying assumptions are developed in partnership and co-owned. Advantage too should be taken of considerable modelling capacity in the University sector, including relevant economic analyses. As well as hopefully aiding the accuracy of predictions, broadening professional involvement is crucial to the more generic process of professional engagement in the development of the future health service.

4.5 EDUCATION AND SELECTION ANALYSIS

An Expert Advisory Panel was appointed to provide the Inquiry with an expert independent view of the educational dimensions of MMC. The Expert Advisory Panel's Report appears in Appendix 4. This section draws heavily on those conclusions as well as on unsolicited submissions from other educationalists and clinicians with training responsibilities. It is also informed by the expectations and aspirations of trainees themselves.

Just as with workforce projections it is crucial that educational programmes have a clear outcome in mind, requiring common resolution and acknowledgement of the roles of the doctor/specialist and the trainee.

As the Expert Advisory Panel makes clear Medical Education has undergone rapid change. Unfamiliarity may breed suspicion that new systems do not match the old. Inevitably it takes time to determine whether a new approach produces the desired outcome as manifest by improved healthcare. In the absence of such data it is clear from trainee feedback, professional bodies and the Expert Advisory Panel that summative assessments critical for selection purposes should include tests of knowledge. Not only are such tests good predictors of overall performance, they recognise the essential knowledge base the practice of clinical reasoning requires. Knowledge tests can also serve to increase confidence in selection as experience with new systems develops and is validated.

Repeatedly we were informed by trainees that they did not qualify in medicine to be 'good enough' as the term competence implies. If we are to nurture this aspiration to excellence it is crucial that assessment processes can effectively discriminate the adequate doctor from the excellent. It is clear from the Expert Advisory Panel that the Foundation programme assessment methodologies do not currently provide such capacity.

Whereas the desire for doctors to be competent is difficult to refute, the value of the assessment of competence is as high as the richness, authenticity and relevance of the test applied. Mature clinical judgement relies on a well developed knowledge base, a breadth and depth of experience that exposes the clinician to the variety of disease expression and treatment response, and the capacity to reflect on and learn from such experience. In other words it is more than a sum of competencies as often currently conceived. Adequate though competency based assessment may be for logging threshold performance, as experience is accrued, critical selection points require a more comprehensive assessment of knowledge, skills and behaviours.

4.5.1 THE MTAS EXPERIENCE

The failure of MTAS to meet the policy objectives of MMC and the personal impact and resultant distress caused by the MTAS selection process has already been considered in Section 4.1.2.2. A fuller critique appears in Appendix 5. The visibility of the perceived failings was undoubtedly made more acute by the inclusion of all eligible candidates in the largely unpiloted process, the non-resolution of the IMG issue and the 'big bang' approach compared with what would normally have been a slow realisation over time by trainees that they were not going to obtain the post to which they aspired.

The decision to allow four applications inevitably meant that the truly excellent candidates ought all to have received four interviews thus reducing the scope for some very able candidates below them.

The objective feedback on the MTAS selection process remains far from comprehensive. The fill rates for run-through posts were: England 91%, Northern Ireland 100% Scotland 100%, Wales 98%.

Trusts, Deaneries and Interview Panels overwhelmingly reported the appointment of strong candidates; this presupposes no judgement as to whether they were the strongest possible appointee in an optimal system but should not detract from their achievement.

Notwithstanding some technical failures of the MTAS process, longlisting where conducted rigorously, proved valuable. The logistics of the system made this difficult, particularly in large Deaneries.

On-line shortlisting was not delivered on schedule as a result of last minute contract specification changes necessitating in some areas manual handling of data for the first week. Shortlisting was also done variably with some Deaneries involving 6 raters, some 2 for the 3 sections of the form. The process also allowed raters to see one another's scores. Despite these inadequacies, strong correlations were obtained between shortlisting and interview scores (e.g. r = 0.68 for ST2 and 3 in General Surgery), comparable with Selection Centre correlations.

The requirements for interview were a minimum of 30 minutes face to face interview, but unfortunately no national framework was provided, a deficiency attributed to the short timescale for implementation. This precluded unsuccessful candidates interviewed in one Deanery having their interview outcome fairly considered in other Deaneries with vacancies.

We have already alluded to the 'dehumanising' nature of the process from the trainee perspective (Section 4.1.2.2). As the Expert Advisory Panel points out the selection process can be made more humane and less stressful by enabling applicants to 'present their story'. Pilot processes for selecting future surgeons in Scotland[15] suggest that exercises that candidates feel are relevant to their day to day work and that really test their clinical attributes instil a sense that they have been properly and fairly examined. Indeed several Colleges presented evidence of the utility of Assessment Centres which probe the qualities pre-determined as essential for that particular specialty.

4.5.2 ASSESSMENT CENTRES

Assessment Centres are not so much places, but rather processes whereby very precise selection criteria for the job are laid out and then work-related exercises developed to assess those criteria. These can include carefully constructed interviews, simulations and written assessments which generate a large number of scores and detailed information for each candidate. This then contributes to an informed expert judgement and ranking as to which candidate best suits the proposed post. Research has demonstrated that using multiple assessments such as this enhances the accuracy, validity and fairness of the selection process.[16]

The total contact time can be as little as two hours, involving two consultants, a patient, a medical actor and several administrators, making the process cost-effective and feasible.

4.5.3 THE TRAINEE MENTALITY

A worrying perception from the trainee workshops was the sense that current day trainees view themselves as trainees first and doctors second. This is perhaps an inevitable consequence of the initial demands for patients to be cared for by 'fully trained doctors' and that trainees will be

[15] *The Right Choice*, Report on a pilot scheme to improve the selection of future surgeons, Rowley, D and Patterson, F, *Surgeons News*, in press
[16] *Selection Centres*, Kidd et al Proceedings AMEE Conference 2006
[17] Proposals for the organisation of Postgraduate Medical Education at the Provider Level. A NACT UK document, July 2007.

'increasingly supernumerary[7]'. Such developments raise concerns at service level (see section 4.8), echoed by the Expert Advisory Panel which recognise the interdependency of training, service and work and the assumption of the role of an employee.

4.5.4 STAFF DEVELOPMENT

It is clear from the experience of trainees that the preparedness of some trainers for the new systems was suboptimal. As the Expert Advisory Panel points out clinicians need skilling in modern educational processes including assessment. Such skilling and the conduct of training itself need appropriate time resource, long recognised in training General Practices. Consultant job plans too need to reflect such legitimate demands. This in turn has implications for Trusts in terms of the incentivisation of engagement in educational activity, an issue currently not adequately addressed by Healthcare Commission inspectors.

4.6 MANAGEMENT OF POSTGRADUATE TRAINING

The Postgraduate Deaneries have played the lead role in the implementation of Modernising Medical Careers. The Inquiry acknowledges the huge amount of work undertaken by Postgraduate Deans and their staff in attempts to optimise the outcome for trainees and service in this year's recruitment round to specialist training.

It is nonetheless clear that there has been considerable variability in the implementation of the programme both in process terms and outcome (e.g. fill rates) and it is instructive to consider the potential reasons for this such that process and outcome may be optimised in the future.

4.6.1 COMPETING PRIORITIES

It should be acknowledged that in addition to leading on the implementation of MMC the Deaneries are responsible for a wide range of other activities many of which have required additional activity during a period of rapid NHS growth. These include:

- Managing the totality of postgraduate medical and dental training, including pre-registration doctors and dentists. This activity embraces recruitment, assessment, remediation, educator development and since PMETB, an expanded role in the quality assurance of Trust and General Practice based education.
- Supporting the work of the NHS in achieving the increase in the number of Consultant and GP staff in recent years, including through international recruitment.
- Supporting the NHS to implement EWTD for doctors in training.
- Leading the development of the Dental Workforce including allied professions.
- Support for Doctors in difficulties.

In addition many Deaneries in England have taken on a range of responsibilities with respect to broader workforce development, particularly since their incorporation into SHAs.

4.6.2 ORGANISATIONAL FLUX

As with other parts of the NHS Postgraduate Deaneries have been in organisational flux over the MMC implementation period in the wake of the Crump Report of 2004, *The future role and responsibilities of postgraduate deans and their deaneries*, and the reconfiguration of SHAs in England in 2006. Postgraduate Deaneries in England are now variably accountable within the new SHAs. As Postgraduate Deanery and SHA boundaries may not be coterminous this clearly adds to the complexity of the managerial arrangements and has demanded the creation of new sets of working relationships. In many instances the new arrangements have led to the creation of interprofessional Deaneries.

4.6.3 FINANCIAL PRESSURES

The work of Deaneries in England is supported by the Multi-Professional Education Training Levy (MPET) managed by the SHAs. Crump pointed out the significant unexplained variation in the management costs between Deaneries. The reforms of recent years and the implementation demands of MMC itself have placed managerial pressures on Deaneries with resultant resource implications. The financial pressures in the critical MMC implementation period 2006-07 were exacerbated by the MPET cuts made by SHAs (as the only significant source of income at their disposal) to assure overall NHS financial balance. For 2007-08 the use of MPET is governed by centrally determined Service Level Agreements but it remains to be seen whether this provides sufficient protection for education and training activity.

4.6.4 SERVICE LINKAGES

Although managed at a Deanery level, postgraduate education and training are delivered within the service environment. Close linkages are essential to ensure successful delivery, and the management arrangements within Trusts need to be appropriately aligned with clear accountability mechanisms. Such links are not always present.

The National Association of Clinical Tutors UK, (NACT UK)[17] has recently published a document proposing a structure to assist in the achievement of these aims including:

- A named executive director to represent medical education at Board or Divisional level.
- A Director of Medical Education responsible to the CEO.
- A clearly defined structure for the delivery and administration of medical education, appraisal and CPD for all medical staff.

The importance of strong links between the local clinical tutors, regional specialty committees and Colleges and Specialty Societies is also emphasised.

4.6.5 ACADEMIC LINKAGES

Although occupying ground between NHS resource management, clinical provider units and academia, Postgraduate Deaneries have variable relationships with Universities and Medical Schools. In relation to the pre-registration year, Foundation Year 1, the relationship is explicit. In other respects the relationship is in the main more tenuous, although in the Devolved Administrations Postgraduate Deans are employed by Universities, as is the Dean in Oxford. Crump pointed out the need for formal arrangements between SHAs and Universities and Medical Schools, but in practice such relationships have been a casualty of NHS reorganisation. Such arrangements are essential to help support joint working, and appraisal, as required under the Follett recommendations for Clinical Academic staff.

A review of international arrangements for the management of postgraduate medical education and training in seven developed countries (Australia, USA, Canada, Singapore, Germany, Sweden, France) reveals some form of formal link with Universities in the prosecution of such activity in four (Appendix 7). Furthermore there is increasing evidence that developed countries are exploring collaborative links between Universities and hospitals through the creation of a variety of academic health centre models. The separation of Postgraduate Deaneries in England from Universities and suboptimal links with service providers does not facilitate such partnerships which are widely regarded as drivers of healthcare quality as well as of research and innovation[18].

[17] Proposals for the organisation of Postgraduate Medical Education at the Provider Level. A NACT UK document, July 2007.
[18] The Nuffield Trust Seminar Note June 2007: Academic Health Centres: http://www.nuffieldtrust.org.uk/

4.6.6 ACCESS TO MEDICAL EDUCATIONAL EXPERTISE

The drive to professionalise medical education and training to assure outcomes in a cost efficient manner demands attention to medical education expertise, particularly in the field of contemporary assessment methodologies. MMC implementation has revealed the limited capacity in this regard and to date only limited progress has been made in establishing a specialty of medical education as also suggested by Crump.

Evidence presented to the Inquiry suggests that closer links between Postgraduate Deaneries and Medical Schools could help secure access to such limited expertise, promote sharing of best practice, and the continuum of medical education. The situation in the Devolved Administrations is instructive in this regard. In Scotland for example each of the four Deans is linked to one of the four clinical medical schools, all possessing at least an honorary contract with the medical school concerned.

4.6.7 COMMONALITY OF APPROACH

Commonality of process, important if national selection systems are to operate effectively can be promoted by informal mechanisms (e.g. sharing of best practice), external regulatory mechanisms (e.g. PMETB, Quality Assurance Framework) or self regulation. The Postgraduate Deans' collective body is instructively termed The 'Conference' of Postgraduate Medical Deans (COPMeD), a semi formal organisation which has no governance role in relation to the activity of member Deaneries. In Scotland NHS Education Scotland (NES) is the common conduit through which the Scottish Health Department pays for postgraduate medical education and training. Thus monies to pay the salaries of all Foundation and Specialist Trainee posts come through NES on their way to the Postgraduate Deans. Although in the past Deans had significant flexibility in the use of these budgets, NES is moving to an increasingly uniform system, an approach that also extends to the use of the Study Leave budget.

4.6.8 LESSONS FROM GENERAL PRACTICE

In many respects the implementation of General Practice Specialty Training Programmes has gone better than other specialisms with 100% fill rates in most Deaneries. Reasons for this are speculative but are likely to include:

- Course organisers/programme directors are selected for their managerial and educational skills and are properly funded.
- Being a trainer brings both status and some financial reward; trainers are selected (and re-selected) after specific preparation.
- There is a clear summative process for assessment of all trainees with national quality control of the actual assessment process, not of the documentation.
- The Assessment Centre approach for selection into the specialty was developed over a seven year period involving consensus, and was designed specifically for the Primary Care environment.

4.6.9 CONCLUDING COMMENT

Views expressed to the Inquiry and the above analysis question whether the current interrelationships of the medical Postgraduate Deanery function in England are optimal given the Deaneries' limited structural links with both local Trusts and Universities. In the interest of equitable service delivery there is also the issue of whether there is sufficient national cohesion and consistency in their function. This must call into question whether their accountability structures and governance arrangements at a national level are appropriate.

4.7 SERVICE PERSPECTIVE

The evidence the Inquiry has received from service representatives suggests that MMC poses a significant risk to the ability of Trusts to deliver the safe, effective and efficient health care service which is their primary responsibility. At the same time EWTD has imposed changes on the junior doctor workforce, compounding the potential impact of MMC on Trusts. Whereas both initiatives had intended benefits for employers and their staff, the service perspective is that concurrent implementation has created significant difficulties. Although the views of service were sought during the development period of MMC, medical and HR manager representation on key bodies was limited.

The fundamental consequence of MMC for Trusts has been a perception of reduced control over the junior workforce who remain crucial to the current delivery of service. The contributory causes suggested to the Inquiry Panel are considered below.

4.7.1 RECRUITMENT

The responsibility for all junior doctor recruitment has now largely passed to the Postgraduate Deaneries, which have no formal responsibility for, nor daily involvement in, the delivery of service.

Misunderstandings resulting from this arrangement present a range of difficulties for Trusts and affect their ability to cover essential service posts. Information about posts being filled, or worse still, not filled, may be deficient. Some doctors elect to have part-time training or apply to transfer elsewhere and information is not always provided to Trusts in a timely manner. When a training post is unfilled, it is usually up to Trusts to find a replacement, in a timescale that may be unrealistic.

Little advantage was taken of engaging Trust HR expertise in the development of processes for selection to specialist training.

Planning the recruitment of specialist trainees for 1 August creates potential safety problems for Trusts with a complete changeover of experienced trainee personnel on one date. The fact that the date coincides with the peak holiday season, particularly for staff with families, compounds the problem.

4.7.2 COMMUNICATION BETWEEN TRUSTS AND POSTGRADUATE DEANERIES

The limited, formal links between the Postgraduate Deaneries and Trusts may result in poor and sometimes inappropriate communication. The communication links that do exist are with those Trust staff responsible for education, who may have no part to play in the management of the Trust.

4.7.3 CURRICULA FOR JUNIOR DOCTOR TRAINING

Whilst there are clear advantages for curricula being set nationally and being resistant to local and short-term changes in service, it is also important that the training of junior doctors follows the overall needs of the service, which are often subject to quite rapid change. At the present time there is no short loop, responsive formal mechanism whereby those

responsible for service can have significant input into the curricula for postgraduate medical training.

The net result is that it has been difficult to engage junior doctors with important policies affecting the provision of medical care such as Health Care Standards, Infection Control Standards, access targets and changes in policy such as the shift of care into the community.

4.7.4 FUNDING MECHANISMS

As discussed, arrangements for the funding of postgraduate medical education vary in different parts of the UK. In England the funding currently comes from the Medical and Dental Education Levy (MADEL). The application of these funds to the salaries of trainees who are a significant part of the service delivery workforce is misleading. Similarly the time senior doctors spend on training and assessment is inadequately resourced. This suggests that the historic educational levies should be phased out and replaced with formally structured and properly resourced educational contracts reflecting volume and quality.

4.7.5 STRUCTURED FORMAL TRAINING

The changes within the MMC initiative involve a much greater reliance on structured, competence based training with the aim of improving the safety of junior doctors as well as the effectiveness and efficiency of their training. This has been supported with a formal framework for assessment, which has required a significant increase in time commitment from both senior and junior doctors. The implementation of these changes has occurred quickly and without adequate recognition of the effects on the service. Whilst the objective of improved training of postgraduate doctors is important and laudable, there have also been doubts expressed by both trainees and senior doctors in some areas about the effectiveness of the new framework.

It is a concern that the service element of junior doctor jobs has reduced significantly, affecting the ability of Trusts to deliver service. There is also a view that the job satisfaction for junior doctors has been adversely affected by this change.

4.7.6 LENGTH OF JUNIOR DOCTOR ROTATIONS

The length of junior doctor rotations has reduced in most cases to 4 months, particularly in the Foundation years. Evidence received by the Inquiry suggests that in most specialties, it takes up to 2 – 3 months for a trainee doctors to assimilate the requirements of the job and become an effective member of the team. The resultant reduction in their contribution to service may have led to a feeling amongst junior doctors that they are contributing less effectively during their first jobs.

4.7.7 MORALE AND ALLEGIANCE OF JUNIOR DOCTORS

The Panel found that many of the effects of MMC on service have also had an adverse effect on the morale of the junior doctors. When added to the extreme concerns caused by the problems with MTAS, the view of service is that the ability of many junior doctors to work effectively has been reduced.

The implementation of MMC with its emphasis on training rather than service, has led to junior doctors being less connected with the operational management of hospitals and feeling little allegiance to the Trust as an employer. This may make the management of junior doctors more problematic.

4.7.8 TEAM WORKING

The dissolution of the 'firm' structure (the hierarchical hospital medical team which had ongoing responsibility for a ward and/or in-patients requiring that team's expertise) has been more the result of EWTD than MMC. The necessity to cut junior doctors' hours has required the introduction of shift working and cross-cover arrangements. However, the need for doctors to overcome the serious communication difficulties posed by this change has created further problems for MMC and Trusts in both the delivery of clinical service and effective training. Ironically it has also eroded the sense of working in a team just at a time when it is widely appreciated that contemporary healthcare is built on effective team working.

KEY ISSUES AND FINAL RECOMMENDATIONS

5

OVERVIEW

Introduction

1 Clarification of policy objectives
Recommendations 1–4

2 The role of the Doctor
Recommendation 5

3 Policy development and governance
Recommendations 6–10

4 Workforce planning
Recommendations 11–17

5 Medical professional engagement
Recommendations 18–20

6 The commissioning and management of postgraduate medical education and training
Recommendations 21–29

7 Streamlining Regulation
Recommendation 30

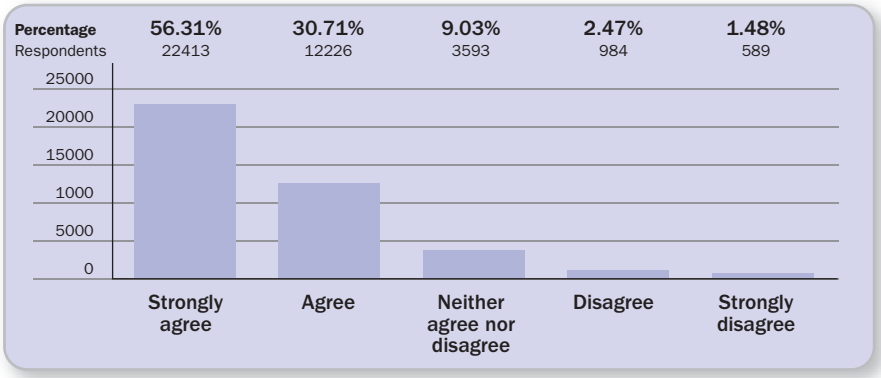
8 The structure of postgraduate medical training
Recommendations 31–45

9 New Recommendations
Recommendations 46 & 47

INTRODUCTION

The Interim Report was subject to consultation from 8 October 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.



To recapitulate, 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.

5.1 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.

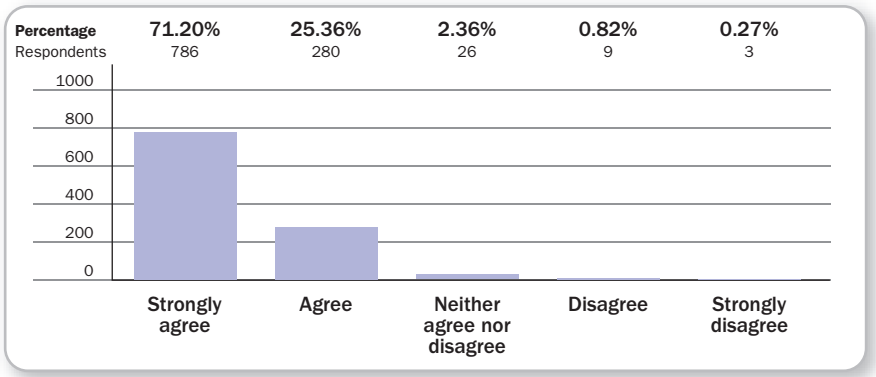
Whereas the educational principles espoused in *Unfinished Business* largely endure, critical elements e.g. broad based beginnings and flexibility, were eroded and workforce imperatives rose in prominence. In a rapidly changing world, policy will evolve but clear articulation of shared founding principles 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:

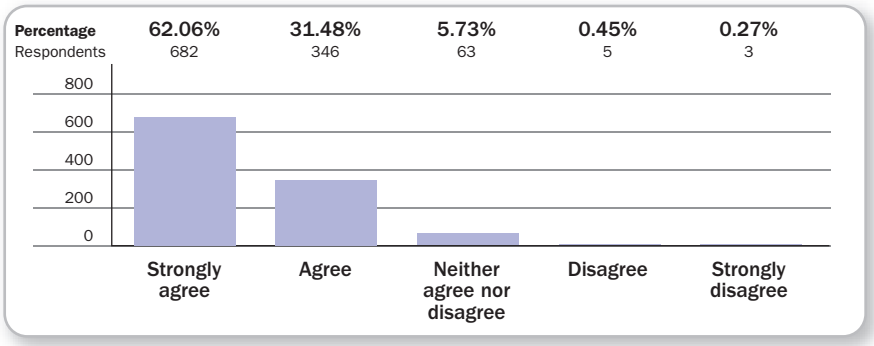
Interim Recommendation 1

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.



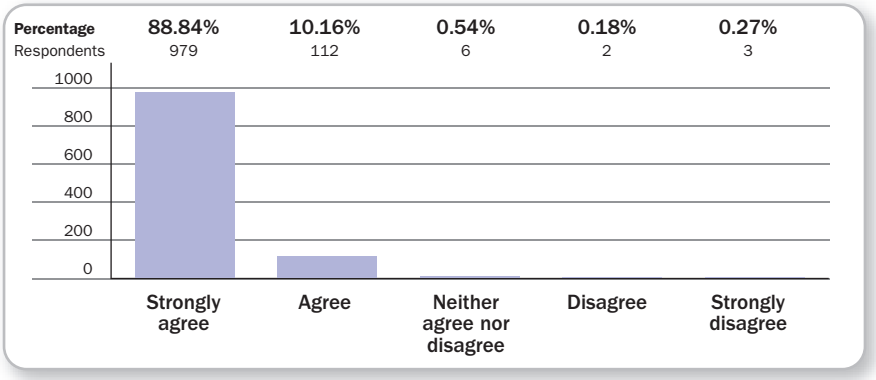
Interim Recommendation 2

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



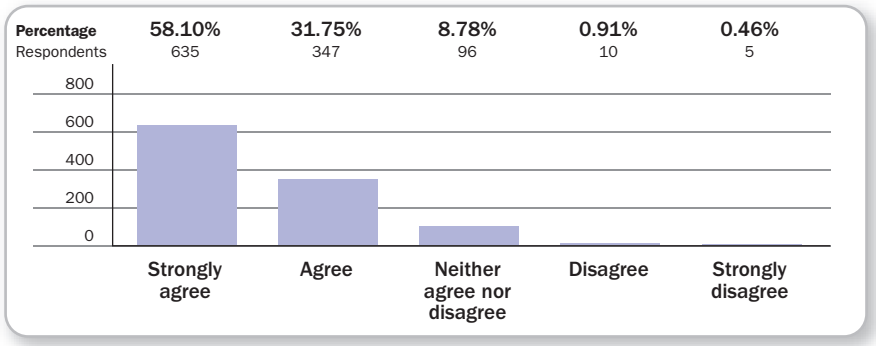
Interim Recommendation 3

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.

5.2 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.

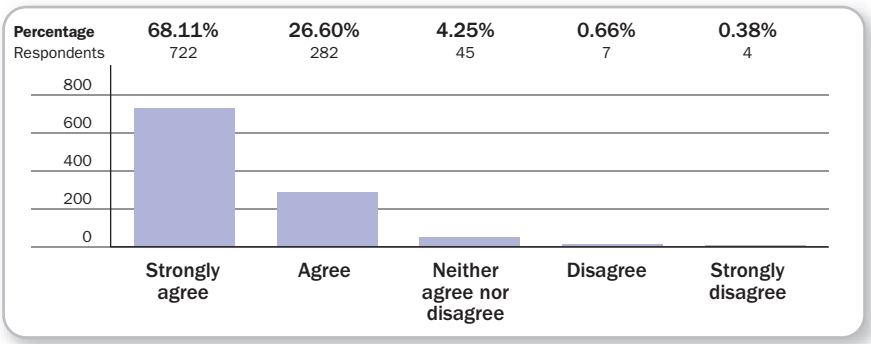
Greater acknowledgement of the service contribution of trainees will help reverse the emerging trend wherein some young doctors in training seem to see themselves as trainees first and doctors second.

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.

5.3 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.

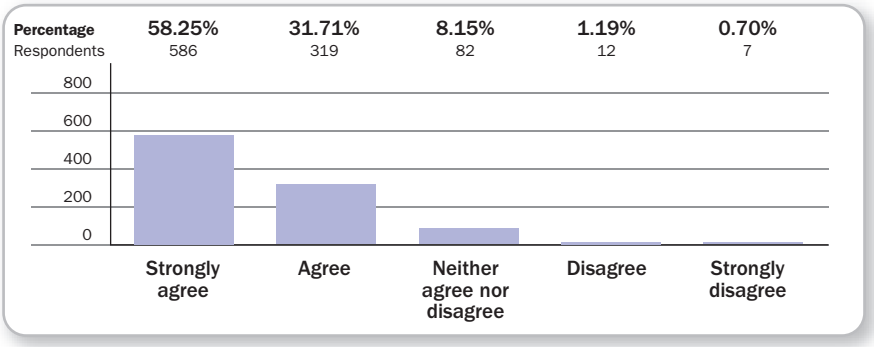
Postgraduate medical education and training is closely integrated with the NHS, involves the University sector and is of key relevance to certain UK industries. The Inquiry revealed that educational links with service are suboptimal and there has been an erosion of the health:education sector partnership 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:

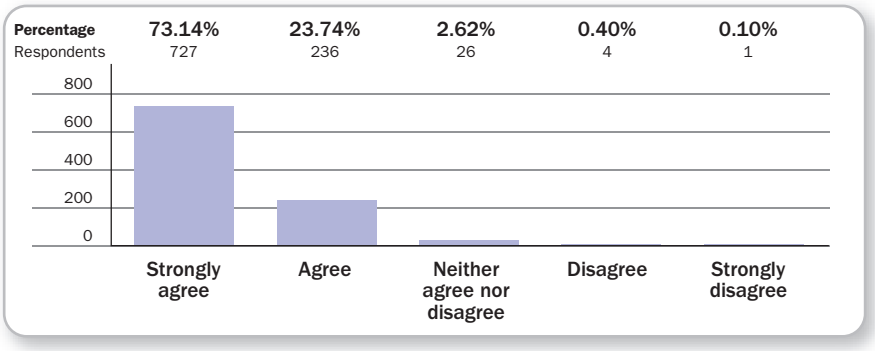
Interim Recommendation 6

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'.



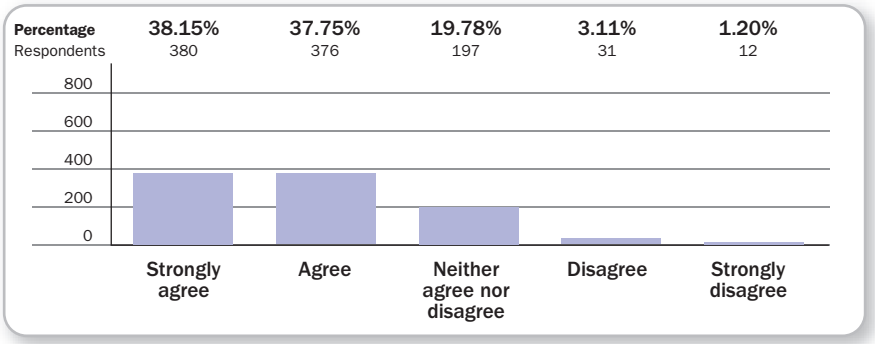
Interim Recommendation 7

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.



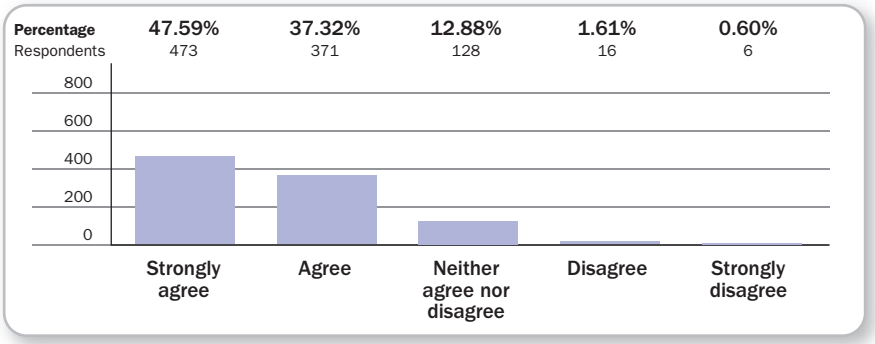
Interim Recommendation 8

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.



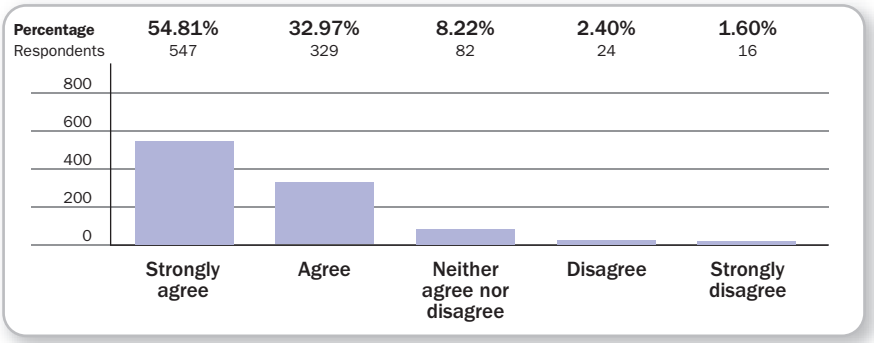
Interim Recommendation 9

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.

5.4 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.

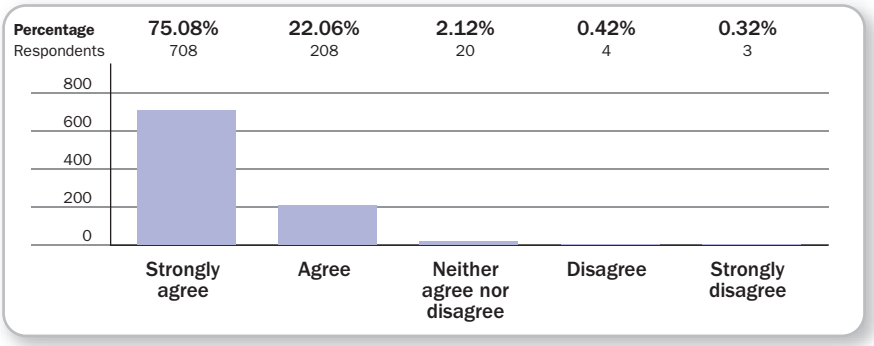
Related to workforce planning is the issue of workforce aspiration. The Panel has been struck by the inconsistency and dearth of information on career opportunities made available to medical students and doctors in training. Without such information, they are unable to make informed judgements on the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

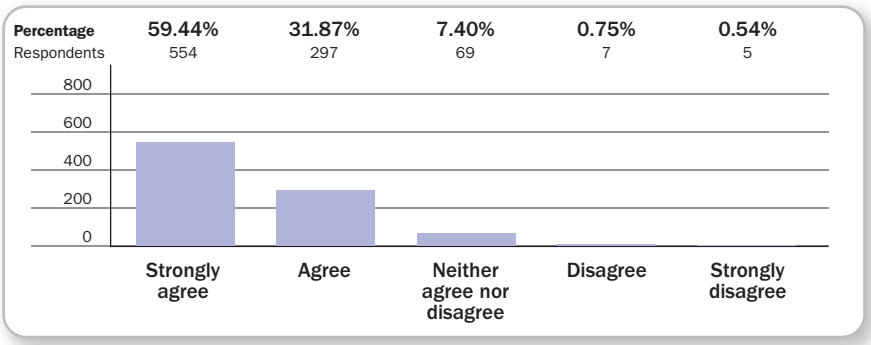


Interim Recommendation 12

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:

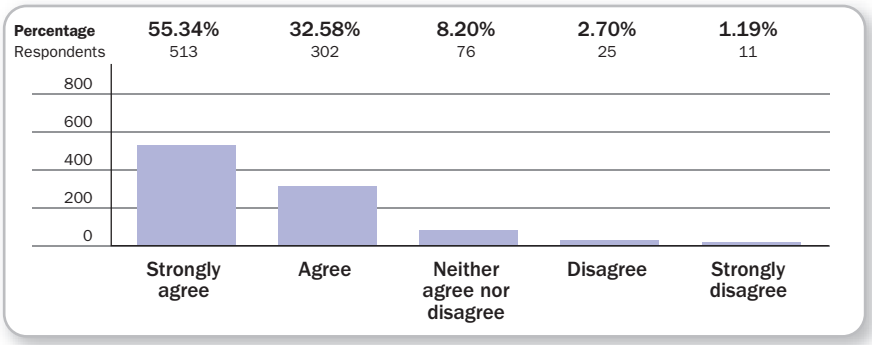
- Medical workforce planning needs to embrace the consensus view of the role of the doctor referred to in Recommendation 5
- Plans should be based on robust information on available and projected medical specialist skills, requiring relevant databases.
- Whilst recognising that doctors are just one part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



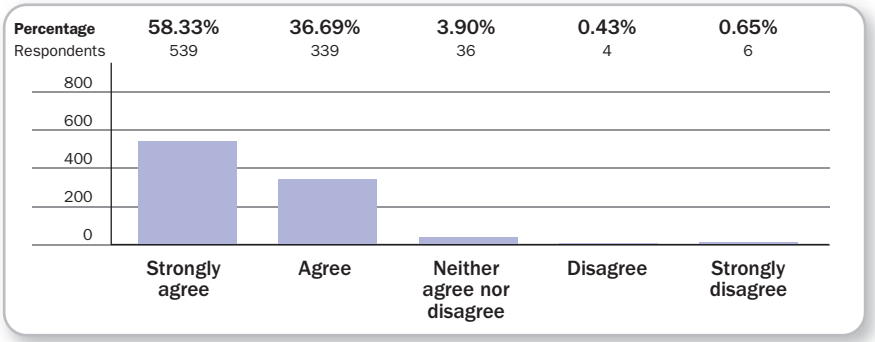
Interim Recommendation 13

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.



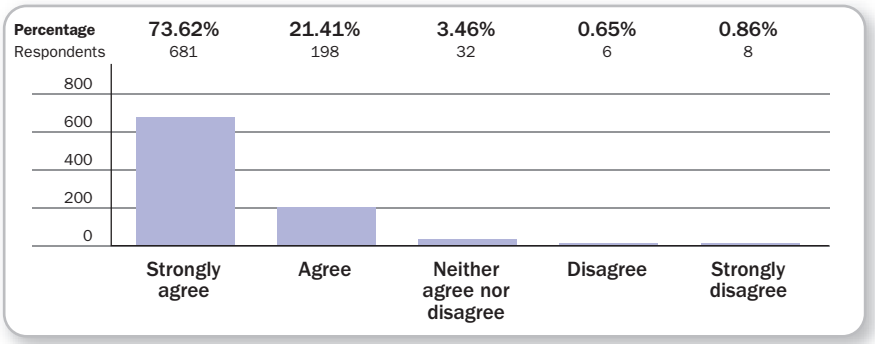
Interim Recommendation 14

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.



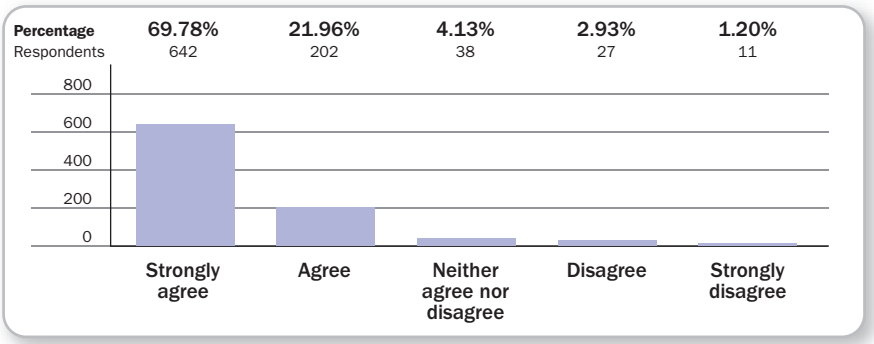
Interim Recommendation 15

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

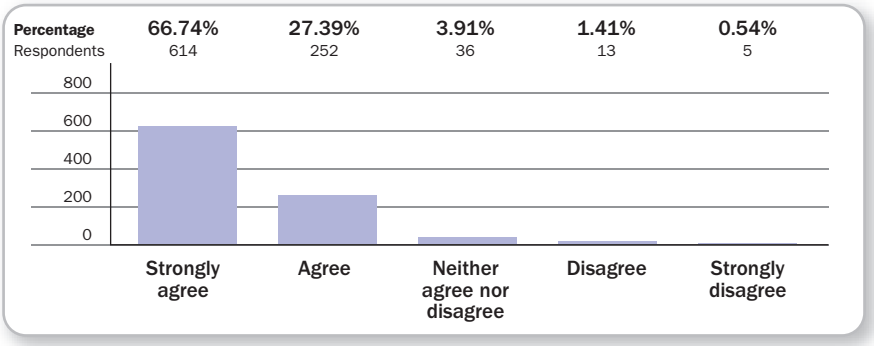
DH should recognise the burgeoning supply of medical graduates it has commissioned and make explicit its plans for the optimal use of their skills for the benefit of patients. It is recommended that sufficient numbers of Core Specialty training posts (see Recommendation 33) should be made available to 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.
- Whilst recognising that doctors are just one part of the workforce, sufficient attention and resource needs to be devoted to medical workforce planning reflecting doctors' crucial roles and the expense involved in their development.
- A national perspective needs to be integrated with regional requirements including the views of service, particularly with regard to the maintenance of sufficient subspecialty expertise to meet the needs of the nation, and the overall health of clinical academia. Consideration should be given to the creation of an arm's length body, NHS Medical Education England, NHS:MEE, mirroring NIHR to undertake commissioning of higher specialist training that is not required in every locality. The criteria for the award of such training positions should reflect the Trust's performance in relation to training, innovation and clinical outcomes.
- Professional advice to the medical workforce advisory machinery needs to include that from doctors at the cutting edge of their discipline with the foresight to project potential developments in healthcare. The Panel believes that this might best be accomplished through arrangements that mirror those in place for the previous Medical Workforce Standing Advisory Committee (MWSAC).

- Regional workforce plans should be subject to a national oversight and scrutiny advisory committee with service, professional and employer representation. Such oversight should encourage local responsiveness and acknowledge issues facing the devolved administrations whilst ensuring national consistency on roles and standards.
- Modelling capacity should be enhanced by drawing on the expertise in the University sector, e.g. health economists, epidemiologists, modellers etc. The assumptions underlying projections should be subject to professional scrutiny and regular review.

FINAL 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.

FINAL 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.

FINAL 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.

FINAL 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.

FINAL 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.

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.

5.5 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.

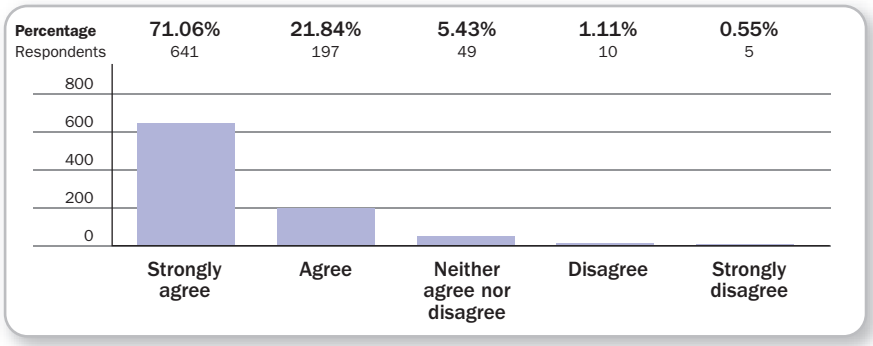
At a national level the Inquiry acknowledges that the medical profession has frequently failed to proffer coherent advice on key issues of principle, reflecting in part a very complex organisational structure, which owes more to history than necessarily function or purpose. There has been a dearth of 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:

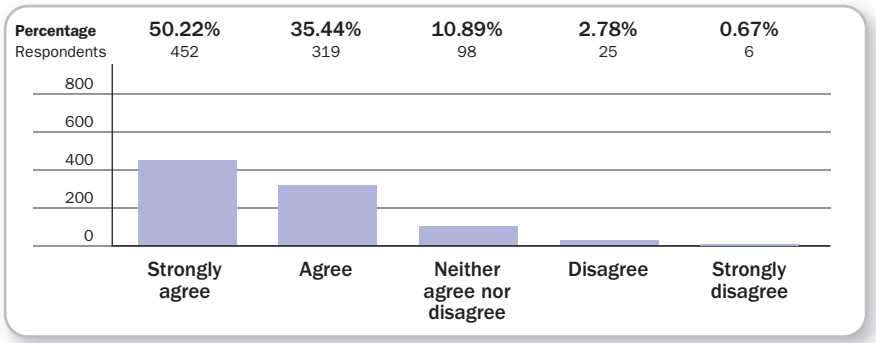
Interim Recommendation 18

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.



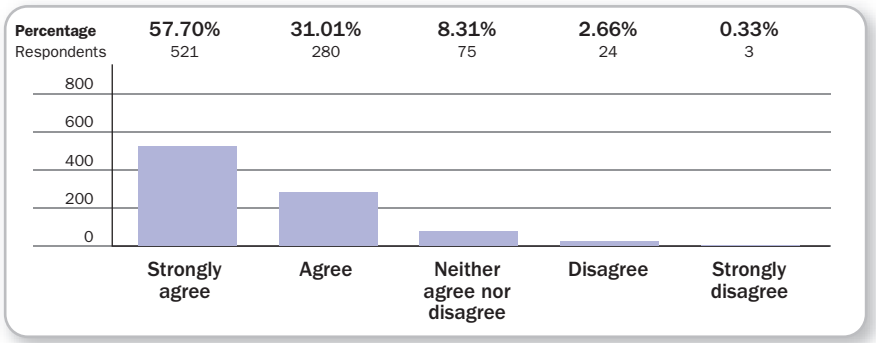
Interim Recommendation 19

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.

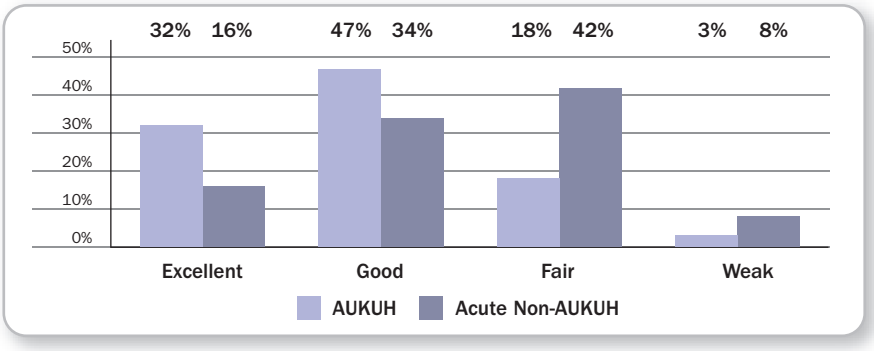
5.6 THE COMMISSIONING AND MANAGEMENT OF POSTGRADUATE MEDICAL EDUCATION AND TRAINING

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 educational benefits that



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

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

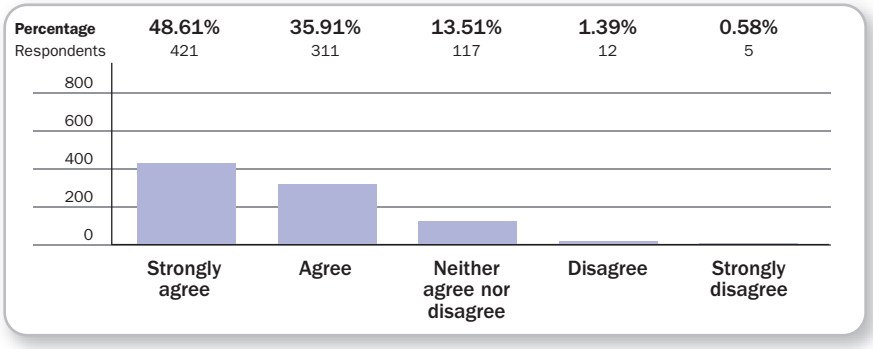
The creation of a DH Director level lead for medical education, review of SHA commissioning of training and contracts for PGMET, as well as review of the English Medical Postgraduate Deanery relationships and accountabilities received strong support.

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.

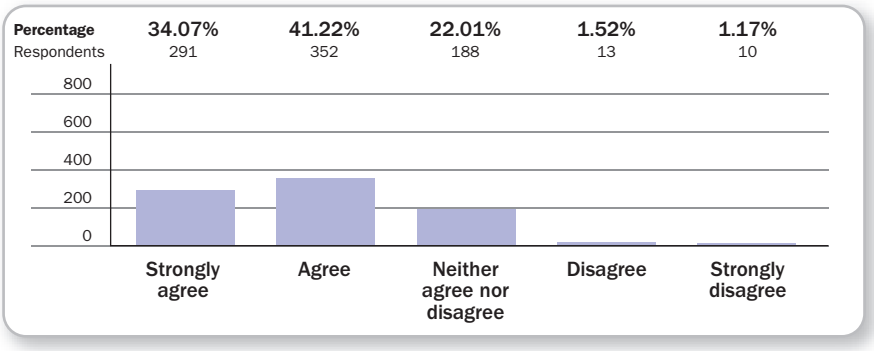
Interim Recommendation 21

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.



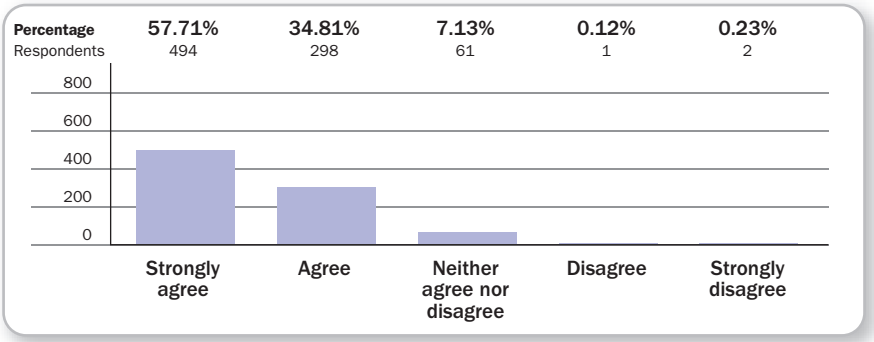
Interim Recommendation 22

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.



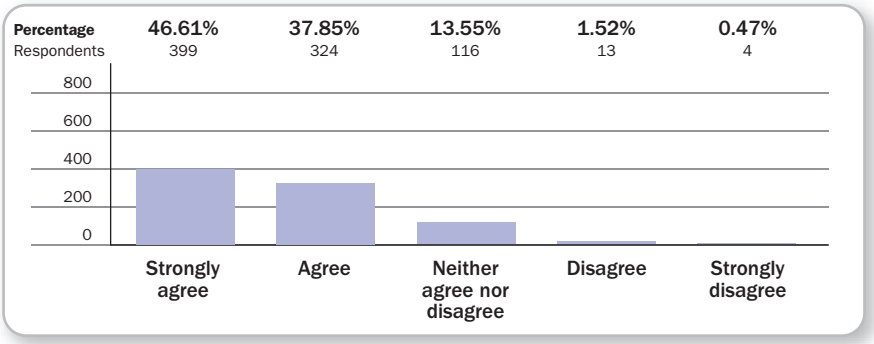
Interim Recommendation 23

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.



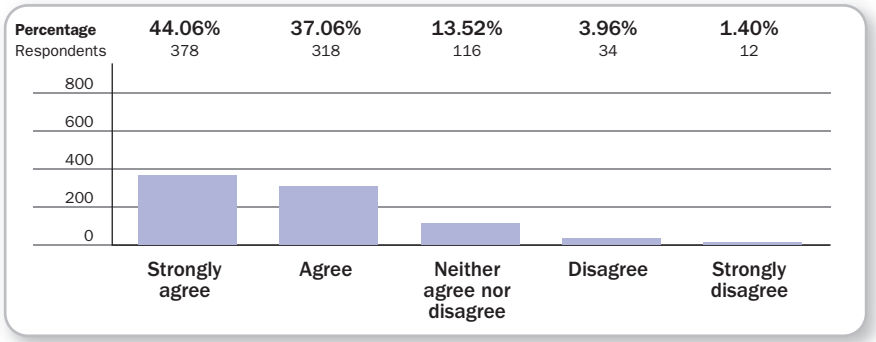
Interim Recommendation 24

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.



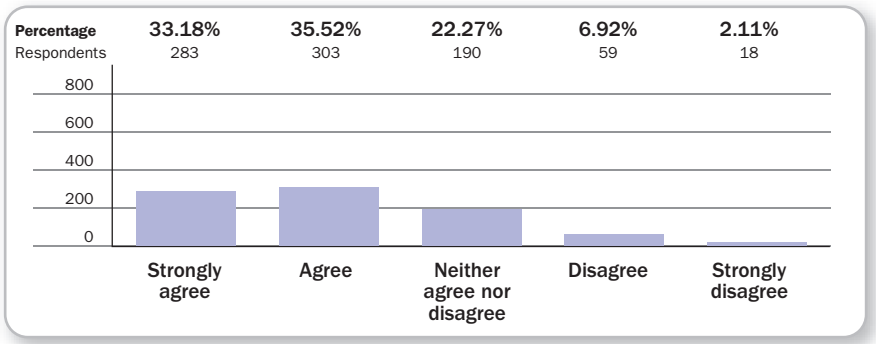
Interim Recommendation 25

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.



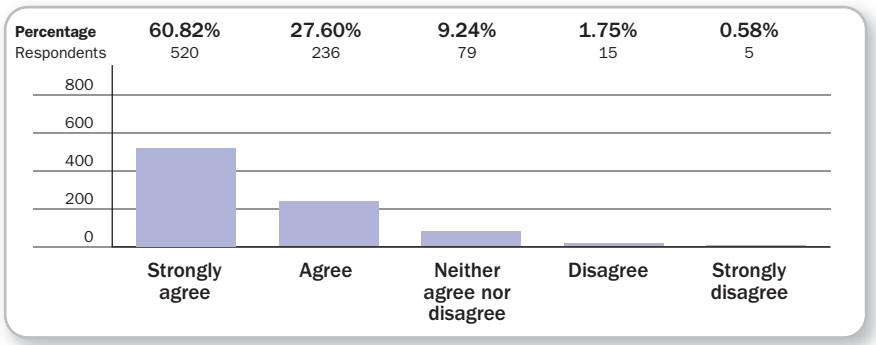
Interim Recommendation 26

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.



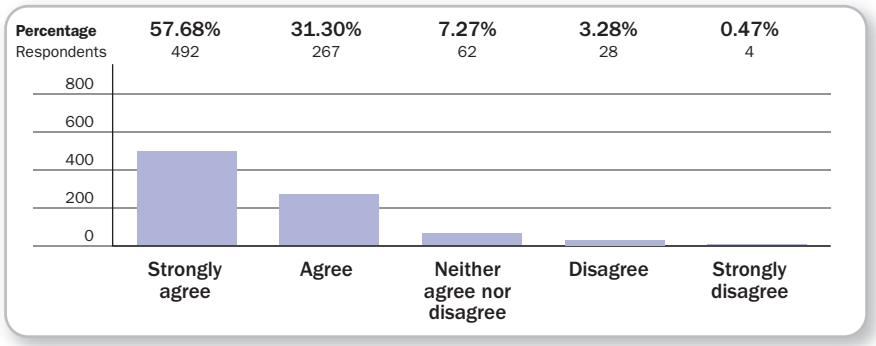
Interim Recommendation 27

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



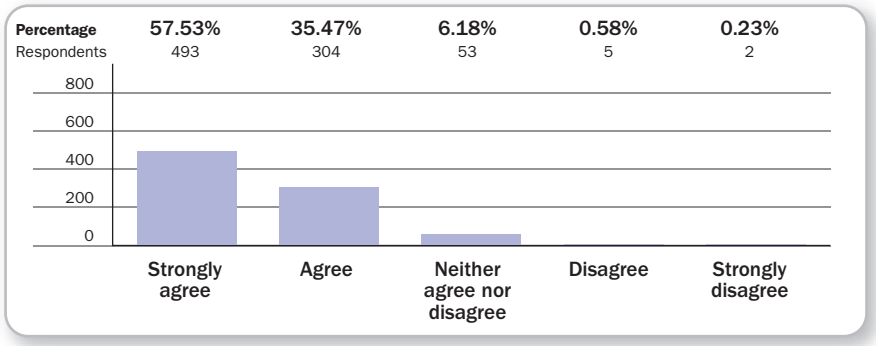
Interim Recommendation 28

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

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

FINAL 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.

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.

5.7 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;

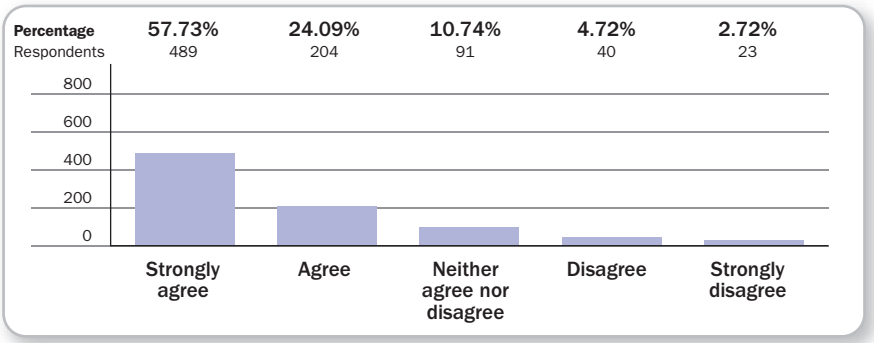
iv it is a body that reports to Parliament, rather than through the monopoly employer, relevant given the non-NHS roles doctors may pursue (e.g. pharmaceutical medicine).

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

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.

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.

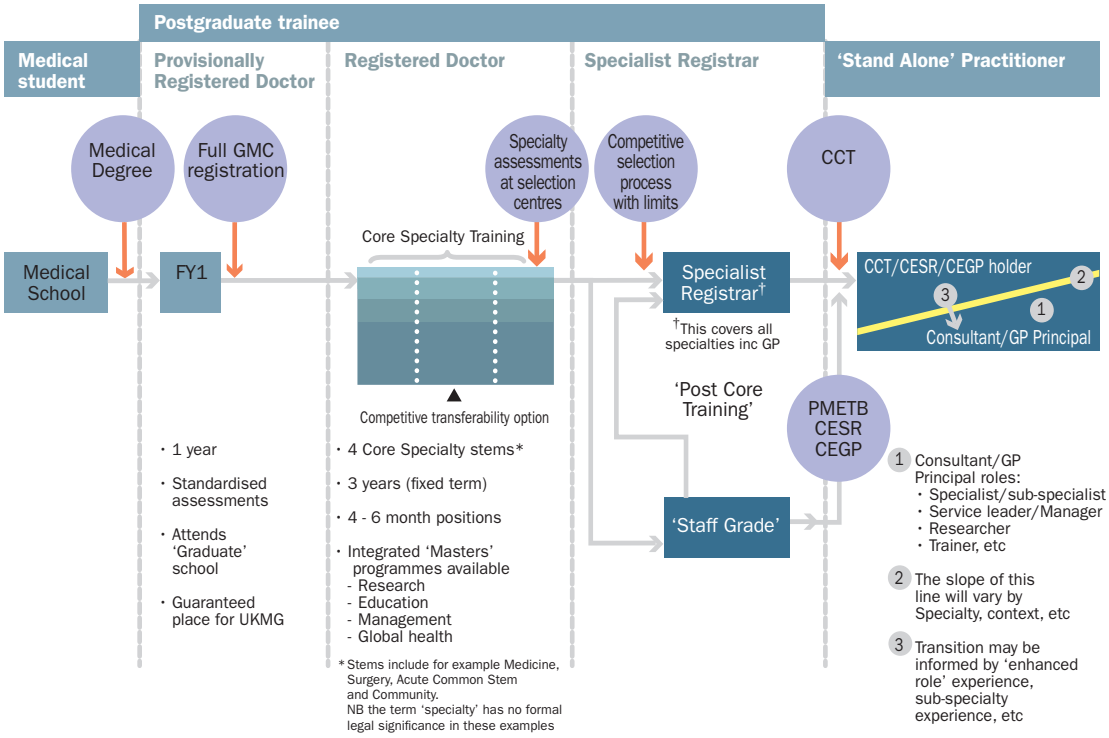
5.8 THE STRUCTURE OF POSTGRADUATE MEDICAL TRAINING

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.

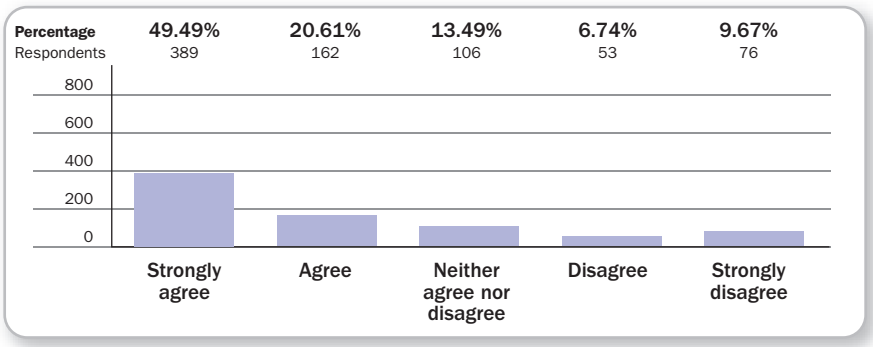
The Interim Report expressed concern that the Foundation Programme was viewed by some as a perpetuation of studenthood and may not sufficiently promote the assumption of an appropriate level of clinical responsibility. However it must be stressed that it was the need to assure FY1 placements for UK medical 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.

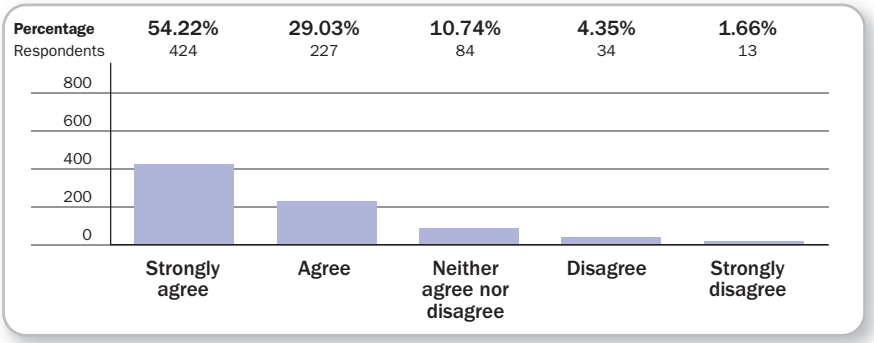
Interim Recommendation 31

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

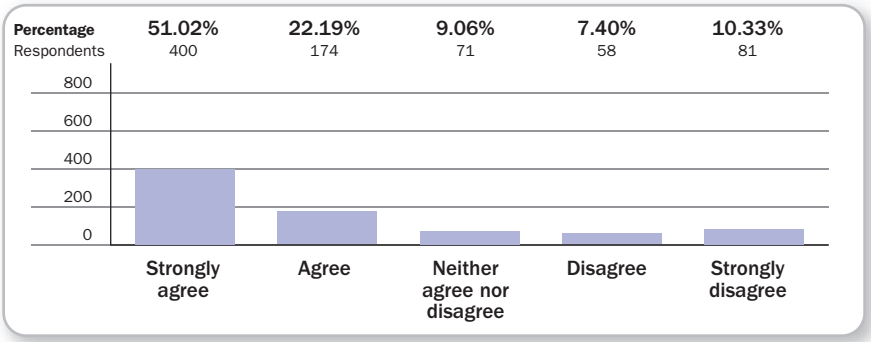
The concept of Core Training replacing current FY2/ST1/ST3 is entirely consistent with the 'broad based beginning' principle expressed by *Unfinished Business.*

CONSULTATION RESPONSE

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

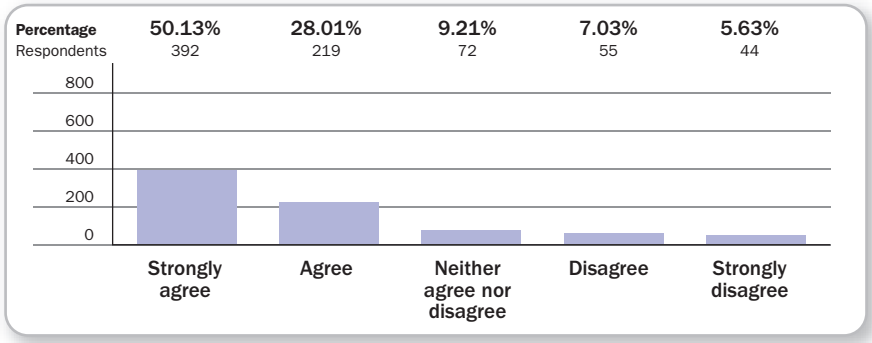
Interim Recommendation 33

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.



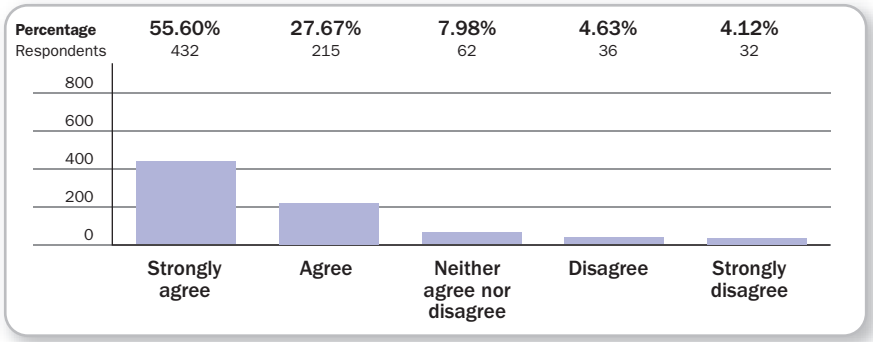
Interim Recommendation 34

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.



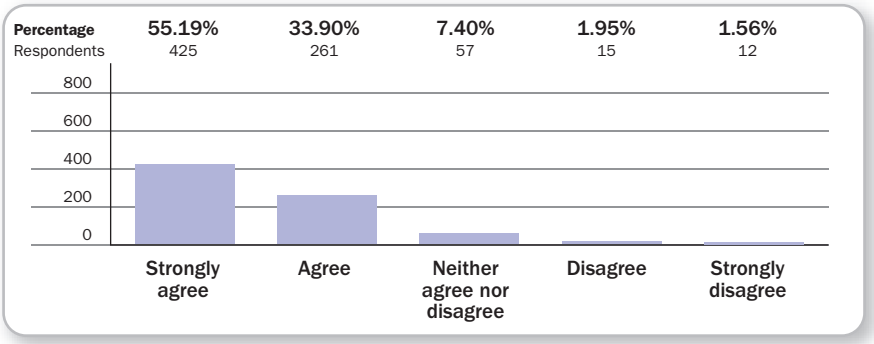
Interim Recommendation 35

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.

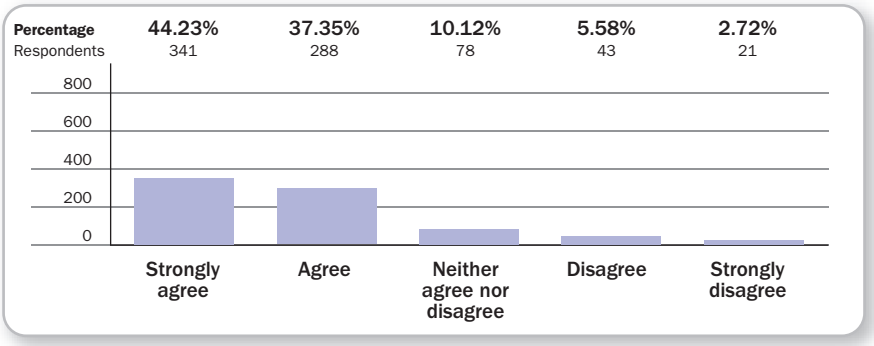
CONSULTATION RESPONSE

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)

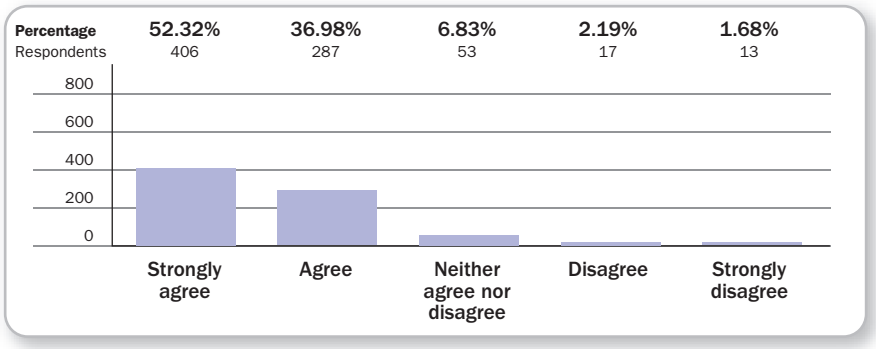
Interim Recommendation 37

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

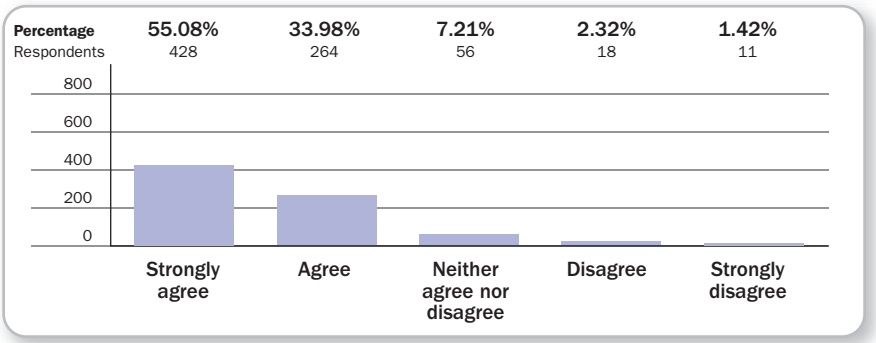
ii selection into Higher Specialist Training.

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).



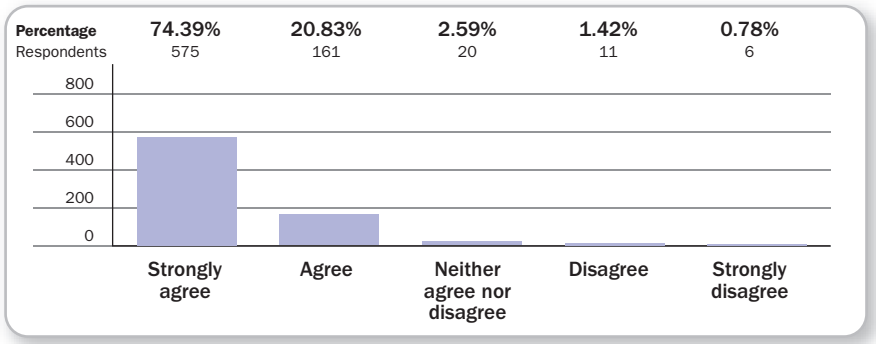
Interim Recommendation 38

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.

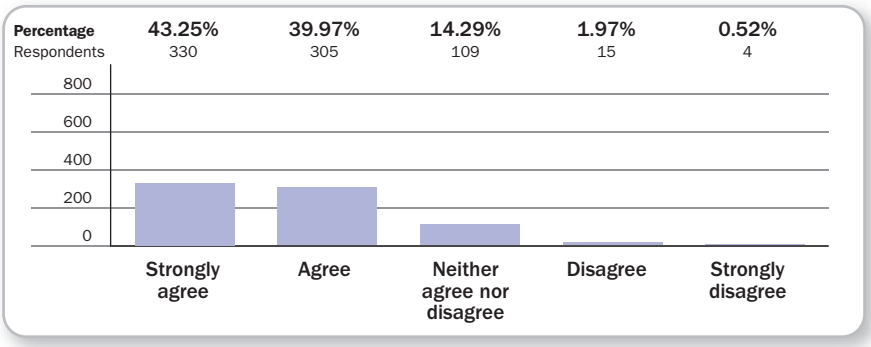
Furthermore flexibility of entry into academia, and return to mainstream clinical practice is limited. Inadequate attention has been given to potential means of shortening the time to complete clinical and academic training.

CONSULTATION RESPONSE

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

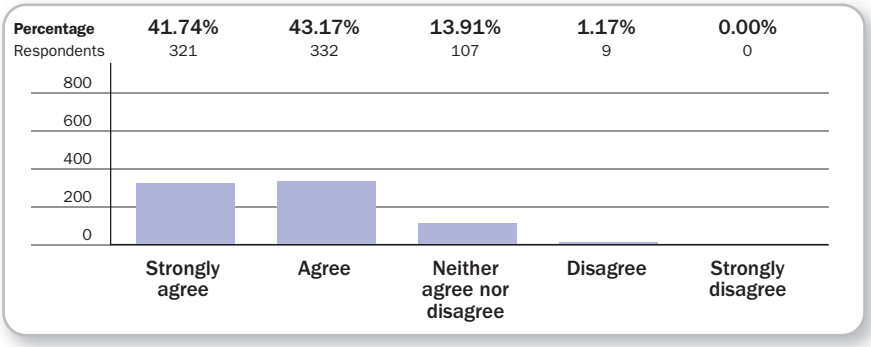
Interim Recommendation 41

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

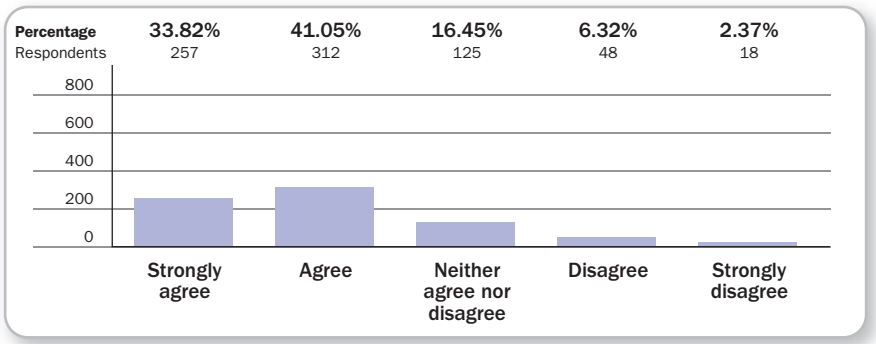
Clinical lecturer posts in England will normally be coincident with higher specialist training (ST3 and beyond).



(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.

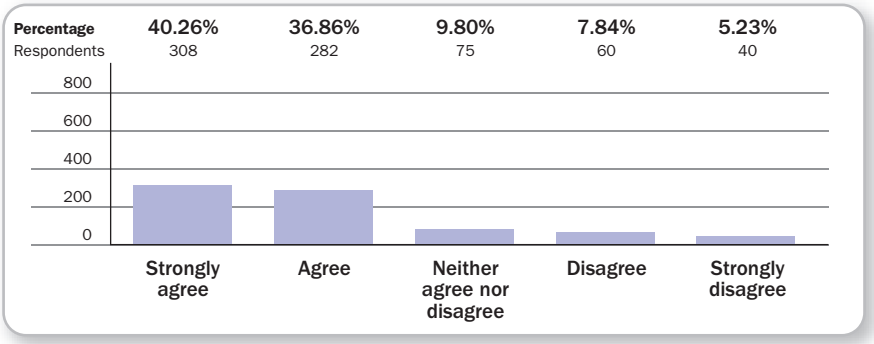
Career paths for enhanced roles for consultants (e.g. researcher, educator, manager) need suitable preparation during the postgraduate training years.

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 acquisi-tion 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.

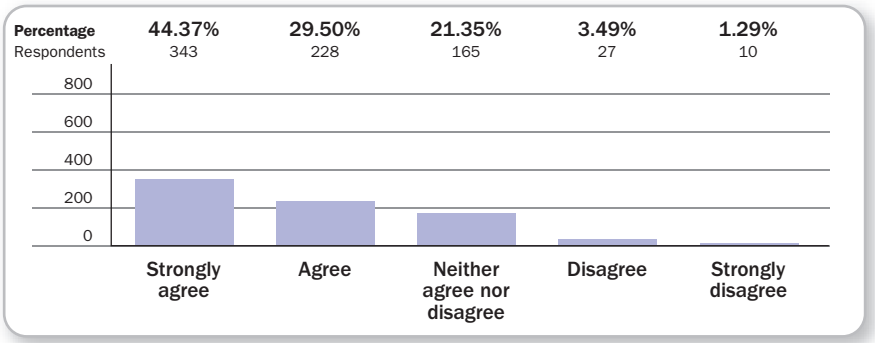
The related ideal that all doctors practising in the UK should have experience of the nature of general practice during their Foundation Years has not been met.

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.

5.9 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

6

OVERVIEW

Recommendations 1 to 47

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.

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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.

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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
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- Coordinate coherent advice to Government on matters relating to medical education
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- 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.

APPENDICES

CONTENTS

APPENDIX 1

E-CONSULTATION

The Inquiry developed an e-Consultation which ran from the 16 May until 31 July. The questions themselves had been devised by the Panel in consultation with academic experts in the field. They were tested across the 4 UK countries and modified in the light of feedback.

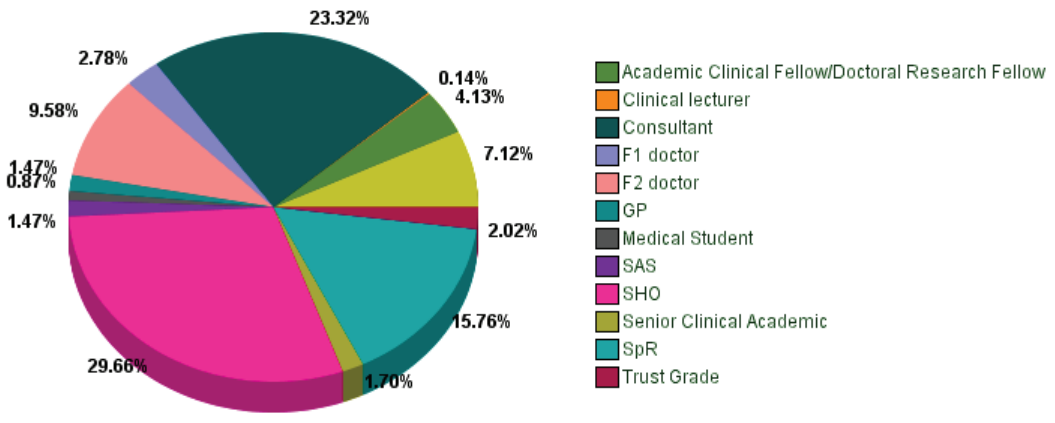
5648 people registered. Data were acquired on gender, country of employment, country of graduation, visa status of non-EU citizens and decade of graduation. Doctors were required to give their GMC Registration number in order to avoid multiple submissions. Registrants were also asked if they were responding on behalf of an organisation.

By the second week of June – which was 4 weeks from the opening of the consultation – 70% of the final total had registered and 68% of the final number had submitted their responses. 4630 people provided 370,127 answers to the Inquiry's questions. 1019 people registered but did not submit answers.

- Of the 4630 participants, the gender split was 58 % male, 41% female, 1% no response.
- Participants were based 78.3 % England, 9.8 % Scotland, 4.1% Wales and 1.7 % N Ireland.
- By decade of graduation, the split was: 0.04 % 1950s, 1 % 1960s, 7.5% 1970s, 10 % 1980s, 20 % 1990s, 50 % 2000s.
- By stage of career, the split was 3% FY1, 10% FY2, 31% SHO, 17% SpR and 23% Consultant.

The detailed breakdown by role is given below:

User Profile Analysis



The questions probed various themes. The first section was designed to assess participants' understanding of MMC. The questions then looked at Foundation Programmes, at selection into specialist training, at run through training, at clinical academic training, at workforce implications and then tried to probe success factors for the future.

The data demonstrate clear mis-understandings of MMC. Of the seven questions posed, only three elicited correct responses from more than 50% of respondents. 94% knew that MMC determined the structure of postgraduate training, 94% recognised that it was incorrect to state that College exams were no longer allowed and 62% knew that it is still possible to take time out of 'run-through'. However only 42% knew that MMC was not established by Act of Parliament – it is simply a government initiative. 49% thought that MMC determined the standards of postgraduate training – when in fact it is PMETB that determines the knowledge and skills doctors need to become specialists. 48% stated correctly that MMC does not determine the number of postgraduate training posts but only 27% of participants knew that MMC does not determine the minimum length of specialty training programmes – which is in fact determined by the EU. There was little difference in the numbers providing the correct answer when analysed by decade of graduation – although worryingly those graduating this century provided an above average number of incorrect answers when asked if 'run-through' training meant that doctors could no longer take time out of programme. This would complement the GMC's observation that fewer doctors appear to have moved overseas to work this year than in previous years – presumably believing that it was vital to remain in the UK to access 'run-through' specialist training. The basis of this is a 12% reduction in the number of requests for Certificates of Good Standing from overseas Regulators to the GMC.

Overall, there was remarkable consistency in the responses whether looking at participants as a whole, or by country of employment, by gender, by stage of career or by age. There were however some striking differences in perspective when considering the Foundation Programme. Whilst consultants and Foundation Years Doctors had similar numbers agreeing and disagreeing as to whether FY1 had been an improvement on the previous PRHO experience, SHOs disagreed in a ratio of 5:1 that it was an improvement. They were even more certain that the selection process for FY1 was worse than the previous system – by a margin of more than 30:1.

- 40% of participants had no opinion as to whether the Foundation Years had linked well with the undergraduate curriculum – whilst the remaining respondees were balanced equally in agreement and disagreement across grades.
- Opinion was again fairly evenly split over whether the assessments used in the Foundation programme were an improvement over the previous system – although again SHOs felt they were worse by a margin of 2:1.
- There was very strong support across all grades for better integration with the undergraduate curriculum and for clearer educational goals – consultants supporting this by 8:1 and Foundation Doctors by 5:1.
- Again, by a margin of 5:1 across grades there was agreement that there should be greater support in confirming that the new doctor is putting into practice those skills acquired at Medical School.
- Whilst consultant opinion was more evenly divided, more SHO and Foundation Doctors disagreed or strongly disagreed with the notion that FY2 provided a useful spectrum of clinical experience by 2:1. By 10:1 SHOs disagreed that FY2 was an advance on their first year SHO experience. Consultants felt the same by 3:1.
- Opinion was split as to whether FY2 builds effectively on FY1, but by 5:1 SHOs and by 3:1 Foundation Doctors disagreed with the statement that

FY2 adds value over and above further patient exposure.

- There was less support from Foundation Doctors than from Consultants for the need for more choice on clinical sub-specialties in FY2 – but strong support across all grades for longer than 4 months in each sub specialty.
- It was very clear that there was little support for selecting a specialty in the middle of FY2 and huge support for additional fixed term posts to allow trainees to sample other disciplines with no detriment to their subsequent application to specialist training. Consultants agreed with this proposal by 24:1 , SHOs by 32:1 and FY1s by 26:1.
- 23% had no opinion, but of the 66% who disagreed that overall the impact of the Foundation Programme on clinical service delivery had been positive, SHOs were in this category in a ratio of 9:1 and Consultants 5:1.

The detailed analysis is provided below. The key messages to emerge are:

- Shortened time to completion of training is not popular with 88% believing patients will not benefit.
- 21% want 'run-through', 67% (2897 respondents) did not.
- 9% think 'run-through' will have a positive effect on clinical service delivery
- 95% wish to see medical professional leadership of selection processes
- 80% would like to see selection run more than once a year whilst 10% had no opinion.
- 88% would like to see appropriately structured College exams as an integral part of selection for specialty training
- 62% would like an exit exam (76% of FY2s and 72% of consultants favoured this option)
- 80% believe UK graduates should be entitled to FY1 posts
- 93% would like additional time to sample other disciplines
- Less than 2% thought the practical management of MMC had been effective.
- 4% thought the selection process for specialty training had been effective
- 52% had never experienced nepotism or patronage, 14% had been frequently aware of such behaviour in the past 10 years.
- 83% aspire to clinical excellence and expertise over and above the achievement of competence.
- 96% wish to see protected budgets for postgraduate education and training.

Results of the e-consultation

Where the options 1-5 are given
1 = Strongly Agree with the statement
2 = Agree
3 = Neither agree nor disagree
4 = Disagree
5 = Strongly disagree

		%	#
MMC was established by Act of Parliament	Don't know	37.33	1613
	No	42.17	1822
	Yes	20.5	886
	Total	100	4321
MMC determines the structure of postgraduate training (e.g. changes to SHO grade; start date of specialty training etc)	Don't know	1.27	55
	No	4.54	197
	Yes	94.19	4084
	Total	100	4336
MMC determines the standards of postgraduate training (e.g. the knowledge and skills that doctors need to become specialists	Don't know	2.66	115
	No	48.82	2113
	Yes	48.52	2100
	Total	100	4328
MMC determines the number of postgraduate training posts	Don't Know	7.37	319
	No	48.49	2099
	Yes	44.14	1911
	Total	100	4329
Run-through training means that doctors can no longer take time out of programme (e.g. to undertake some training overseas	Don't know	12.21	528
	No	61.58	2664
	Yes	26.21	1134
	Total	100	4326
Run-through training means that College exams are no longer allowed	Don't know	3.81	165
	No	94.11	4077
	Yes	2.08	90
	Total	100	4332
MMC determines the minimum length of specialty training programmes	Don't know	6.68	289
	No	26.62	1151
	Yes	66.7	2884
	Total	100	4324
Do you agree that the principles behind MMC are sound?	Don't know	8.82	382
	No	61.94	2684
	Yes	29.24	1267
	Total	100	4333
Patients will benefit from doctors reducing their length of training to the shortest possible time consistent with delivering a competent	Don't know	4.24	184
	No	88.26	3828
	Yes	7.49	325
	Total	100	4337
Do you agree that the practical management of MMC has been effective?	Don't know	1.5	65
	No	96.81	4189
	Yes	1.69	73
	Total	100	4327
Do you agree that you have been kept properly informed about MMC as it has developed?	1	2.14	93
	2	9.22	400
	3	9.13	396
	4	28.6	1241
	5	50.91	2209
	Total	100	4339

Which of the following aims associated with MMC do you support? Q1.12 A : A clear pathway from Medical School to a definitive career post (e.g. GP Principal, consultant in hospital practice, non-training post)	1	16.12	700
	2	35.86	1557
	3	12.37	537
	4	22.34	970
	5	13.31	578
	Total	100	4342
Q1.12 B : Assessed achievement of pre-defined knowledge and skills	1	18.53	805
	2	52.79	2293
	3	13.77	598
	4	9.39	408
	5	5.52	240
	Total	100	4344
Q1.12 C : Shortened time to completion of specialist training	1	3.06	133
	2	7.96	346
	3	9.57	416
	4	34.83	1514
	5	44.58	1938
	Total	100	4347
Q1.12 D : 'Run through' specialist training following the Foundation Programme	1	5.39	234
	2	15.32	665
	3	12.55	545
	4	31.38	1362
	5	35.36	1535
	Total	100	4341
Q1.12 E : A consultant provided service with a higher ratio of consultant posts to training posts	1	13.09	569
	2	31.45	1367
	3	24.34	1058
	4	21.07	916
	5	10.05	437
	Total	100	4347
Do you agree that the following features have been successfully encapsulated within MMC? Q1.13 A: The encouragement of clinical excellence/expertise over and above the achievement of minimum acceptable standards.	1	0.65	115
	2	5.35	232
	3	8.95	388
	4	31.13	1350
	5	51.91	2251
	Total	100	4336
Q1.13 B: Opportunities for breadth of experience before committing to a single specialty	1	2.58	112
	2	4.11	178
	3	3.69	160
	4	16.04	695
	5	73.58	3189
	Total	100	4334
Q1.13 C: The flexibility to extend the training period	1	2.54	110
	2	3.16	137
	3	9.97	432
	4	27.96	1212
	5	56.38	2444
	Total	100	4335

Q1.13 D: The flexibility to take time out of training	1	2.56	111
	2	3.21	139
	3	12.7	550
	4	26.54	1149
	5	54.99	2381
	Total	100	4330
Do you agree that the following principles need to be included in taking MMC forward? Q1.14 A: Valid methods for addressing individual doctor's aptitudes for a particular career path	1	39.1	1694
	2	41.82	1812
	3	9.46	410
	4	5.63	244
	5	3.99	173
	Total	100	4333
Q1.14 B: Additional "Foundation" opportunities to inform career choice through broader experience	1	32.64	1415
	2	37.21	1613
	3	12.92	560
	4	11.37	493
	5	5.86	254
	Total	100	4335
Q1.14 C : Entrance examinations as part of the process for gaining entry to specialist training programmes	1	24.65	1069
	2	27.98	1213
	3	20.43	886
	4	17.71	768
	5	9.23	400
	Total	100	4336
Q1.14 : Valuing clinical experience as well as the achievement of competence	1	63.73	2766
	2	27.86	1209
	3	3.53	153
	4	2.26	98
	5	2.63	114
	Total	100	4340
MMC Foundation Year 1 Do you agree that Foundation Year 1 has been an improvement on the previous PRHO experience?	1	4.08	134
	2	15.79	518
	3	24.54	805
	4	29.63	972
	5	25.97	852
	Total	100	3281
Do you agree the selection process for Foundation year 1 trainees who will start in August 2007 has been better than previous methods of selecting for PRHO jobs?	1	2.15	70
	2	7.63	248
	3	40.84	1328
	4	24.26	789
	5	25.12	817
	Total	100	3252
Do you agree that the Foundation year 1 links effectively with undergraduate education and training?	1	2.61	85
	2	26.78	871
	3	41.16	1339
	4	17.8	579
	5	11.65	379
	Total	100	3253

Do you agree that the curriculum for Foundation year 1 is appropriate?	1	3.23	105
	2	29.13	946
	3	37.97	1233
	4	18.54	602
	5	11.12	361
	Total	100	3247
Do you agree the assessment processes used in Foundation year 1 are an improvement on previous assessment of PRHOs?	1	6.79	221
	2	27.06	881
	3	24.02	782
	4	22.11	720
	5	20.02	652
	Total	100	3256
Do you agree that each of the following are ways in which the Foundation year 1 experience could be improved? Q2.6 A: Better integration with the undergraduate curriculum	1	13.69	442
	2	41.07	1326
	3	34.59	1117
	4	8.7	281
	5	1.95	63
	Total	100	3229
Q2.6 B: Clearer educational goals	1	14.53	470
	2	42.38	1371
	3	29.61	958
	4	11.07	358
	5	2.41	78
	Total	100	3235
Q2.6 C Greater support in confirming the new doctor is putting into practice those skills learned at Medical School	1	16.27	526
	2	45.31	1465
	3	26.32	851
	4	9.93	321
	5	2.17	70
	Total	100	3233
Q2.6 D: Greater exposure to different specialties in the Foundation years	1	13.43	435
	2	24.69	800
	3	22.1	716
	4	28.52	924
	5	11.27	365
	Total	100	3240
Foundation Year 2 Foundation Year 2 provides a useful spectrum of clinical experience to help inform career decisions.	1	3.12	101
	2	26.18	847
	3	23.28	753
	4	30.63	991
	5	16.79	543
	Total	100	3235
Foundation Year 2 is a valuable educational experience.	1	5.63	182
	2	35.43	1146
	3	29.09	941
	4	19.63	635
	5	10.23	331
	Total	100	3235

Foundation Year 2 is an advance on first year SHO experience	1	2.49	81
	2	10.04	326
	3	18.42	598
	4	31.41	1020
	5	37.63	1222
	Total	100	3247
Foundation Year 2 builds effectively on FY1	1	3.51	113
	2	27.73	892
	3	42.93	1381
	4	16.51	531
	5	9.33	300
	Total	100	3217
Foundation Year 2 adds value in ways over and above further patient exposure	1	2.12	68
	2	13.16	423
	3	32.32	1039
	4	30.7	987
	5	21.71	698
	Total	100	3215
Foundation Year 2 could be improved by: Q2.12 A: Offering more choice of clinical sub specialties	1	12.99	419
	2	32.87	1060
	3	22.48	725
	4	21.15	682
	5	10.51	339
	Total	100	3225
Q2.12 B: Longer time in each sub specialty area	1	26.89	871
	2	35.94	1164
	3	19.36	627
	4	14.05	455
	5	3.77	122
	Total	100	3239
Experience in Foundation years 1 and 2 supplemented by good career advice should provide sufficient basis on which to base specialist training choices.	1	4.33	141
	2	17.15	558
	3	10.94	356
	4	32.42	1055
	5	35.16	1144
	Total	100	3254
Additional fixed term posts should be available to allow trainees to sample other disciplines with no detriment to their subsequent application to specialist training.	1	62.16	2032
	2	30.47	996
	3	3.58	117
	4	1.87	61
	5	1.93	63
	Total	100	3269
Do you agree that in a global market a UK graduate cannot expect guaranteed access to an F1 position in order to complete training and become registered with the GMC ?	1	4.24	139
	2	8.37	274
	3	7.11	233
	4	17.4	570
	5	62.87	2059
	Total	100	3275

Do you agree that overall, the impact of the Foundation programme on clinical service delivery has been positive?	1	1.53	50
	2	10.06	329
	3	22.65	741
	4	29.06	951
	5	36.71	1201
	Total	100	3272
Selection into specialist training Do you agree that the selection processes for specialist training used so far in 2007 have been effective?	1	1.13	46
	2	3.07	125
	3	2.71	110
	4	10.75	437
	5	82.34	3348
	Total	100	4066
In the last 10 years have you been aware of nepotism or patronage on the part of appointment Panels in making appointments to medical posts.	Frequently aware	13.79	556
	Have experienced on 1 or 2 occasions	34.18	1378
	Have never experienced	52.03	2098
	Total	100	4032
Do you think selection should be run more than once a year?	1	52.54	2133
	2	27.71	1125
	3	9.7	394
	4	5.44	221
	5	4.61	187
	Total	100	4060
Do you agree it is appropriate to involve lay, non-clinicians in scoring the applications forms?	Yes	12.86	522
	don't know	4.33	176
	no	82.81	3362
	Total	100	4060
Have you been involved in the selection process for 2007?	No	36.85	1496
	Yes - as an Interviewee	49.93	2027
	Yes - as an interviewer	13.23	537
	Total	100	4060
Do you believe that the interview process in which you were involved was good?	1	8.41	269
	2	22.55	721
	3	20.89	668
	4	20.05	641
	5	28.09	898
	Total	100	3197
Do you believe that the interview process this year was an improvement on previous interviews for specialist trainees you have experienced ?	1	3.87	136
	2	8.23	289
	3	23.46	824
	4	21.09	741
	5	43.35	1523
	Total	100	3513
Which of the following criteria should have been used or figured more strongly in the selection process? Q3.8 A: Undergraduate academic achievements	1	23.37	938
	2	33.37	1339
	3	22.15	889
	4	15.82	635
	5	5.28	212
	Total	100	4013

Q3.8 B: Postgraduate academic achievements e.g. College exams	1	51.47	2077
	2	36.43	1470
	3	6.32	255
	4	3.17	128
	5	2.6	105
	Total	100	4035
Q3.8 C: Experience obtained in the particular specialty applied for	1	58.73	2369
	2	29.75	1200
	3	5.92	239
	4	3.02	122
	5	2.58	104
	Total	100	4034
Do you agree that too much emphasis is placed on achievement of competence at the expense of the pursuit of excellence?	1	45.49	841
	2	30.71	1243
	3	14.83	600
	4	6.6	267
	5	2.37	96
	Total	100	4047
Run through specialty training programmes Are you concerned that trainees who do not achieve a training position this year may be excluded from future rounds?	No	5.52	211
	Yes	94.48	3614
	Total	100	3825
Do you agree that there is insufficient flexibility in assessing the clinical experience that counts towards Certificates of Completion of Training	1	48.82	1858
	2	27.93	1063
	3	15.84	603
	4	4.86	185
	5	2.55	97
	Total	100	3806
Compared with current arrangements, what level of involvement should the medical Royal Colleges Q4.3 A: Curricula	Don't know	7.34	279
	Less	2.26	86
	More	90.39	3435
	Total	100	3800
Q4.3 B: Standards	Don't know	6.92	263
	Less	3.08	117
	More	90	3419
	Total	100	3799
Q4.3 C: Appointments	Don't know	29.92	1135
	Less	17.03	646
	More	53.05	2012
	Total	100	3793
Compared with current arrangements, what level of involvement should PMETB have? Q4.4 A: Curricula	Don't know	17.57	664
	Less	72.17	2728
	More	10.26	388
	Total	100	3780
Q4.4 B: Standards	Don't know	18.66	706
	Less	65.77	2488
	More	15.57	589
	Total	100	3783

Q4.4 C: Appointments	Don't know	20.69	781
	Less	74.22	2801
	More	5.09	192
	Total	100	3774
Compared with current arrangements, what level of involvement should the Deaneries have? Q4.5 A: Curricula	Don't know	25.09	942
	Less	43.1	1618
	More	31.81	1194
	Total	100	3754
Q4.5 B: Standards	Don't know	22.98	863
	Less	33.39	1254
	More	43.64	1639
	Total	100	3756
Q4.5 C: Appointments	Don't know	14.81	560
	Less	15.32	579
	More	69.87	2641
	Total	100	3780
Compared with current arrangements, what level of involvement should the Medical Schools have? Q4.6 A : Curricula	Don't know	37.09	1392
	Less	26.89	1009
	More	36.02	1352
	Total	100	3753
Q4.6B : Standards	Don't know	38.01	1427
	Less	28.48	1069
	More	33.51	1258
	Total	100	3754
Q4.6 C : Appointments	Don't know	42.86	1605
	Less	38.5	1442
	More	18.64	698
	Total	100	3745
Do you favour an exit exam at the completion of specialist training that assesses knowledge and understanding?	Don't know	8.7	332
	No	29.32	1119
	Yes	61.98	2365
	Total	100	3816
The impact of run through specialist training on clinical service delivery will be positive	1	2.67	102
	2	6.47	247
	3	15.93	608
	4	30.56	1166
	5	44.37	1693
	Total	100	3816
Overseas clinical experience should be recognised as a legitimate component of the post-graduate training of doctors	1	34.19	1307
	2	39.5	1510
	3	15.43	590
	4	7.22	276
	5	3.66	140
	Total	100	3823
Selection for Clinical Academic Training Positions Should appointments to academic specialist training posts be run concurrently with appointments to non academic specialist training posts (with appropriate committee membership and criteria).	Don't Know	19.87	590
	No	22.69	674
	Yes	57.44	1706
	Total	100	2970

When appointing to clinical academic training positions more emphasis should be placed on academic achievements at undergraduate level ?	Don't Know	11.93	354
	No	7.95	236
	Yes	80.12	2378
	Total	100	2968
When appointing to clinical academic training positions more emphasis should be placed on academic achievements at postgraduate level?	Don't Know	18.45	547
	No	40.92	1213
	Yes	40.62	1204
	Total	100	2964
When appointing to clinical academic training positions do you agree that if a threshold level of acceptable clinical competence and experience is exceeded, selection should be on the basis of academic potential?	1	39.21	1161
	2	42.52	1259
	3	12.83	380
	4	3.78	112
	5	1.65	49
	Total	100	2961
Workforce Implications Do you agree that in a global market UK graduates should not expect guaranteed employment in the specialty of their first choice?	1	18.71	686
	2	49.18	1803
	3	9.68	355
	4	11.76	431
	5	10.67	391
	Total	100	3666
Do you agree that in a global market UK graduates should not expect guaranteed employment in the NHS?	1	6.91	253
	2	19.32	708
	3	9.39	344
	4	29.37	1076
	5	35.02	1283
	Total	100	3664
Do you agree that the implementation of the European Working Time Directive has benefited senior doctors?	1	2.16	79
	2	7.97	292
	3	15.56	570
	4	34.31	1257
	5	40.01	1466
	Total	100	3664
Do you agree that the implementation of the European Working Time Directive has benefited junior doctors?	1	7.28	267
	2	24.22	888
	3	11.59	425
	4	26.81	983
	5	30.11	1104
	Total	100	3667
Do you agree that the implementation of the European Working Time Directive has not harmed the NHS?	1	3.36	123
	2	10.04	368
	3	13.07	479
	4	31.69	1161
	5	41.84	1533
	Total	100	3664

Success factors for the future Q6.1 A: Better career advice	1	44.82	1641
	2	38.57	1412
	3	10.41	381
	4	4.62	169
	5	1.58	58
	Total	100	3661
Q6.1 B: Clearer Indication of applicant: trainee application ratios for each specialty	1	35.21	1288
	2	39.53	1446
	3	15.55	569
	4	7.55	276
	5	2.16	79
	Total	100	3658
Q6.1 C: A commitment to the pursuit of excellence	1	65.24	2387
	2	28.15	1030
	3	4.67	171
	4	1.07	39
	5	0.87	32
	Total	100	3659
Q6.1 D: Emphasis on appropriately structured College exams as an integral part of the process	1	59.58	2183
	2	33.24	1218
	3	3.93	144
	4	2.21	81
	5	1.04	38
	Total	100	3664
Q6.1 E: The flexibility to take more than seven years to CCT	1	71.92	2635
	2	22.6	828
	3	3.06	112
	4	1.28	47
	5	1.15	42
	Total	100	3664
Q6.1 F: A clear recognition that there is a role for a properly supported Trust doctor career position.	1	28.24	1031
	2	36.48	1332
	3	19.12	698
	4	9.53	348
	5	6.63	242
	Total	100	3651
Q6.1 G: A clear recognition that there is a role for a properly supported staff and associate specialist career positions	1	31.31	1143
	2	41.36	1510
	3	16.74	611
	4	6.35	232
	5	4.25	155
	Total	100	3651
Q6.1 H: Greater medical professional involvement in the selection processes.	1	79.31	2906
	2	16.16	592
	3	2.97	109
	4	0.76	28
	5	0.79	29
	Total	100	3664
Q6.1 I: Medical professional leadership of the selection processes involved.	1	80.33	2940
	2	15.74	576
	3	2.54	93
	4	0.55	20
	5	0.85	31
	Total	100	3660

Q6.1 J: Protected budgets for Postgraduate education and training	1	82.91	3033
	2	12.88	471
	3	2.87	105
	4	0.44	16
	5	0.9	33
	Total	100	3658
Q6.1 K: An emphasis on developing experience and expertise, not just competence.	1	86.91	3181
	2	11.07	405
	3	0.82	30
	4	0.38	14
	5	0.82	30
	Total	100	3660
Q6.1 : Closer and more consistent working between the Medical Royal Colleges	1	67.25	2458
	2	24.1	881
	3	6.95	254
	4	0.85	31
	5	0.85	31
	Total	100	3655
Q6.1 M: Closer liaison between the Colleges and Postgraduate Deaneries	1	61.62	2248
	2	28.73	1048
	3	7.84	286
	4	0.9	33
	5	0.9	33
	Total	100	3648
Q6.1 N: Closer liaison between the Postgraduate Deaneries and Medical Schools	1	44.64	1627
	2	29.27	1067
	3	22.36	815
	4	2.66	97
	5	1.07	39
	Total	100	3645
Q6.1 O: Closer liaison between the Colleges and PMETB	1	42.82	1557
	2	24.97	908
	3	18.95	689
	4	5.2	189
	5	8.06	293
	Total	100	3636
Familiarity with research is a critical component of the training of all doctors	1	31.23	1143
	2	44.45	1627
	3	11.37	416
	4	9.73	356
	5	3.22	118
	Total	100	3660
Engagement in research by doctors who are not pursuing a clinical academic career is of benefit to the Health Service	1	33.8	1238
	2	35.3	1293
	3	14.03	514
	4	11.77	431
	5	5.11	187
	Total	100	3663

APPENDIX 2

MMC INQUIRY TRAINEE WORKSHOPS

WERE HELD IN:
BELFAST
BIRMINGHAM
CAMBRIDGE
CARDIFF
EDINBURGH
LEEDS
LONDON X 2

This is what the 450 doctors who attended had to say:

Question 1 What are the pros and cons of 'run-through' training? Please list them.

Pros

- Stability/certainty regarding career path and geographical location.
- Perceived advantage if the trainee knows what they want to do.
- Reduced requirement for interviews/jumping through hoops
- Recognised training experience
- Stops applicants doing half-hearted research to get training
- Focused, structured training. Sense of progression
- Focus more on clinical abilities, not just exams
- Acute common stem is very good/there should be more common stems
- Potential for continuity of educational supervision
- More structured assessment
- 360 degree appraisals
- Better planning of service provision and workforce by Trusts
- Opportunity to separate training from service provision
- Online application better than paper-based application

Cons

- Premature career choice
- Not good for those uncertain of career preferences at the outset
- Shorter training
- People interviewed at start of process were disadvantaged compared to those interviewed later as questions did not change.
- Problem with transferring competencies
- Some experience of deaneries making, then revoking, offers
- People in jobs they do not want, therefore poorly motivated workforce
- Big problems for those who don't get a job first time
- Selection criteria too rigid
- Discrimination against experienced candidates
- Artificial limit in number of jobs that can be applied for
- Units of application too large (e.g. whole of Scotland)
- No provision for VSO, foreign posts, sabbaticals.
- Sample days not enough in foundation scheme
- May be in one hospital for prolonged periods
- Bottleneck at ST1
- Four month placements in Foundation too short
- No clear end-point
- No out of programme experience
- Perceived rigidity/lack of flexibility
- Reduced flexibility a particular problem for women; no option for part-time/flexible training in training posts
- Maternity leave not considered as a good reason for deferral
- Less flexibility for dual training
- Single annual entry
- Lack of confidence that end point (CCT) would equip trainee to assume a consultant role/ less experienced consultants
- Inability to accommodate additional experience to broaden base for future development.
- Inadequate training to produce confident specialists
- Less suitable for specialties requiring broad based experience or acquisition of practical skills
- Too many restrictions on the number of jobs that can be applied for
- Dangers of reducing all training to a checklist of competencies/ leads to learning the science of medicine rather than the art of medicine
- Insufficient autonomy for local deaneries
- Inconsistencies across the country/deaneries in quality of rotations
- Time consuming process for assessments takes seniors away from training
- Demotivating/decreases competition
- Exams do serve a purpose and should not be devalued
- Deskilling – competency vs. excellence
- Problems for international

medical graduates, due to changes in visa regulations.
- Dangers in all-change in August
- System appears to be forcing people into non-training posts
- Application process seen as a lottery; MTAS criticised e.g. for application form being over-reliant on literary ability rather than objective measures, not discriminating between candidates, not being transparent, having security breaches.

In the light of this analysis, what amendments would you suggest?

- Mostly can be inferred as remedying the identified weaknesses
- Later entry i.e. 3-4 years post-qualification
- RITA may be a useful way of avoiding patronage but obtaining a longer historical perspective of a candidate's competence.
- More attention to personal circumstances, particularly issues for couples
- Need for more career counselling
- Encourage opportunities for research/time out/deferment
- Better feedback required to unsuccessful candidates
- All offers should go out on one day, then subsequent rounds to fill unaccepted posts
- Clarification required on role of exams
- Better training for selectors
- One suggestion that application forms be completed under exam conditions, to prevent others doing it for them.

Comments

- In all workshops the consensus was that the 'cons' outweighed the 'pros'.
- Some suspicion about political agendas having driven change
- Concerns about how FTSTA can/does fit in. Does FTSTA get looked on unfavourably? It should be made an alternative option for trying out specialty (and suggestion that name should change)
- Discrimination against overseas graduates? Immigration status and correlation with various job applications should be made clearer
- Strength of feeling (in Scotland) that the situation is worse in Scotland than in England (no safety net of round 2 interviews etc)

Question 2 How far do you believe FY2 has: a) built on FY1, b) given you the opportunity to sample the specialty you are interested in; c) been a valuable clinical experience; d) delayed involvement in a specialty area in which the doctor is interested?

a) built on FY1

- Experience was very variable, broadly split between those who had enjoyed coherent rotations that were relevant to their future career intentions to those that felt no connection with the specialty they had been allocated.
- FY2 rotations too random to provide minimum valuable experience
- Trainers less interested in those who don't plan to pursue that specialty
- Opportunities for broad breadth experience (for some)
- Foundation trainees can drift through the programme unless trainees and trainers are on the ball
- More responsibility for some, though highly placement-dependent. Some report no increase in responsibility between FY1 and FY2.
- No clarity about what FY2 year is – sometimes treated as House Officer and sometimes as, say, surgical SHO despite not having relevant FY2 experience; FI + FY2 seen by some as equivalent to old PRHO year.
- Less respect as an FY2 than as a SHO.
- Some feeling that this has doubled the house officer year
- Depends on specialty and trainee's personal attitudes
- Variable across Trusts, and different in big and small hospitals
- Introduction of specialist nurses deskilling FY1/FY2

b) given you the opportunity to sample the specialty you are interested in

- Lack of appropriate mix for career plans
- Limited sample days
- Not enough chance to decide
- Had to specialise too early, with adverse effects on chosen specialty
- Rotations changed with no consultation to accepted applicants
- Very limited chance to experience specialties of interest
- Assessments pointless as you can choose who fills the form in for you
- Minority felt that they had seen specialties they would not otherwise have seen.
- Limited by having to apply for specialty training after 1 rotation or mid-second rotation; for many the experience of the specialty they elected to try for at ST1 came after they had to make their choice.

c) been a valuable clinical experience

- More structured training
- Just service provision
- Filling gaps
- Loss of autonomy
- A general sense that a four month slot was too short (especially for some specialties e.g. public health).
- May not get specialties you are interested in – not necessarily themed appropriately

- Experience may be in sub-specialties, rather than generic
- Variable – some seen as supernumerary student learners, not expected to undertake on-call, for example.
- Too much emphasis on soft skills (assuming that clinical ability is up to scratch)
- General practice experience would be a benefit
- What is the point of DOPS?
- For many they felt relatively redundant in the team, not having the experience to contribute (as an SHO on a rotation may have had).
- EWTD limits opportunities for acquiring clinical skills
- Little opportunity to build on competencies as have to move after 3-4 months
- Lack of study leave is a problem (limited funding, and not even time to do self-funded study)
- Given less responsibility than former SHOs so more falls on senior team members

d) delayed involvement in a specialty area in which the doctor is interested?

- Delayed involvement through foundation programme is necessary due to EWTD and time needed to acquire generic competencies.
- This does happen, but breadth of experience is not a waste
- Delays may occur through lack of opportunity to work in specialty
- No. Felt pushed too quickly to decide on a specialty

Question 3 The health service does not envisage every medical graduate operating at the level of consultant, or principal in General Practice. How could the status and attractiveness of 'non-training' grades be improved? What should be the principles that underpin such other roles?

- There should be a real choice
- Staff grade may be a lifestyle choice e.g. flexible 9-5 job/ Could be 'sold' as more flexible
- Clear communication required about what the grade entails
- Major need to destigmatise and clarify the scope of the role(s)
- Need more respect and involvement in management decisions regarding service provision; to work with consultants and not for them.
- Medical students should be educated about alternative medical career paths
- Nomenclature needs to change (e.g. to hospital specialist)
- Apply learning from general practice: salaried GPs vs. partners
- No doctor should be in a 'non-training grade' – all should have access to educational opportunities/study leave
- Concern about two tiers of doctors
- Suspicion that there is an 'agenda' to create a sub-consultant grade
- Public perception of non-consultants is an issue
- Staff grades need greater say in running of service and service provision
- Re-entry routes should exist
- Years in non-training grade should be acknowledged if moving into a training post
- Staff grades should have an assessment of their competencies
- Limited autonomy for experienced doctors in this role should be available
- Teaching, research as well as service contributions should be encouraged
- The role offers a useful one for consolidating experience for those temporarily stepping off the specialist training ladder
- There is discrepancy between specialties e.g. surgical specialties use staff grades to keep waiting lists down, with little educational input
- The advantage of working for a consistent team over a prolonged period of time should be more widely acknowledged
- Need terms and conditions and employment rights, including better pay and study leave, and pay to reflect experience, beyond annual increments; pay should reflect contribution to out of hours work and anti-social hours
- Contract negotiations must be finalised urgently with training and professional development addressed.
- Retain representation within Royal Colleges/BMA/GMC etc.
- Article 14 should be made easier
- Length of contract often short so need repetitive job applications
- There should be no such term as a non-training doctor

Comment

Although fearful that such careers could easily represent a cul-de-sac, many trainees were positive about the role if the above concerns could be addressed.

Question 4 More medical graduates want to undertake higher specialist training, particularly in some specialties, than service requires. What should be the principles guiding selection into specialist training recognising this reality?

- Workforce planning is understood to be important and legitimate
- Trainees accepted the need for competitive selection
- Suggested that medical student numbers should be limited; medicine is a vocational degree and should lead to a job especially as the NHS is a monopoly employer for trainees
- Trainees resented the use of methods that had no professional face validity.
- They were broadly in favour of uncoupling with selective entry at ST3

- They supported tests of knowledge and aptitude for the specialty, structured CVs and interviews as well as references; also possible use of psychometric tests (though these can be 'skewed')
- Academic qualifications seen as very important
- Recognition of non academic qualities (e.g. teamwork) also seen as important
- Need to show evidence of commitment e.g. log book, audit, patient feedback, references.
- More weight to be given to references
- Need better/more through interview process to differentiate between candidates
- Need better system for feedback about performance at various stages of application/ assessment
- They regarded MTAS as dehumanising in the following respects:
  - an electronic portal
  - poor communication
  - a system which meant they could be destined to a job separated from their partner, somewhere in a very wide geographical area
  - anonymised with no reference information utilised
- Different application procedures may be required for different posts/specialities
- They acknowledged that not everyone could pursue the career of their choice and saw as essential better competition ratio information and more information about specialties and the skills they require from medical school onwards
- More career guidance needed

Comment

This question was addressed at different levels. Some looked at broad issues (e.g. selection in relation to workforce planning) while a far greater number commented on the minutiae of the actual applications process.

Other issues

- Appreciation and approval of keeping junior doctors involved in the review process
- Some worries about whether Tooke Inquiry will be listened to.
- Real resentment regarding the perceived inadequacy of current workforce planning and suspicions that the Government planned to over produce doctors to drive down costs.
- A sense that doctors were being systematically deprofessionalised and trainees infantilised
- A sense that this was not the career they signed up for – they aspired to excellence, not mediocrity.
- Concern about the role and power of PMETB

APPENDIX 3

ORAL AND WRITTEN EVIDENCE

The Panel initiated its Inquiry by undertaking a forensic analysis of over 800 documents provided by the Department of Health and by the MMC teams. They included the Minutes of the DH and NHS Management Boards, of the UK Strategy Group, the Workforce Programme Board, the MMC Programme Delivery Board, the MMC Advisory Board, of the Medical Recruitment Board, the Recruitment and Selection Steering Group, of COPMeD and of JACSTAG and of relevant Policy documents from 1988.

The Panel then invited all the main representative organisations with an interest in MMC to provide written evidence to the Inquiry. It received 116 submissions from: the CMOs, from the Medical Royal Colleges and Faculties, from many of the Specialist Societies, from the BMA, from the Academy of Medical Sciences, from PMETB, from the SHAs, from the Deaneries, from NHS Employers, and from many Trusts. The Panel is grateful for the cooperation received. In weighting the evidence provided, the decision was taken to give more weight to the views solicited from representative organisations than to the unsolicited evidence which was received. There were 226 unsolicited submissions.

Sir John has spoken to all 4 CMOs and to David Nicholson, Chief Executive of the NHS. In addition the Inquiry has taken oral evidence from the following 75 people.

Departments of Health

Clare Chapman
Andrew Foster
Nic Greenfield
Debbie Mellor
Ian Mallett

Workforce Review Team

Andy Knapton

MMC England

Professor Alan Crockard
Professor Steve Field
Professor Derek Gallen
Professor Shelley Heard
John Higton
Dominic Hurndall
Keith Smith

Specialty Application team

Professor Fiona Patterson of WPP
Professor Sarah Thomas

PMETB

Professor Peter Rubin
Paul Streets
Patricia le Rolland
Lesley Hawksworth

GMC

Professor Sir Graeme Catto
Finlay Scott

Remedy UK

Dr Matthew Jameson Evans
Dr Judy King
Louise Bayne
Dr Tim Nedas
Dr Chris McCullogh

Deaneries

Professor Lis Paice
Professor David Sowden

BMA

Dr Hamish Meldrum
Dr Jonathan Fielden
Dr Jo Hillborne
Dr Mohib Khan
Professor Michael Rees
Mr Jim Johnson

Wellcome Trust

Professor Mark Walport
Dr Yaho Namazaki

NHS Confederation

Dame Gill Morgan

NHS Employers

Steve Barnett
Barbara Levy

SHAs

Neil McKay

Medical Professional Bodies

Professor Dame Carol Black, AoMRC
Dr Ian Gilmour, RCP
Dr Patrick Cadigan, RCP
Bernard Ribeiro, RCS E
Professor Neil Douglas, RCP E
Dame Janet Husband, Dr David Lindsell, Dr David Spooner, RC Radiology,
Brenda Billington, RC Ophthamology,
Jim Wardrope, Ed Glucksman, Faculty of Emergency Medicine,
Professor Adrian Newland, RC Pathologists,
Dr Judith Hulf and Dr Griselda Cooper, RC Anaesthetists,
Brian Rowlands, John MacFie, Ewen Harrison, Nick Gair, Association of Surgeons of GB and Ireland

Dr Patricia Hamilton, Dr Mary McGraw RC Paediatrics and Child Health
Dr David Snashall, Faculty of Occupational Medicine
Dr Mayur Lakhani, RCGP
Professor Sir Roy Pounder, RCP
Professor Alan Templeton, Dr Maggie Blott, RC Obstetrics and Gynaecology
Dr Sheila Hollins, Dr Nick Brown, RC Psychiatrists

Fidelio

Professor Morris Brown
Dr Nicholas Boon
Professor Rod Hay,
Professor Stephen O'Rahilly FRS,
Professor Mark Pepys FRS,
Professor Sir Nicholas Wright

Medical Workforce Standing Advisory Committee

Professor Sir Colin Campbell
Professor Sir Keith Peters

APPENDIX 4

SELECTION AND ASSESSMENT PROCEDURES USED IN SELECTION FOR SPECIALIST TRAINING

REPORT OF AN EXPERT ADVISORY PANEL FOR THE TOOKE INQUIRY

JULY 2007

PANEL MEMBERS:

John Bligh (Chair)
Kevin Eva
Robert Galbraith
Charlotte Ringsted
Cees van der Vleuten
Julie Brice (Secretariat)

CONTENTS

1 EXECUTIVE SUMMARY

This is the report of an Expert Assessment Panel to the Tooke Inquiry into selection and assessment procedures used in selection for specialist training in the UK.

It considers selection for specialist training in three parts:

- Undergraduate education, and how it feeds into the later years of medical training;
- The Foundation programme in terms both of its curriculum and the assessment methods employed during the Foundation years;
- Selection for specialist training, looking particularly at the three 'yes/no' stages involved in this process – longlisting, shortlisting and assessment centres.

While recognising much that is consistent with good practice and acknowledging the considerable energy and commitment invested by the various stakeholders, it makes specific recommendations for improvement at each stage. These recommendations are informed by evidence presented to the panel from a variety of sources and based, where possible, on current international research literature drawn both from medical education and from other disciplines.

2 SUMMARY OF RECOMMENDATIONS FOR IMPROVEMENT

At undergraduate level

- Introduce a national test of knowledge.
- Encourage a climate, supported by organisational changes, in which medical schools and the NHS can work together more efficiently to organise the best possible conditions so that doctors in training can make the transition to independent practice.

During the Foundation Years

- Raise the profile of medical education both as a discipline and as a legitimate field of study to encourage clinicians to feel more engaged. This may include provision of basic minimum training in education techniques for all doctors and more specific advanced skills training for some.
- Allow more time and resources for training of supervisors and assessors.
- Assessors in particular should be trained and rated. Consider using specialist assessors.
- Broaden the range of assessment tools and reinforce the existing assessment approaches in line with the most up-to-date research.
- Make rotations in pre-specialty general training longer.
- Allow students more choice for career sampling.
- Do not time-limit training: there should be opportunities to repeat years without stigma.
- Raise the status of the NCCG (non-consultant career grade) doctor by improving terms of service and in particular by offering opportunities for training and personal development.

MTAS

Drop the white space boxes on the application form and ask only for verifiable information OR allow personal statements, but do not use them for shortlisting.

- Allow CV submission or require information on particular aspects of portfolio.
- Explore other sorts of computer markable tests of aptitude/ knowledge, such as computer adaptive testing.

Shortlisting

Introduce regular, longitudinal and summative assessment earlier and use the results of these tests as part of the shortlisting process. Exam results are still the best predictor of overall performance.

- More biographical information should be given to local shortlisters.
- Make blueprinting clearer for generic vs specialty-specific competencies.
- Provide a better transition from the national to the local, combined with better training and feedback opportunities for shortlisters so that they are more engaged.

Assessment Centres

- Make the selection process more humane and less stressful by enabling applicants to 'present their story'. However, information obtained by more subjective, informal means should not be allowed to outweigh more objective measures.
- Improve the feedback given to candidates following the assessment centre process.
- Look again at the minimum standards for selection (currently 3 x 10-minute interviews).
- Make the scores transferable between deaneries.
- Offer better training for assessors.
- Facilitate earlier experience with summative assessment and use the results of these tests as part of the final selection process.
- Rank nationally.

3 INTRODUCTION

3.1 What the panel was asked to do

Following the crisis in the Modernising Medical Careers (MMC) process towards the end of 2006 and during 2007, Professor Sir John Tooke was asked by the Secretary of State for Health to conduct a review of the selection and training of junior doctors into specialist posts.

He, in turn, asked Professor John Bligh, Professor of Clinical Education and Vice Dean at the Peninsula Medical School, to form an Expert Assessment Panel (EAP) to provide 'a succinct evidence-based synthesis of the issues to inform the main panel'.

The issues Professor Tooke requested the EAP to look at are, specifically:

- the selection and recruitment methods used and whether these follow recognised best practice;
- 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.

3.2 The panel

Panel members were invited as international experts in selection and assessment, not as experts in the UK system. All panel members were selected for their wide ranging understanding of the research literature and current theory surrounding selection and training in medical education. In addition, they have detailed world-leading expertise in the three particular areas of workplace assessment, selection and recruitment and curriculum and training. No-one involved in the research and writing of this report had any competing interests. (Please see Appendix 2 for CVs.)

3.3 Methods and limitations

There is a significant amount of published literature on selection, recruitment and assessment in medical training, including information from academic journals, government and other websites, books and policy documents. An archive of literature was established and placed in a secure shared file space, and a select bibliography is attached (Appendix 4).

Information on how the selection process performed in practice is still coming in; we are grateful to those people who were willing to share with us their personal experiences, and were hugely impressed by their hard work, expertise and commitment to the process. Our particular thanks go to those people who agreed to be interviewed and who supplied informal draft reports, case studies and other, as yet unpublished, information.

The panel spent a considerable amount of time synthesising and discussing the information and formulating recommendations both by email, telephone and in a two-day face-to-face meeting.

The panel recognised that there were organisational, resource and logistic shortcomings with the recruitment process in 2006/7 (difficulties with the MTAS computerised system, problems with administration etc) but was not charged with considering these and did not consider them in any detail. It confined its considerations to the curriculum and its assessment in the Foundation Programme, implications for selection for Specialist Training, and the methods of selection.

4 UNDERGRADUATE EDUCATION: THE BASICS

4.1 Background and current situation

The panic and distress caused to junior doctors during the recent recruitment crisis has roots that go right back to medical school, so it is important to consider the changing culture of undergraduate education in the UK as it feeds into the Foundation Years and beyond. There have been seismic shifts in the medical school curriculum in recent years, driven by various policy documents and initiatives (cf. Tomorrow's Doctors, The New Doctor etc). At the same time academic medical education has developed, adopted and evaluated innovations such as problem-based learning and new types of assessment and new, more integrated and student-centred curricula; and it has embraced interprofessional learning opportunities. Learner-centred education is more inclined to take account of the fact that students mature and develop at different rates; many medical students are already graduates before entering medical school. Finally there have been technological advances in terms of learning materials (web based platforms, managed electronic learning environments, simulation technologies etc). As a result of research in the field of medical education, there is a strong and developing emphasis on self-directed learning, with a new focus on the patient and the student as legitimate focuses for learning.

Modern medical students and recent graduates in the UK, as a result of these developments, are considerably more inclined to question, to seek feedback, to be better communicators and to expect a more collaborative and integrated approach to learning and medical practice than their predecessors of even 20 years ago. At the same time there is a strong shift towards making the transition from medical school to Foundation as smooth as possible. An increasing proportion of modern medical graduates understand the basic concept of competence based assessment and will be familiar with the types of formative assessment employed in Foundation – portfolio, mini-CEX, peer assessment etc. These cultural trends towards emphasising autonomous, deep approaches to learning and a more team-based, constructive learning style are evident to some degree in all UK medical schools.

Despite these advances, difficulty still arises when individuals are suddenly expected to make a transition in culture and self-actualisation as they move from medical school to the Foundation Years. Students become employees; simulation and classroom learning become actual practice; tutors are replaced by managers and bosses; NHS replaces University; constructive feedback becomes summary judgement; peer support and group learning becomes competition for posts; senior students become junior doctors.

To help us to understand and address these problems, we need answers to some fundamental questions. How does an individual student from one institution compare with another from a different institution? Where should that student be ranked nationally? Are there any predictors for later careers choices and are these evident in undergraduate training? Which medical schools' students are best prepared for the Foundation Years and, crucially, what makes the difference?

4.2 Recommendations for improvement

- A national examination would provide the information that is currently lacking and at the same time encourage development within medical schools, serve as a safeguard when medical schools are developing new curricula, and ensure core knowledge and skills are taught and assessed. National exams are used in other countries. For example, medical students in the US are required to pass three Steps of a four Step national licensing exam prior to entry into residency (specialist training). The majority of medical schools also require passage of these same exams, in effect an independent audit, prior to graduation. A similar strategy exists in Canada where students are expected to sit Part 1 of a two-part licensing exam at graduation from medical school. One can move into residency six weeks later, regardless of outcome, but must eventually pass before progressing through that training level.
- In addition, we need to ask how medical schools and the NHS can work together more efficiently to organise the best possible conditions so that doctors in training can make the transition to independent practice. This would logically include continuing the work of making the transition from medical school to hospital less abrupt, and adding mechanisms and incentives to encourage Deaneries and Universities to work more closely together. Universities are responsible for F1, but this now needs to be operationalised more effectively.

5 FOUNDATION PROGRAMME: CURRICULUM AND ASSESSMENT

5.1 The training curriculum and its delivery

Those who are dissatisfied with the system as it has been implemented sometimes exhibit a tendency to look back nostalgically on pre-MMC PRHO/SHO training. It is important to remember the educational impetus for the process of reform, which commenced with the 1993 Calman Report (Hospital Doctors: Training for the Future) and has continued up to and including MMC. In 2002, Sir Liam Donaldson's report Unfinished Business criticised the system as it then existed as offering:

- poor job structure: half of all SHO appointments were short-term and did not form part of any training rotation or programme;
- poorly planned training: there was no defined end-point to SHO training. Time spent in the grade varied and was often independent of training requirements;
- weak selection and appointment procedures: these were not standardised and were frequently not informed by core competencies;
- increasing workload;
- inadequate supervision, assessment, appraisal and career advice;
- insufficient opportunities for flexible training;
- unsatisfactory arrangements for meeting the training needs of
- non-UK graduates;
- the relationship between Royal College examinations and their relevance to training programmes varied greatly.

- The type of opportunistic learning on which the old system was based will always be uneven, undirected and ultimately involve students and junior doctors in waiting around for something to happen. The long hours involved in training were expected to compensate for the lack of educational focus, but frequently did not do so. It was not surprising that the term 'Lost Tribe' was coined to describe the plight of junior doctors in training during the early 1990s.

MMC represents a concerted effort to improve the educational experience for junior doctors. Education in the Foundation Years is based in the workplace and time limited to two years. The structure of individual programmes varies, but at least five or six different attachments are offered. In the first year attachments must include three months in medicine and three months in surgery and in the second, at least one attachment must offer experience in acute care. All students are expected to maintain a portfolio, which includes a copy of the full list of the competences for the Foundation Programme. Assessment is done by educational supervisors in the workplace. Assessment tools may include multi-source feedback (mini-PAT, TAB or other tools for 360-degree assessment), direct observation of clinical encounters (mini-CEX, DOPS) and case-based discussion.

The EAP was united in agreeing that the philosophy and learning principles laid down in the Foundation Curriculum represent an increased emphasis on self-directed learning as opposed to the more traditional focus on passive administration of training. This shift is appropriate, timely, and exemplary and effectively addresses many of the previous difficulties. The high level vision is exciting and something of which the framers can be justifiably proud.

5.2 Assessment

A lack of clarity persists as to whether assessment in the Foundation Years in its current form is fully supportive of the clear vision articulated for training. For example, are we actually testing what we need to test, and are we asking the right questions? Are we getting the right data – accurate and appropriate to purpose – and are our analyses adequate? And when we have the right data, are we using it in the right way?

The locus of accountability is also unclear. When is it aimed at supporting self-improvement and remediation (lower stakes), and when is it regulatory and summative (high stakes)? Similarly, is testing purely for assessment of the individual, or is the evaluation of training programmes also a salient purpose? Are the assessment processes able to differentiate between excellent and satisfactory performance?

The tools recommended for use in the Foundation Years are all recognised formative instruments capable of providing adequate reliability and validity. Their particular strength is in the rich variety of feedback they offer and their validity in terms of offering information about actual performance in practice. Their use does, however, pose some problems.

Firstly, we have received evidence that in a significant minority of cases, educational supervisors are not taking them seriously enough (just going through the motions and ticking every box as excellent) or using them ineffectively (by, for example, filling out a DOP form weeks after the procedure was performed).

Secondly, trainees are routinely marked as above average: this is a common phenomenon within formative feedback, and an inevitable consequence of making supervisors into observers/assessors with little or no experience or formal training. There is some evidence that educational supervisors who have concerns are using informal routes, such as private conversations, to alert programme directors that a junior doctor is having problems; but programme directors are then faced with difficulties where the paper records do not formally reflect these concerns. Preventing a struggling doctor from progressing is impossible unless the grounds for doing so are clearly established.

Thirdly, despite the emphasis on self-directed learning, the reality is that the programme is only two years long. Time based programmes are frequently at odds with competency-based assessment and especially with a learner-driven assessment process. It is contradictory to say that the learner should be allowed to learn at his or her own pace if, in fact, certain competencies must be achieved within a certain deadline (for example, the end of the rotation).

5.2.1 The assessment methods

These tend to be mainly:

- Portfolio: There is a lack of clarity about how the portfolio is to be used and how it can be assessed. Formative assessment tools such as portfolios can generate a large amount of qualitative data. Presentation and content are less important than function. Please see box 1 for a list of the characteristics of a good portfolio. To make the portfolio as effective as possible, it should support and encourage the F1 and 2 trainee to:
  - Collect data, so that information can be collected not just about what he or she does but also about how he or she is doing;
  - Reflect on his or her performance;
  - Select and report key elements.

- **Multi-source feedback**
  - This should be as comprehensive as possible.
  - The focus should be on down-stream reactions.
- **Direct observation of clinical encounters:** In this method, making use of multiple samples is crucial to the validity of the assessment. This is also true for:
- **Case-based discussion**

Framing education and assessment in terms of specific competences (competencies in the US) has led to major progress in envisioning and implementing a broadening of the base of assessment, and, in particular, a new emphasis on performance in context. However, this approach is essentially deconstructionist. Using a blueprinting process to identify the desired learning outcome measures and breaking them down into a set of measurable competences is consistent with good practice, but if

There is a lack of breadth of assessment in the Foundation programmes which makes it difficult to build up a holistic picture. The information that students have achieved a set of basic competences is too basic to allow a broad picture to be built up if one hopes to be able to use the assessments to assist in selection decisions. Broad based assessment should assess knowledge, skills and behaviour (previously attitudes) both in simulated settings (e.g. competence) and in real settings or context (e.g. performance). In the Foundation Years, there is a particular lack of assessment at the cognitive level.

In addition, for maximum reliability in assessment, there should be a longitudinal focus (moving picture) as well as point-in-time measures (snap shot). This longitudinal focus should be commenced during the undergraduate years and continue right into actual practice and beyond. Currently, the competence-based assessment in the F1 and 2 years provides a snapshot of performance during each rotation, but past performance (longitudinal information) and rate of progress are unlikely to receive much attention unless a doctor is clearly struggling.

Box 1: Characteristics of a good portfolio

Portfolios must have learning value and help in directing study and make a genuine contribution to doctor's progress

Content is less important than function – so 'lean and mean' would be useful as a way of thinking about them

Social interaction with, for example, peers, mentors or coaches is essential to make portfolios work because they ineffective if for individual's use only

Using portfolios as part of an assessment system will prolong their life and meaningfulness

Portfolios can be seen as part of progress testing and can be used to demonstrate development

If they are used then they should be used as part of any subsequent selection method

A formal 'moment' of assessment may be necessary

Reflection is crucial but it must be based on verifiable evidence

5.2.2 Overall focus of assessment

The question we need to ask of the assessment framework in F1 and 2 is: "Will this process provide enough evidence to enable us to decide if this person has the necessary skills, knowledge and behaviours to practise independently as a clinician?" Additionally we may wish to add to that question a supplementary one: "Based on the evidence that this process supplies, are we able to decide if this person has the necessary aptitude to train as a specialist, and if so, in which specialty?"

selection is to be included at the end of the course, there needs to be some way of (a) aggregating scores to form a more holistic picture so that students can be ranked, and (b) identifying and acknowledging excellence.

For the best possible assessment of competence, assessment needs to be both externally directed and self-directed. Externally directed assessment involves high stakes, summative tools, adaptable for the dual purpose of engaging students in active learning and for programme evaluation. Self-directed assessment is more low stakes, and should be practice-specific and linked to the education process to encourage reflection and engagement. It may involve mentorship.

5.3 Career and personal development: Learning? Working? Or both?

Three or four month rotations do not allow trainee doctors to feel as if they are useful team members. Because they move through the system so rapidly, trainees are less motivated to make the necessary psychological investment into the team and the specialty within which they are based. At the same time senior team members know that the trainee will not be around long enough to create lasting relationships and develop real expertise, thereby becoming a worthwhile member of the team. The new consultants' contract has recognised the role of senior doctors as educational supervisors; the downside of the new contract

is that many academic activities which used to be undertaken voluntarily, such as developing skills in medical education, have been squeezed out by more pressing service demands. Busy educational supervisors consider it fruitless to invest much time or effort in training staff who will be moving on in a matter of weeks, and over whose eventual recruitment to a full training appointment they may have little or no influence.

This perpetuates, in trainees and supervisors alike, the perception that F1 and 2 trainees are not 'real doctors'. They remain both practically and attitudinally students, rather than real contributors to the workforce.

Students who are interested in a particular career may not get an opportunity to experience it as a rotation during the two Foundation Years. Rather than altering the selection process to discount experience, which has the effect of failing to reward commitment and previously demonstrated aptitude, the training system itself needs to be adjusted to allow students more flexibility in their choice of rotations.

Since the introduction of the Non-Consultant Career Grade (NCCG) Doctor post in 1987, there has been widespread concern, particularly among some of the Royal Colleges, that NCCGs are overlooked. NCCGs are often appointed by trusts to fill gaps in services when doctors in training are not available. They are viewed as 'dead-end' appointments, and are frequently filled by doctors from overseas who have come to the UK for training but have failed to find training posts or have been unsuccessful in passing examinations. They are also the destination for some women (and increasing numbers of men) who need to balance working with domestic responsibilities. NCCG posts are a necessary and important part of the NHS workforce, performing a valuable service largely unrecognised and unrewarded. While efforts have been made to improve terms of service for these doctors, career grade posts will always be unattractive. Until conditions for NCCGs are improved, doctors who feel forced by circumstances into accepting an NCCG post (for reasons that may include a lack of specialist training places or failure to make the required progress within the specified timescale) will inevitably feel as if they have failed in their careers.

5.4 Recommendations for improvement

- Raise the profile of medical education both as a discipline and as a legitimate field of study to encourage clinicians to feel more engaged. This may include provision of basic minimum training in education techniques for all doctors and more specific advanced skills training for some.
- Allow more time and resources for training of supervisors and assessors.
- Assessors in particular should be trained and rated. Consider using specialist assessors.
- Broaden the range of assessment tools and reinforce the existing assessment approaches in line with the most up-to-date research.
- Make rotations longer.
- Allow students more choice for career sampling.
- Do not time-limit training: there should be opportunities to repeat years without stigma.
- Raise the status of the NCCG (non-consultant career grade) doctor by improving terms of service and in particular by offering opportunities for training and personal development.

6 SELECTION FOR SPECIALIST TRAINING

6.1 Background and current situation

The method used for shortlisting and selection in 2006/7 was adapted from one developed and piloted by Work Psychology Partnership in consultation with a small group of deaneries and Royal Colleges. General Practice used a very similar method, including the use of MTAS, but it was introduced more slowly, it took five years to develop, involved fewer numbers, and by comparison was more expensive and complex.

The selection method for all specialty training was introduced in a fairly short time frame. Each candidate could fill out up to four applications. Highest scoring candidates were shortlisted. This meant that some people were offered four interviews, but others got none. It appears that the numbers of candidates selected for interview were generally determined by the amount of time available to interview them.

It is plain from information presented to the House of Commons and reported in Hansard that there were not enough posts to go round and many applicants were disappointed. There is considerable public controversy around the question of whether the best and most suitable applicants were eventually selected, but those to whom we spoke and from whom we received evidence reported that they thought subjectively that the system had been no worse than previously. Most reported that the assessment centre part at least had been perceived as much fairer and more reliable. Objective evidence is still being gathered.

6.2 Application, longlisting and shortlisting

All applicants for specialist training posts were required to fill out an electronic MTAS application form. The applicants were required to prove their eligibility to apply by demonstrating that they met entry criteria (competencies, experience, eligibility to work in UK etc). These entry criteria were not ranked. Longlisting was carried out by deanery staff.

Once longlisting had been carried out, the information on career experience was set aside, so that those doing the shortlisting did not see it. This was to avoid the situation where those who had been lucky enough to get an F1 or 2 rotation in their preferred specialty would not be unfairly advantaged over those who had not. Shortlisting looked at the other areas of the form: clinical skills; academic/ research skills; personal skills and probity; commitment to specialty. For selection purposes, these were blueprinted and ranked against person specifications for each specialty previously drawn up in consultation with the Royal Colleges in accordance with general advice from the GMC.

To demonstrate these areas, the candidate had to fill out a series of 'white boxes' containing general questions such as: 'Why are you motivated to pursue a career in this specialty?' and: 'What experience of delivering teaching do you have?' Some applicants received advice and training on how to do this; others did not. Applicants did not have access to the Reference Framework for Shortlisting so they were unaware of exactly how their personal statements in the white boxes were graded. Some people may have been creative at this stage (ranging from getting advice and asking others to assist in writing sections, to plagiarising or even buying answers), but it isn't known how many.

For shortlisting, the forms were scored by a group of consultants in the specialty against a Shortlisting Scoring Indicator. Between two and six people usually did this, and there may have been some variation introduced by the disparity in numbers. The candidates were given access to the Shortlisting Scoring Indicator.

6.3 Assessment centres

It appears that the title caused some confusion among candidates. The assessment centre is not a place, it is a process of interview and selection. There was a national standard by which each shortlisted candidate would receive a minimum thirty minute interview broken down into three ten-minute sections. But assessment centres varied widely between locations and specialties, and there was not enough national training for assessors. This meant that it was up to the regional specialty teams to make up their own minds about how to select under the guidance of experts from local Deaneries, thereby making the use of a uniform term such as 'assessment centre' somewhat misleading. Selection methods used may have included portfolio assessment, multi-station interviews, written tests, clinical skills tests, presentations etc. (See case studies at Appendix 1.)

6.4 Evidence and issues

6.4.1 MTAS

A national electronic application process is a good idea. Candidates who have applied to UK Universities through UCAS will already be familiar with the principle. It works successfully in other countries (e.g. Canada and the US). We find no problem with allowing non-clinicians to sift out ineligible applicants. However, apart from the technological issues which are already well documented, there were three important issues with MTAS.

First, a distributed online application system which requires unverifiable free text statements cannot be made secure against cheating and plagiarism.

Second, candidates were not informed about how the free text statements were rated against the Reference Framework for Short Listers which meant that they were writing their statements in ignorance about how they would be scored. This led to resentment and insecurity, and may have been a factor in stimulating some people to cheat.

Third, important biographical information (for example, when, where and in what timescale qualifications were achieved) was not conveyed to shortlisters, who were then concerned that good candidates had been overlooked. Some selectors wanted, for example, to be able to weight in favour of UK educated candidates, to select those whose native language was English, to select those who had already clearly demonstrated a preference for certain types of practice (for example, rural medicine). They felt that a nationally-implemented system needed to be better harmonised with local needs.

6.4.2 Shortlisting

The principle of sifting applications using agreed profiles is consistent with good practice. More work needs to be done on the distinction between generic skills and specialty-specific skills to enable qualities such as aptitude and potential to be assessed.

The chief problem with the shortlisting process is that it is summative, whereas candidates' prior experience through two Foundation Years is formative, with no real sense of competition with their colleagues and no high stakes assessments at all. The need to select and rank candidates, therefore, puts pressure on the exclusively formative assessments underpinning the Foundation Years, for which the reliability and validity are not yet well established in this context.

It is at shortlisting that the system moves from national, to regional and local. It is clear to us that this progression was not seamless, and assessors in particular appear to have felt some sense of frustration where the breadth of information they wanted was not supplied to them by the national system.

6.4.3 The Assessment Centre

The notion of the assessment centre, making use of nationally agreed profiles to assess candidates in a series of independently-rated stations with a variety of assessors is consistent with good practice. We discovered many examples of innovative design and planning, together with careful and considered implementation and detailed monitoring. We consider the anaesthetics case study, described in Appendix 2 below, to be one such example of local excellence. On the other hand, there were widely varying standards between specialties and locations, despite the minimum requirement for three ten-minute interviews.

We would also like to make mention of the work done by the National Office for GP Recruitment, which is a clear example of where investment, planning, research and careful piloting over several years has led to a system that its designers believe has produced most of the outcomes for which it was intended but, most importantly of all, has been perceived by most participants and stakeholders to be fair and equitable and therefore has achieved significant 'buy-in' nationally.

On the other hand, there is some evidence that not all assessors were fully trained, meaning that they may have lacked confidence in the system. In addition, people wanted a more personal process and some missed the old-fashioned interview. This is natural; many candidates wanted the opportunity to explain why they felt called to undertake training in a particular specialty and to talk about their enthusiasm and motivation. They found the new system impersonal and felt cheated when they were denied this opportunity. In addition, selectors wanted to be able to give consideration to how candidates would fit in with their teams. However, it is one thing to allow people to explain their motivation and enthusiasm and quite another to select people on the basis of who is able to tell the most plausible story; and most of the people to whom we spoke were well aware of this distinction.

6.5 Recommendations for improvement

6.5.1 MTAS

- Drop the white space boxes on the application form and ask only for verifiable information OR allow personal statements, but don't use them for shortlisting.
- Allow CV submission or require information on particular aspects of portfolio.
- Explore other sorts of computer markable tests of aptitude/knowledge, such as computer adaptive testing.

6.5.2 Shortlisting

- Introduce regular, longitudinal and summative assessment earlier and use the results of these tests as part of the shortlisting process. Exam results are still the best predictor of overall performance.
- More biographical information should be given to local shortlisters.
- Make blueprinting clearer for generic vs specialty-specific competencies.
- Provide a better transition from the national to the local, combined with better training and feedback opportunities for shortlisters so that they are more engaged.

6.5.3 Assessment Centres

- Make the selection process more humane and less stressful by enabling applicants to 'present their story'. However, information obtained by more subjective, informal means should not be allowed to outweigh more objective measures.
- Improve the feedback given to candidates following the assessment centre process.
- Look again at the minimum standards for selection (currently three ten-minute interviews). The more thorough the assessments, the more candidates appeared satisfied that the outcomes were fair.
- Make the scores transferable between deaneries.
- Better training for assessors.
- Facilitate earlier experience with summative assessment and use the results of these tests as part of the final selection process.
- Rank nationally. This should help to overcome some of the concerns that the best candidates missed opportunities because they were interviewed only at the most popular UoAs or in specialties where competition was fiercest.

7 FINAL DISCUSSION AND CONCLUSIONS

British clinical medicine has a reputation second to none for providing the highest quality in practice. This reputation has not been lightly gained. It has been hard won, involving over 150 years of teaching excellence and the rigorous application of intellectual analysis to the unique functions of a medical clinician. The high standing in which medicine in the UK is held is a tribute to the effectiveness of the partnership between the Universities and the NHS in providing first class clinical care and clinical training.

Recent changes to the educational programmes of medical schools promise to produce a new generation of doctors, more highly skilled at graduation and more capable of outstanding technical performance in the workplace than ever before. Plans to introduce educational processes and structures into the early years of training have been developed to enhance still further the quality of these young doctors. However, the implementation of this educational programme, its assessment and its evaluation has been less than optimal.

Confusion about the use of assessment - as a developmental tool on the one hand, and as an instrument for selection for specialist training on the other -have led to its implementation being accompanied by operational and logistical problems. Errors in the determination of workforce numbers have compounded the effects. Our review of the selection and admission process and of the educational principles that apply to the development of doctors has revealed a number of areas for further development.

First, it is clear that the best doctors are able to combine a high level of knowledge with excellent clinical reasoning processes. It is more important than ever before that doctors are able to use up to date and science based knowledge in their thinking as they make differential diagnoses and management plans, and that they have good communication and performance based skills. These last two are secondary to a sound and effectively-used knowledge base. Therefore we strongly recommend the introduction of knowledge testing in the period from the end of undergraduate medical education through to the introduction of specialist training.

Secondly, we recognise that external pressures to shorten the period of training of junior doctors are important, but we recommend the abolition of Foundation Year 2 (FY2) and the introduction of a three-year period of General Professional Training (GPT) to follow Foundation Year 1 (FY1) and to precede entry into specialist training. This will allow young doctors to gain not only a depth of clinical experience in a range of disciplines, but will also provide them with a much needed range of opportunities to allow them to make choices about their clinical careers.

Thirdly, we appreciate that there is a conflict for young doctors surrounding their identity. Many young doctors believe that they are in a learning environment and have not yet grasped the implications of being an employee in a clinical service. Therefore we encourage the development of a culture between F1 and GPT that embraces not only training but also service and work.

Finally, well intentioned though the new curriculum is, in the Foundation Years it has acted as a leveller of performance and achievement. This outcome is being reinforced by the selection processes for specialist training which have not taken into account individual achievements. If British clinical education is to retain and, it is hoped, to strengthen its position and reputation for excellence in clinical practice, it is essential that new education and training programmes and assessment and selection methods identify and reward excellence.

Doctors are different. This is not because they are more highly paid or because they come from a particular social background. It is because they serve a common need to provide rigorous diagnostic and treatment programmes for people who are ill. On a daily basis, they apply cognitive and performance based skills within a complex and changing environment. The acquisition and maintenance of these skills is not easily achieved and represents not only years of structured and intensive preparation but also maintenance of skills both in and through the working environment. If we do not emphasise the importance of knowledge to clinical practice, then not only is the reputation of British clinical excellence imperilled, but also the nation's health and productivity.

8 APPENDICES

Appendix 1: Case Studies – How Three Assessment Centres were conducted in the South West Peninsula Deanery

As information on this is still coming in, we took the opportunity to talk to the organisers of several assessment centres in the South West Peninsula Deanery to find out what they did, how they felt the process had gone, and what their perspectives for the future were likely to be. Three of these short case studies are repeated here, as they represent the broad range involved: Anaesthesia, which used a formalised, standardised and carefully blueprinted set of OSCE-style stations; General Practice, which had undertaken to implement nationally agreed standards by the National Office for GP Recruitment; and Radiology, which used three short standardised interviews in line with the national minimum requirements.

1 Anaesthesia

The South West School of Anaesthesia developed an OSCE style interview process using four ten-minute stations. The stations were developed to test the seven main personal competencies identified as desirable by the Royal College of Anaesthetists:

- problem solving and decision-making
- communication skills
- managing others and team involvement
- vigilance and situational awareness
- coping with pressure
- organisation and planning
- empathy and sensitivity

The interview process was used to assess nearly 300 applicants at several levels: Acute Care Common Stem Anaesthesia (ACCS) ST1 and ST2, and Anaesthesia ST1, ST2 and ST3. The stations therefore varied according to the level, and were designed to compare candidates against their peers. At ST1, some applicants had little or no clinical experience in anaesthesia, so the interviews aimed to assess attributes, personal and generic medical skills.

The four stations were: a presentation; a structured interview; a simulation station based around Sim Man; and a portfolio check. All four stations were blueprinted against the competencies. Each station tested at least three competences and all competences were tested in at least two stations. Questions and scenarios at the first three stations were varied throughout the interview period to ensure confidentiality.

In the presentation station, candidates were given a choice of two broad topics (for example: describe the roles of an anaesthetist; the changing roles of nurses; the effects of MMC) and ten minutes in which to prepare a five minute presentation. In the structured interview, two assessors using behavioural interviewing techniques interviewed candidates for ten minutes, probing the candidates' response to behavioural challenges. This was designed to elicit information concerning their problem solving and decision making skills, situational awareness, communication and teamworking skills. In the simulation station, candidates were required to deal with a clinical scenario using a manikin; two nurses assisted the simulation process. The portfolio station was run by three assessors; one assessor checked the portfolio and two conducted an interview using identical structured questions to probe candidates about their portfolio development, career progress and planning.

Candidates were marked by two assessors at each station (three for the portfolio station) using a generic marking sheet for each competency. Each competence was scored between 1 and 4, with an additional global rating score. The total maximum score was 124 to allow as wide a spread of marks as possible to reduce the likelihood of tied marks.

Following the interviews, candidate feedback was sought and was generally positive in terms of the interview's relevance, fairness and the opportunity it gave candidates to demonstrate their ability. The Sim Man simulation station was the most favourably received. Job offers are currently being prepared (June 2007) and evaluations are continuing. Successful candidates will subsequently form part of a longitudinal study to establish the validity and reliability of the interview process.

2 General Practice

General practice selection is organised on a national basis with the active involvement of the Deaneries. The selection process has been evolving in recent years, moving away from reliance on personal interviews towards a more objective assessment of skills. As with the other specialties, eligibility was established through MTAS. All long listed candidates nationally then sat two machine-marked tests of clinical problem-solving and professional dilemmas on a single Saturday in February 2007. The cut-off point was kept deliberately low and the highest scorers were invited to the assessment centre.

The assessment centre assessed the personal skills dimensions outlined in the National Person Specification for General Practice. These are:

- Empathy & Sensitivity
- Communication Skills
- Conceptual Thinking & Problem Solving
- Coping with Pressure
- Organisation & Planning
- Managing Others & Team Involvement:

In the South West, 200 candidates were assessed over two days. The assessments were all set nationally. There were three stations lasting around 30 minutes each: a written examination; a clinical scenario role play with a simulated patient; and a group situation role play. Each station tested several dimensions; all dimensions were tested more than once. All assessors received training which included equality and diversity issues. A HR advisor was on hand throughout in case any issues arose during the assessment process.

The written examination tested the candidates' judgement in handling a variety of scenarios; it did not test clinical skills, but looked at communication, problem solving, professional integrity and coping with pressure. There was a structured mark scheme; three trained lay assessors and one clinician marked the scripts. In the other stations, clinician assessors were used. The same clinical scenario was used in all Units of Application (UoAs) across the country. It involved breaking bad news to a worried patient. Each candidate's performance was assessed against pre-set criteria to measure empathy and sensitivity, communication skills, professional integrity and coping with pressure. The simulated patient also assessed the candidate using a standard form but this information was considered only where borderline candidates were under discussion. The third station was a group role play. Four candidates at a time were required to negotiate a solution in a hypothetical conflict. Four clinician assessors observed each role play. This station assessed candidates' empathy and sensitivity, communication skills, problem solving skills and professional integrity.

The scores are accepted nationally. Unsuccessful but high-scoring candidates may still be considered by other Deaneries without having to be re-assessed. All candidates are given feedback on their performance and any dissatisfied candidates will receive a personal interview to explain the outcome. Each candidate was given a feedback form to return to the National Recruitment for GP Training and these data are still being evaluated. From talking to candidates informally at the time and subsequently, staff members feel that the candidates were generally positive. In particular, they reported that candidates felt well informed and knew what to expect, and that it was an objective and thorough process. However some candidates expressed disappointment that they did not have a chance to talk to anyone on an individual basis at interview about their prior experience and commitment to the specialty.

It was a very expensive process; although the South West Peninsula Deanery is relatively small, it estimates that it has still cost around £30,000 to implement. Nearly 50 staff (clinicians, SPs, administrators, supervisors and trained assessors) were involved in the process. However, the general view is that some of the start up costs will not be incurred again and that by recruiting the most suitable candidates, savings will be made elsewhere.

3 Radiology

Shortlisting in radiology has always been difficult because there are between ten and eleven candidates per training post, with an enormous range and variation in the quality and experience of applicants.

The radiologists took the view that the previous interview system had generally been fairly reliable in the past and that interviewing as a technique could provide enough information if the interviews were well structured and standardised, the right searching questions were asked and if the environment was appropriate. It was felt that the MMC 3-station interview process would be an improvement on the single interview, but the fact that the previous process had been considered satisfactory was a factor in deciding that it would not, for example, be worth introducing skills or knowledge testing.

Previously

Before the new system came into place, shortlisting and scoring of applications and CVs was done locally. Applications were long listed and then scored against a local system, which was weighted in favour of candidates with the appropriate level of experience. Ideal candidates should have enough experience to evidence an interest in radiology as a career, but not too much as this might indicate over-specialisation at too early a stage (a problem with candidates from some non-EU countries) or failure to progress at a reasonable speed. In addition, there was an unwritten rule that 2nd or 3rd year SHOs with FRCS, MRCP, PhD or equivalent were preferred.

Personal qualities that were sought were drive, leadership, communication skills, familiarity with the environment and team working abilities and it was felt that these could be determined well enough from the CV to be able to short list.

Single interviews, lasting around 30-45 minutes, were held with a panel of up to eight. Panel members might include the Head of the Radiology Academy, college tutors, the regional sub-dean, Deanery representative, and other professionals. In addition, it usually also contained a lay observer and a trainee, neither of whom had voting rights but who were able to offer their opinion. Each questioner scored his or her own questions and inter-rater reliability was good, though there were concerns that the process was a little time consuming and the large panel rather intimidating.

2007 selection process

Shortlisting from the MTAS information supplied was difficult because of the lack of biographical information. The pace at which candidates had achieved certain milestones and where these had been achieved was not evident and this was problematic. Similarly, it was hard to assess motivation from the information supplied. The selectors wanted to give priority to those who had put the South West at the top of the list as this was an indicator of motivation; but the information was not available.

Under MMC, the minimum requirement for the assessment centre was for there to be three ten minute interviews. Accordingly, shortlisted candidates were interviewed by three panels consisting of two clinicians and an observer. Each of the two interviewers was given five minutes to ask questions, plus five minutes to discuss them with the candidates. The questions were standardised in order to elicit information on:

(1) the candidate's motivation and insight into the attributes required in radiology;

(2) skills and knowledge regarding audit, research and current issues in the field;

(3) the candidate's performance when asked to discuss what he or she would do in a particular scenario.

There was also a bank of supplementary questions. Answers were graded against a standardised score sheet and the results compared and aggregated. Subsequent analysis showed that the reliability between the three stations had been good, and it was felt that the best candidates had been selected, although there are plans to follow up and compare to see how the new recruits perform.

APPENDIX 2: THE PANEL

Professor John Bligh (Chair)

John Bligh is Vice Dean, Professor of Clinical Education and Director of the Institute of Clinical Education at the Peninsula College of Medicine and Dentistry. After training as a family doctor and practising in Chester in the north west of England he joined the University of Liverpool, firstly as senior lecturer in medical education to establish a Medical Education Unit, and later as professor of medical education and head of the department of health care education. John was one of the foundation staff of the Peninsula Medical School and lead on curriculum design and quality assurance. He has extensive international experience of curriculum modernisation at undergraduate and postgraduate levels and has published widely on aspects of medical education. Professor Bligh was the editor of Medical Education, the leading international journal in scientific education, from 1997 to 2005.

Dr Kevin Eva

Kevin Eva completed his Ph.D. in cognitive psychology by examining the psychological factors pertaining to premature closure during diagnostic decision-making. During that time he also completed a fellowship in Health Professional Education. He is currently an Associate Professor and the Associate Chair in the Department of Clinical Epidemiology and Biostatistics at McMaster University and a member of both McMaster University's Program for Educational Research and Development and the University of Toronto's Wilson Centre for Research in Education. Dr. Eva also serves on the Executive Committee of the Undergraduate MD program at McMaster as Chair of their Evaluation Committee.

Dr. Eva's research interests include the development, maintenance, and evaluation of competence and expertise, including such issues as the selection of students for medical school, clinical reasoning strategies, performance assessment, and the role of self-regulation in professional practice. He maintains expertise in Psychometrics, Cognitive Psychology, and Statistics. He currently sits on the editorial boards of four journals and is a Deputy Editor of Medical Education. Dr. Eva has published over 50 scholarly works, some having been translated into both French and Spanish. Recent awards including the Canadian Associate of Medical Education's Junior Award for Distinguished Contributions to Medical Education.

Dr Robert Galbraith

Robert M. Galbraith graduated from King's College Medical School in London in 1971. He then trained in Medicine at Hammersmith and Brompton Hospitals, and in Hepatology at the King's College Hospital Liver Unit. Following a period of clinical service and research as a Hepatologist, he joined the Medical University of South Carolina in Charleston USA as a National Institutes of Health Fogarty International research fellow. On the basic science side, he built a nationally-funded research lab, obtained a Research Career Development Award, and became Professor and Chair of the Department of Microbiology and Immunology. On the clinical side, he became Chief of the Hepatology section, and implemented a Liver Transplant Program for which he served as Medical Director.

Joint interest in both basic and clinical sciences and broad educational experience led to service on several committees related to the US Medical Licensing exam (USMLE Steps 1 and 2) at the National Board of Medical Examiners (NBME), and in 1995 he joined the staff of NBME as Senior Medical Evaluation Officer and Deputy Vice President. With reorganization of the NBME in 2001, he became co-Director for the Center of Innovation. His major interest is in envisioning important changes in the role of the physician and the delivery of health care, and developing new assessment approaches that support these activities. He is currently leading collaborative projects on new assessment approaches with the Federation of State Medical Boards, the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine.

Professor Charlotte Ringsted

Charlotte Ringsted graduated as MD in 1978, and became a specialist in Anaesthesiology in 1991, leaving clinical medicine in 1993 for a career in medical education. She designed and implemented the first Skills Lab in Denmark in 1996. She obtained a Master degree in Health Professions Education (MHPE) from Maastricht University in 1997 where her thesis was: 'The effect of a medical skills centre on the students' activities in the clinical clerkships. In 1997 Dr Ringsted was appointed the leader of a new Postgraduate Medical Institute for the Copenhagen Hospital Corporation. In 2004 she defended a PhD thesis at Maastricht University, Faculty of Health Science on in-training assessment in a work-based postgraduate medical context. Later in 2004 she became the leader of the Centre for Clinical Education, which is a merge of the Skills Lab and the Postgraduate Medical Institute. The Centre for Clinical Education serves Copenhagen University and all hospitals in the Capital Region of Denmark.

Professor Ringsted was appointed Professor of Medical Education in June 2007. She has been president of the Danish Association of Medical Education and is currently a member of the board of Association of Medical Education in Europe (AMEE). Current research interests are simulation-based training, work-based learning and assessment, assessment of specialists' continuous professional development, and students and patients as teachers.

Professor Cees van der Vleuten

Cees van der Vleuten is Scientific Director, School of Health Professions Education and Chair of the Department of Educational Development and Research, University of Maastricht. In 1982 he received an MA in Psychology (cum laude) from the University of Tilburg, and PhD in Education from the University of Maastricht in1989. In 1996 he was appointed Professor of Education at the University of Maastricht and was awarded the Spinoza Professorship of the University of Amsterdam in 2004. In 2005 he was awarded the John P Hubbard Award by the National Board of Medical Examiners, Philadelphia.

Professor van der Vleuten is co-ordinator of the assessment and evaluation project in the Faculty of Medicine at the University at Maastricht. His main research interest is the assessment of professional competence and the evaluation of educational interventions, and he is also interested in evaluative and theoretical research in problem based learning. He has expertise in consultancies and delivers workshops on PBL, assessment, management and organisation, evidence on PBL, role of educationalists in professional training programmes. Professor van der Vleuten's publications include 233 international peer reviewed publications, six books, 31 completed PhD supervisions and 28 in progress.

APPENDIX 3: ACKNOWLEDGEMENTS

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APPENDIX 5

MEDICAL TRAINING APPLICATION SERVICE (MTAS) ISSUES

1 RATIONALE FOR A NATIONALLY CO-ORDINATED ON-LINE SYSTEM

A nationally coordinated application system for selection into specialist training has some obvious attractions, including transparency, consistency and cost savings both for Trusts and for individuals. It also appears to operate successfully in other countries[1]. It was anticipated that significant savings would accrue year on year from reduced manual administration and from elimination of large scale advertising of posts. Savings would also result from elimination of multiple SHO appointment rounds within the service.

2 THE DEVELOPMENT OF ON-LINE APPLICATIONS

The MMC team began thinking of an on-line application IT system in 2004. The responsibility for delivering a suitable recruitment system was given not to the MMC team but to the DH Workforce Capacity Directorate although crucially the business requirements, also known as 'The Rules', were developed by the MMC team. The decision to make funding available for an electronic application system was not taken until February 2006.

The specification of the on-line service sought to provide:

- secure, on-line applications and assessments
- improved communications with candidates and others
- the ability for assessors to receive and score applications
- the ability for Deaneries to monitor progress
- automated candidate matching
- the capacity to be fully auditable.

Expressions of interest were sought in March 2006 from a Government list of pre-tendered suppliers who might be able to provide the data storage and retrieval tools. The requirements had been developed in workshops with the Deaneries and the MMC team.

Following expressions of interest five suppliers were asked to tender and two did – Triad Group and Methods Consulting Ltd. Methods was selected.

The capacity defined in DH's invitation to tender was 100,000 website visits a day; 30,000 candidate users; 15,000 applications per recruitment round; 10,000 posts to be filled a year.

The invitation to tender did not differentiate between recruitment into Foundation Programmes and recruitment into specialist training. The DH has accepted that it misjudged the capacity figures.

The technical development of the on-line system was run in parallel with, but depended upon input from workstreams described below to develop the application form, the scoring regime, the rules for matching candidates, guidance for candidates and assessors and definition of key dates.

After signature of the contract additional changes to the specification were made resulting in 8 contract change notes. There were late changes and increases in scope of the project. Deadlines to deliver person specs, the wording for application forms and standard messages for applicants were missed. The software was however delivered on time, albeit with technical staff working long hours.

3 SELECTION INTO SPECIALTY TRAINING

3.1 Contractual issues

On 21 April 2006 DH put out an Invitation to Tender (ITT) for Selection into Specialty Training. The selection process had, of necessity, different objectives for over- and for under-subscribed specialties. For over-subscribed it was deemed important to devise a mechanism to rank fairly. For under-subscribed specialties, the need to assure competence was thought to be paramount.

The scope of work stated: 'The number of applicants expected to apply for entry into Specialty Training is approximately 6,000+. Applications will be via a single electronic national portal system (separate project)….' The original ITT was to deliver a short-listing process for ST1. The companies tendering were *not* asked to deliver the selection methodology for doctors in 'transition' via ST2, ST3, ST4, nor for FTSTAs.

The methodology adopted was based on the understanding that there would be sufficient posts for most applicants, that competition ratios would not be too high and that short-listing would be relatively 'light touch'.

The Work Psychology Partnership (WPP) was awarded the contract in June 2006 but did not receive the contract document until 17 February 2007.

[1] Accreditation Council for Graduate Medical Education, USA, Annual Report 2005–06

Question		Competency	No evidence	Real concern at answer	Relevant but too general or leaving doubts	Clearly answered & makes sense	Answered with depth "individual/ real"	Short-listers score
			0	1	2	3	4	
A – Commitment to the specialty	1	Personal statement						
A – Commitment to the specialty	2	Learning and personal development						
A – Commitment to the specialty	3	Relevant activities/ achievements						
B – Clinical, academic and research skills	1a	Clinical knowledge and expertise						
B – Clinical, academic and research skills	1b	Clinical skills						
B – Clinical, academic and research skills	2	Research skills						
B – Clinical, academic and research skills	3	Additional qualifications			PhD/MD			
B – Clinical, academic and research skills	4	Prizes and other academic distinctions	No evidence	Any under-graduate/ postgraduate/ prizes/ distinctions/ awards	National/ internal awards as in column to left			
B – Clinical, academic and research skills	5a	Publications	No evidence	Non peer reviewed	Peer reviewed publication (including abstracts)			
B – Clinical, academic and research skills	5b	Presentations/ posters	No evidence	Regional/ national presentation/ poster	International			
B – Clinical, academic and research skills	6	Experience of delivering teaching	Informal	Deliver of formal teaching	Been on formal teaching &/or involved organising teaching prog/ study day			
B – Clinical, academic and research skills	7	Experience of audit/ research	Particip-ated but little evidence of impact on practice	Initiated and managed audit/ research – some evidence of impact on practice	Initiated or managed audit/ research			
C – Personal skills	1	Communication skills						
C – Personal skills	2	Managing others and team involvement						
D – Probity	1	Professional integrity						
			TOTAL SCORE					

Original score allocation for ST1 Psychiatry ACFs:

The figure originally published on this page of the Interim Report was erroneously presented as the Round 1 scoring sheet. It was in fact developed for Round 1B following extensive collaboration with the academic community.

Although the tenderers had been told there were 16 specialties, in autumn 2006, WPP was asked to produce a further 110 Person Specifications to include those in transition at ST2, ST3, ST4 and FTSTAs; these were signed off by College representatives. In November 2006 the company declined to become involved in developing a recruitment methodology for academic posts.

3.2 The application form

With less than 16 weeks to design the application form it was judged prudent to use existing materials. The 2007 form was therefore based largely on the basic template used successfully in the past in the London and Yorkshire Deaneries. In the London Deanery, the basic template had been adapted for use by each individual specialty and where appropriate, sub-specialty. On the MTAS application form specialty (in the broadest sense, i.e. Medicine rather than Cardiology) specific questions were added to generic 'white box' questions. Whilst 'white space' questions have previously been used for short-listing in medical selection, the form designers accepted they do not offer a long term solution because of the concerns regarding plagiarism. The section of the form available to short-listers did not include details of the candidate's career history – although this was part of the template used by the London Deanery and was always considered when applicants for SpR posts were short-listed. This career history was taken into account by short-listers in marking other areas of the application form such as publications and presentations.

Relevant experience, posts completed, and other CV related information are indicators of competence that would normally be used to aid selection decisions. Documents seen by the Panel indicate that there was a misunderstanding, by the BMA and by the COPMeD Steering Group of PMETB's requirements. PMETB stated clearly that it was unacceptable to require applicants to have undertaken a particular post. This was taken to mean applicants should not disclose *any* of the posts they had undertaken.

Unfortunately this crucial point of detail appears not to have been appreciated by either side when the framework for application and selection was taken to PMETB for approval on 25 August 2006.

The system was therefore based on the premise that candidates could not score points for particular posts/experience as this would potentially disadvantage candidates who might have gained the necessary competences in a different way. Candidates were either eligible or not eligible for entry at a particular level based on the level of competence they had achieved. Experience was therefore a long-listing criterion rather than a scoring/short-listing criterion.

A short-listing scoring framework was developed, informed by and consistent with existing short-listing frameworks previously used for selection into specialty – but with the crucial difference that career history was not scored. The COPMeD Steering Group also advised WPP that College exams were not to be scored/used to rank individuals. Short-listing assessed the following selection criteria: Clinical, Academic and Research skills; Personal skills and probity; Commitment to the specialty. The weighting of the different sections of the application form varied between specialty levels.

It is unclear to the Panel how much medical professional input there was into scoring allocations although College submissions show their involvement was extremely limited. It is clear that for academic training posts, which were brought into the system only in late 2006, the academic community was not involved in the allocation of scores for the academic questions which are shown in the table opposite:

3.3 Four choices

In November 2006 the decision was taken with the support of the BMA's JDC to increase the number of candidate choices from two to four. The MTAS team was aware that this would lead to the risk of a low fill from Round 1. Deaneries would interview the top scoring applicants whilst those with lower scores would be left with no interviews. This was raised at the MTAS Recruitment Board in February, and the view was that Round 1 should be about offering applicants maximum choice, whilst Round 2 was about filling posts. It was suggested that this concept needed to be more widely publicised, but the decision was taken that it would not be helpful at that stage. In retrospect the Board has agreed this was probably an error as neither applicants nor their consultants found acceptable the situation where nearly half of applicants had no interview.

32,000 eligible applicants with 4 choices each were competing for the 44,000 interview slots arranged for Round 1. In practice 17% of interview capacity was taken by candidates receiving four interviews, reducing the availability for other candidates.

Although the process reliably identified high scorers, with the numbers applying, it was not enough to score in the top 25% if only the top 10% were invited to interview, as happened in oversubscribed specialties and localities. There were on average 9.2 applications per vacancy across all specialties and entry levels, increasing to over 19 applications per vacancy for surgical posts.

3.4 Application timescales

Prior to MTAS, application to specialist training would be spread over the year. The FY1 application process allowed applicants six weeks to complete their application. Application for specialist training had to be made within a two week application window, with the vast majority of applications submitted in the last four days. Compounded by

the huge increase in applications that was unanticipated when the system was first procured, put the functional capacity of the system under pressure.

3.5 IT System technical performance

Although many of the problems associated with the specialist training application process were attributed to MTAS a formal review of the IT system activity and performance revealed that MTAS exceeded its contractual availability level of 99.5%. There were however two well documented serious security breaches which precipitated abandonment of the system for recruitment purposes.

Nonetheless Methods Consulting has acknowledged that the system could not cope with the volume of applications at peak times on two of the days during which applications were being accepted. Two performance failures lasting circa 24 hours and circa two hours, occurred.

Many other reported failings were not, on investigation, attributable to the IT system. Inability to access MTAS (at times when it was functional) were attributed to difficulties penetrating Trust firewalls. This fundamental issue and the fact that many applicants would be applying from their place of work does not appear to have been anticipated. Lost applications were not attributed to technical failure. Some posts were not uploaded at the start of the application process. Neither was the invitation of applicants to inappropriate interviews a fault of the IT system, but was attributed to human error at Deanery level.

Although there was the reported potential for individuals being able to change other candidates' scores there was no evidence that this did (or did not) occur.

Other technical problems encountered included

- Insufficient helpdesk support
- Difficulty submitting references
- Difficulties sorting applications or printing forms with page breaks

In practice applicants and Deanery administrators struggled with the system which they reported as slow, user-unfriendly and unforgiving of error. A simple issue of the reference number appearing only on the front page of the form meant that it had to be handwritten onto every subsequent sheet of the form. In London alone that meant writing the number on every page of 23,000 forms, multiplied by the number of copies needed for assessors.

3.6 Scorer confidence

It appeared to scorers that many of the questions seemed to encourage 'creative writing' rather than the detailing of verifiable achievements. Guides with model answers were available at low cost on the internet and agencies offered 'rewriting' services. The availability of these was well known to the scorers and lessened their confidence in scoring. The absence of an employment history concerned many scorers. The sheer volume of applications, taken with delays in printing and distribution, made an onerous task extremely irksome or in some cases impossible to complete. When those involved in scoring discovered the number of good applicants left without any interviews, they became very distressed, and concerned that by taking part they had let their junior colleagues down. It was clear from feedback from trusts that the short-listing process was a blunt instrument for distinguishing between the good and the average.

3.7 Plagiarism

Plagiarism software was provided by Methods, but was not available until the interview process of Round 1 was well underway. It was not sophisticated and depended on the investigator identifying a suspect phrase and entering it, whereupon all forms using this exact phrase, up to a certain limit, were flagged up. The limit was originally set at 50, but was subsequently extended to 500, still a very low limit when dealing with 128,000 application forms. Many scorers commented on the frequency with which a small number of relatively rare conditions was mentioned by applicants. Simply entering the name of the condition would have been a useful way of checking this, but in most cases the 500 limit was exceeded and so this was not possible. Material copied word for word from model answers in an internet guide was identified in 0.5% of forms. Scorers commented on the formulaic nature of many responses. The nature of the stem and follow on questions, and the limited word count per question may have encouraged such formulaic responses.

3.8 Interviews

Although the conduct of interviews differed from Deanery to Deanery, the interview process was arguably the strongest feature of specialty selection recruitment. Many unsolicited reports suggested robust processes and the appointment of strong candidates. However as noted in the Douglas Review, others noted a number of short-comings detailed in Appendix 9. In particular it was felt that interviews should be able to review curricula vitae and portfolios and use probing, non-formulaic questions.

3.9 General practice

General practice recruitment used a machine markable test of clinical knowledge and situational judgement. Interviews were replaced by selection centre methods, using workplace simulations to assess applicants against a framework of required attributes. A national evaluation of MTAS GP applicants has shown overwhelming confidence in the selection centre process. The selection methodology was backed by a national recruitment office which coordinated recruitment across Deaneries and standardised the processes and quality management. The national short-

listing system enabled applicants to be allocated in rank order to their highest available Deanery of preference. The scores of unplaced applicants were cascaded into Deaneries where the applicant was prepared to train and which still had vacancies.

3.10 Devolved administrations

In N Ireland the Service is in the midst of a fundamental reorganisation and yet the process was managed smoothly despite engendering a significant degree of anxiety amongst doctors in training. It has been seen as satisfactorily building on changes emanating from the 2002 Report into previous recruitment mechanisms into the first year of the SHO grade.

In Wales all the deadlines for short-listing were met despite the lack of response to queries from the MTAS Helpdesk. The Welsh CMO's evidence to the Inquiry highlights various issues: 'The MTAS system sat outside the MMC office…..within the Department of Health (England). This caused confusion and reflected the overall lack of leadership and clear lines of responsibility … On-line short-listing for Wales was not delivered on schedule. Consultants in Wales had to handle applications for the first week manually … No IT training module to support the on-line process was provided… . Consultants considered the application form not fit for purpose for ST3….'

Scotland was deeply dismayed by the MMC England decision not to include FTSTAs at level 3. Having been led to believe partners' applications could be considered alongside one another to ensure geographical co-location, this facility seemed absent from the system when it was rolled out. Evidence to the Panel states that 'there is no clear evidence that the short-listing process designed by MTAS offers any benefit over conventional short-listing based on CVs'.

4 COMMUNICATIONS

The move from an old to a new application system, particularly one of such high stakes as the entry to specialist training in 2007 required optimal communication with stakeholders including Deaneries, Trusts, the trainees themselves and their trainers and senior colleagues.

As pointed out by the Douglas Review communications failed to adequately relay to candidates or their mentors that many good candidates would not get posts or even interviews in Round 1. There appeared to be no widespread understanding of the consequences, in terms of decreasing chances of obtaining an appointment in Round 1, of limiting applicants to four choices, whereas prior to MTAS they could apply for multiple posts.

A lack of understanding of the Rules developed by the MMC team inevitably resulted in criticisms levelled at the IT system through which they were applied.

Once under way, the Helpdesk arrangements proved inadequate to deal with policy and process issues, which largely fell to the MTAS technical helpdesk. Many applicants reported an inability to gain advice or communicate effectively at a Deanery level over this period.

5 MTAS PERFORMANCE DATA

Notwithstanding the technical, usability and communication deficiencies the question remains as to whether the MTAS system resulted in strong candidates being selected for interview. Despite concerns about the discriminatory potential of the application form, from the limited data available comparison of short-listing and interview scores indicates that in Round 1a candidates were in the main strong, particularly at the higher entry points. A study from two independent public health specialty training programmes showed that short-listing discriminated well between appointable and not appointable candidates.[2] In Round 1b the correlation between interview and short-listing scores was not strong enough to provide a reliable way of distinguishing between the bulk of applicants in the middle of the rankings.

The anecdotal feedback from around the country is that this was the case in the majority of Deaneries.

It is of course speculative whether a system that was optimised from a stakeholder perspective would have resulted in a stronger group of applicants being called for interview. The much publicised rejection of some with very strong CVs suggests that such might be the case.

6 COORDINATION/GOVERNANCE

As pointed out above the DH MTAS team led the MTAS IT delivery project whereas 'The Rules' were developed by the MMC team. DH acknowledges that 'to a certain extent these two teams operated independently of each other'. Although they came together under the MMC programme board formally, the DH MTAS team did not fall under the (two) Senior Responsible Officers accountable for MMC.

The result of this schism in responsibilities was that it was difficult to accommodate changes to 'The Rules' which became more complex with time and changed up to and beyond the system going 'live'.

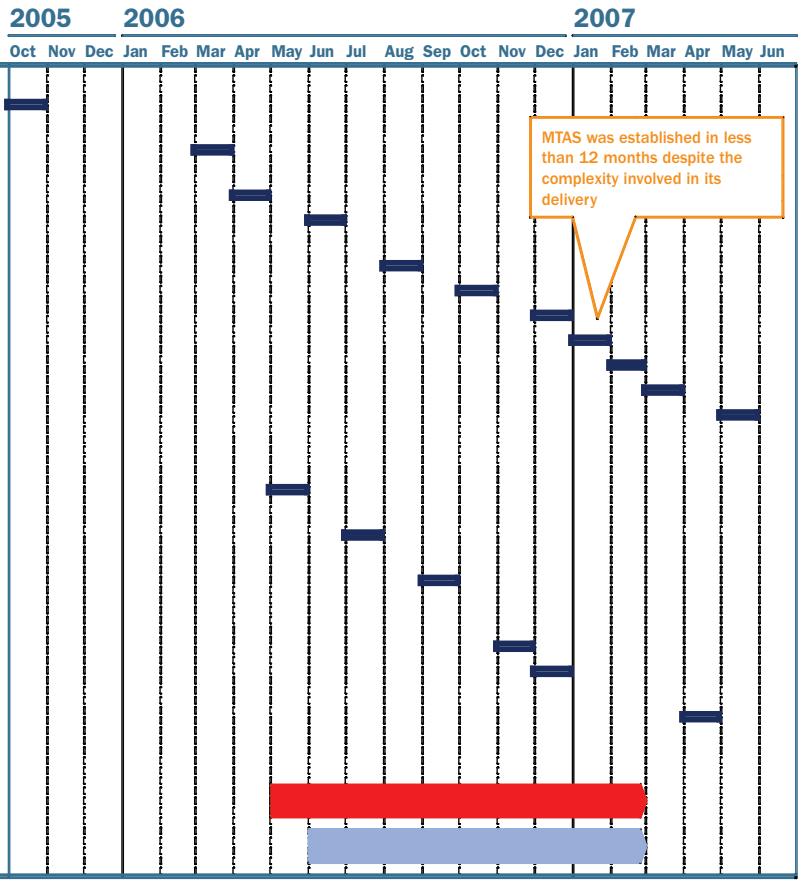
The extremely contracted timescale for development of a highly complex system posed very significant risks which were acknowledged but little action appears to have resulted calling into question the risk management and governance arrangements.

7 CONCLUSIONS

A summary of the critical steps in the development of MTAS appears in Figure 1. Perceived failings of the MTAS IT System developed to aid selection to specialist training posts in 2007 were the catalyst for the creation of an Independent Inquiry into MMC.

[1] Pashayan et al, J of Public Health, Sept 2007, pp1–7

What were the specific issues with MTAS implementation[1]?



Key MTAS event

- COPMeD agrees centralised processing should take place for F1, F2, CP and specialist training
- Tenders called for – 5 companies invited but only 2 groups, Triad Group and Methods Consulting respond
- Methods Consulting wins contract
- Workforce Programme Board decides to use MTAS over existing system
- Process and rules defined with stake-holder involvement
- Foundation enrolments via MTAS with no major problems
- 'Drop dead' date moves from 19 Dec to 12 Jan
- MTAS opens for speciality applications
- Variations in efficacy of MTAS throughout Feb & Mar
- DH announces review into round 1 of MTAS announced
- SoS announces MTAS abolished for recruitment purposes

Internally

- MMC Programme Risk Log notes "It may not be possible to accommodate change on such a grand scale"
- U.K. strategy group agrees on framework for national selection with input from Deans, JACSTAG and AoMRC
- Gateway review states that for MMC "major internal risk lies with the online application system MTAS" – PMETB approves application & selection framework for MTAS
- MMC PDB recognises U.K. graduates may be displaced
- DH workforce staff and Methods consulting maintain view MTAS is viable
- National Director MMC England, and National Clinical Advisor to MMC, resign

Risk rating

- Red risk rating for MTAS issue noted in MMC Programme Log from May 06 – Feb 07
- No change in risk description for speciality training and MTAS in MMC Programme Log from Jul 06 – Feb 07

1 Based on UKSG minutes 2006-2007, PDB minutes 2006, WPB minutes 2006 and MMC Programme Risk Logs 2006-2007

Figure 1

Accelerated development of the system, changes to the specification and an unanticipated increase in the volume and intensity of the applications that were received revealed technical deficiencies.

However, several difficulties attributed to the IT system were not in fact technical failures.

The division between the management of the IT Delivery System and 'The Rules' that informed its development created fundamental problems for a high risk project. Risk management was inadequate. Communication too, particularly with applicants and their mentors about the nature of Round 1, was deficient, fuelling the perception that the system had failed.

In practice many strong candidates were selected for Round 1 interviews but the lack of face validity of the shortlisting process employed damaged confidence in the process as a whole.

APPENDIX 6

REPORT OF THE SERVICE PERSPECTIVES SUB-GROUP

CONTENTS

1 INTRODUCTION

1 MMC is a major reform of postgraduate medical education designed to achieve better-managed and structured training in streamlined, competence-based programmes. The objective is to produce a more flexible and responsive medical workforce which is fit for purpose. It was meant to ensure that there was less reliance on 'trainee' junior doctors, so that the majority of patient care would be delivered in future by fully-qualified specialists and GPs. At the same time, the advent of the Postgraduate Medical Education and Training Board (PMETB) has led to a fundamental review of specialty and GP curricula.

2 The first phase of MMC was launched in August 2005 with the introduction of two-year programmes of structured training (FY1 & FY2 Foundation Programmes) for new medical graduates. The next step was to replace both the existing SHO grade and higher specialist training with new, unified run-through specialist and GP programmes (following Foundation, up to the completion of specialist training) in August 2007 based on the curricula approved by PMETB. In parallel there was to be a modernisation of the non-consultant career grades.

3 The key objectives of the MMC initiative were to improve the standard of postgraduate education and accelerate the training of specialist doctors and GPs. This was intended to enable more patients to be treated by fully trained doctors rather than the old model of using trainee junior doctors to provide a large volume of service work. However, this objective has been compromised by a failure to consider adequately the effect on the provision of medical care and financial responsibilities at a service level. This may have occurred because those with an educational rather than a service responsibility have driven the process.

4 There has been a number of consequences as a result of this omission but perhaps the most significant is that there has been a failure to recognise the vital role that trainee junior doctors play in the provision of clinical service. The corollary of this is the vital importance that service and clinical experience have in the education of junior doctors (the apprenticeship role).

5 This sub-group of the MMC Inquiry was charged with identifying the shortcomings that have resulted from MMC implementation to date from a service perspective so that the Panel might make recommendations on how changes could be made to improve medical service provision within the context of a new medical career structure.

6 During the work of the sub-group, it has become apparent that 'Service opinion' has been taken from a variety of sources during the MMC reforms but it is notable that little or no advice has been taken from medical managers working in the providers of Health Care. This omission may have resulted in underestimating the effect the changes would have on the ability to provide care.

2 ISSUES AND CONSIDERATIONS

The ability and capacity of trainee doctors to deliver clinical service

1 The amount of time that trainee junior doctors have to provide clinical service has markedly reduced, as has their duty hours of work, as a result of both European Working Time Directive (EWTD) implementation and the more structured training required within MMC programmes. In addition to pure time availability, there is an impression gained by many within hospital medicine, that junior doctors are less confident, less able to shoulder responsibility and less able to make decisions. This view is shared by many junior doctors themselves.

2 Learning how to make effective decisions requires confidence in one's seniors to be competent as a trainer, provide appropriate support and enough practical mentorship early in a placement to allow the junior doctor to develop from core knowledge to a working ability to decide on how to manage patients within their skills and competences. The loss of the 'medical firm' structure has significantly reduced the support available to junior doctors as well as adversely affecting the continuity of care.

3 Training needs to ensure there is sufficient experience gained in team working and an appreciation of the value of personal responsibility for patients. It is essential mechanisms are adopted which build effective teams thereby enhancing teaching and training and enable juniors to take personal responsibility for their patients.

4 Both clinical service and training provide the basis on which experience is gained. It is essential that the appropriate balance between structured, supervised training and clinical experience is achieved for effective service provision and good education. These demands are competing with shorter hours of work (compliant working patterns – EWTD) and coupled with rapid rotation in four-month blocks between increasingly disparate specialties, junior doctors are likely to feel unsettled and therefore lack the experience, confidence and relevant training to be able to make independent decisions and effectively contribute to service provision of healthcare.

5 Current implementation of MMC has reduced the duration of rotational specialty placements to four-month blocks for 'Foundation' (FY1 & FY2) and 'Basic Specialty Training' (ST1 thro' ST2). "Higher Specialty Training" (ST3 and above) has generally retained six to twelve-month placements. The increased number of rotational placements ultimately leads to a lack of meaningful experience as the trainee has little time to establish working relationships which enable core knowledge to be built upon and translated into developing clinical practice – exposure is not the same as experience.

6 The effect of EWTD has forced most acute Trusts to implement 'full-shift' as opposed to 'on-call' working practices with some junior doctors being relieved of all night time cover. This has reduced the experience of medical management of patients during the night and it is felt this has had a negative effect on the confidence and self reliance of junior doctors. It may also have reduced experience in how to work effectively in a team. This is likely to be also reflected in the quality and capability of candidates for more senior positions. It was felt particularly important that all trainees in acute care should be involved in a balanced provision of service outside that of 'core' hours. In this regard, the 'Hospital At Night' initiative may have a deleterious effect on gaining experience in basic clinical tasks (e.g. blood cultures etc.).

7 Service providers have had significant problems associated with the employment of flexible trainees. The rules for how banding payments have to be applied provide a significant burden of extra financial commitment in many cases, which is a disincentive for promoting flexible working. The fact that trainees only have to announce their intentions regarding flexible training after their appointment also creates serious problems for service providers. It is however recognised and fully accepted that flexible training should be promoted in a modern medical workforce and therefore, it is suggested that the mechanisms should be reviewed to advance this objective.

3 TRAINEE JUNIOR DOCTORS' ALLEGIANCE

1 Junior doctors are a vital part of the delivery of health care, particularly in the hospital setting and indeed are one of the major staff groups involved in front-line patient care. However, it appears that they are barely connected with the operational management function of hospitals. Most junior doctors would consider that their accountability is mostly to their Educational Supervisor, Programme Director or assigned individual Consultant rather than the Trust's medical management structure (Head of Service, Clinical Director or Medical Director). This is likely to make the management of junior doctors difficult and may also make them feel disconnected and unsupported by the Trust. Medical management should be an integral part of training.

2 Every effort should be made to build a valued and supportive relationship between the trainee junior doctor and the service provider (Trust / Specialty rotational placement). It has been considered in the past that protection and support for junior doctors can only be effectively provided by Deaneries. However, it should be recognised that employers, are at least as strongly motivated to support and provide training for junior doctors as a vital part of their workforce. The creation of an environment that provides appropriate and adequate facilities which adds value to the learning/training experience (including embracing leading edge electronic communications) would foster greater allegiance to the Trust. Greater use of email and text messaging systems to keep trainees in touch would be beneficial. However, to be effective, the flow of information should be restricted to essential and useful dissemination of information regarding rotas, training sessions or grand rounds.

3 The whole concept of the administration of employment of trainee junior doctors should be re-examined. Deaneries tend to see these as purely administrative processes, when in fact there are complex contractual relationships.

4 THE MEDICAL WORKFORCE PLAN

1 We believe that there is an important principle, which has been lost during the implementation of MMC. It is that all qualified doctors from FY1 onwards provide important and useful work, which is required by Trusts to deliver clinical services – particularly the emergency service. The largest part of the training of all junior doctors is the experience they gain providing a clinical service. For this reason it is our belief that Trusts, as the providers of service must have the primary responsibility for the employment, workforce plan and recruitment of all junior doctors.

2 However, it is also recognised that there should be a period of 'core training' for all which is guaranteed for all those successfully completing an undergraduate course in the UK in order to avoid unnecessary waste of skilled doctors. The period of such 'core training' would include the Foundation Year(s) and up to two further years of posts designed to give doctors core practical experience and competence.

Trusts would need to have a responsibility to accommodate this requirement within their workforce. This would be managed and coordinated by the Post-Graduate Deanery.

3 After this 'core training', a qualified doctor will be capable of undertaking more advanced service work, specialist training or a combination of both. Employment after this stage will depend primarily on the needs of the service and will no longer be determined by supply. In virtually all specialties it is expected that Trusts will wish to employ more doctors at this level than are required for training.

4 The decision about which posts, between core training and CCT, will be deemed 'formal training' posts will be the decision of the Post-graduate Dean.

5 The need for more junior doctors than are required for formal training has been addressed in the past by employing International Medical Graduates (IMGs) on short term contracts. However, this is at odds with the Government's policy of self sufficiency.

6 We suggest that Trusts should employ a medical workforce following 'core' training consisting of pre CCT Trust Doctors, post CCT specialists and consultants. The numbers of each would be determined locally according to the needs of the service. The pre CCT Trust doctors may be split into those undertaking fast track training (Specialist Registrars) and those undertaking a greater preponderance of service work. Progress to CCT could be made against agreed curriculum and competence assessment.

7 GP training should also follow core training (which may include some GP placement) in a similar manner.

8 Coordination, guidance and advice on training at all stages would be provided by the Post Graduate Deans.

5 MANAGING, DELIVERING AND FUNDING OF EDUCATION AND TRAINING

1 We suggest that the management of the delivery of education and training for doctors should sit alongside the responsibility for workforce planning, employment and recruitment – i.e. with individual Trusts. Trusts should appoint a responsible officer within their medical management structure.

2 Performance management of the Trusts in their educational delivery should be the responsibility of the Post-Graduate Deans as well as the coordination of rotations across Trusts and advice on workforce planning. We suggest that the accountability of Post-Graduate Deans should not sit with the Strategic Health Authorities.

3 Educational funds might be channelled through either the Service Tariff or through the Post-Graduate Deanery or a combination of both. This is open to debate. The use of educational funds for specific junior doctor posts has however caused considerable confusion. It has fostered the view that junior doctor posts are to a large extent supernumerary and the needs of the service are of secondary importance, at best. We do not believe that this has been healthy for the service or the requirement that these doctors have for experience. As has already been stated the junior doctors at all stages are an important part of the service provision and we therefore suggest that their funding should come from the Trusts through their service contracts (tariff).

4 However, the costs of training are significant to Trusts because the burden of training slows service, the training activity by teachers has to be paid for and there may be excess costs because Trusts may have to guarantee posts in the early years after graduation. Educational funds should be directed at compensating Trust for these factors rather than funding the junior doctor posts.

6 THE NON-TRAINING JUNIOR/ SENIOR DOCTOR WORKFORCE

1 As has already been stated, a small but significant part of the workforce has been provided by Non-Consultant Career Grades (NCCG/SAS) and other service designated posts – particularly since the advent of EWTD. As the workforce begins to depend increasingly on UK trained doctors, we believe that this will become an increasingly large and important part of the workforce – both pre- and post-CCT/CESR. This group of skilled service doctors are also becoming increasingly important in order to deliver the increasing volume of routine cases required by the NHS. Consideration should be given to granting post-CESR/CCT doctors, autonomy to practise in their own right. Currently, this is only given to Consultants in hospital practice.

2 Until now this part of the workforce has not been seen to have a satisfactory career path and indeed in some quarters has been seen just as an undesirable 'sump'. We believe that it is important that this impression is changed radically so that these jobs are both desirable and have a future. The jobs need to have potential for progression of a career and have opportunities for continuing education and training. We believe it is essential that all post-holders of these jobs should be able to apply for Specialist Training posts at a later stage.

3 We suggest that it may even be possible to consider these staff as the same as those undertaking Specialist Training – the difference would be the amount of structured training there was. Those in ST jobs would then be seen on a faster track to CCT than those in the

rest of this part of the workforce.

7 CONSULTANT TRAINING CAPACITY

1 The structured training and assessment requirements associated with MMC have necessarily increased the amount of time consultants and other trainers have to commit to formal training delivery and related assessment.

2 In many cases this is adequately accommodated within the consultants' Supporting Programmed Activity element (SPAs) of the job plan. However, there are cases where consultants' time is not appropriately accounted for. It is therefore important that teaching time is more closely monitored and appropriate time allocated within consultant job plans. In fact, it may be anticipated that teaching requirement will increase in the future years as the reforms take effect.

8 NOMENCLATURE AND TERMINOLOGY

1 Given that one of the key objectives of the MMC initiative was to enable patients to be treated by fully trained doctors, thereby ensuring the majority of patient care is delivered in future by fully-qualified specialists and GPs, it would seem essential that appropriate nomenclature and associated terminology reflects this if the public's perception is to be assuaged.

2 The title used in relation to any doctor must be relevant to patients and carers and inform them of the status of the doctor. Such titles as Foundation Trainee etc., do not fill this criterion. The terms House Officer, Senior House Officer and Specialist Registrar are known to the public but may not convey the right perception relating to their competencies.

3 All doctors are trained but are subject to lifelong learning. All doctors undergo further training and development after initial qualification. Steps along this pathway include specialty and sub-specialty training and continued learning as a specialist and consultant.

4 All doctors have a role in providing service to patients; the different grades of doctor provide different aspects of the overall service, together with other healthcare professionals. Currently the service is Consultant led in the secondary and tertiary care sectors with a significant degree of Consultant delivery.

5 'A Guide to Postgraduate Specialty Training in the UK' ('The Gold Guide') states that the model of learning will be a 'general balance of workplace based experiential learning, independent self-directed learning and appropriate off-the-job education'.

6 It is therefore entirely appropriate for doctors in foundation training, basic specialty training, higher specialist training and fixed-term training to provide service as part of that training. The service provision must be subject to supervision and review. The concept of all service being provided by 'trained doctors' is flawed. It does not apply to any other health professional.

9 VARIABILITY OF IMPLEMENTATION

1 Implementation to date has been variable and failed to address the perceived fundamental mal-distribution of trainee posts between London and elsewhere in England. This has lead to confusion, service and cost implications for those Trusts in the counties.

2 The re-designation and overall reduction in formal training posts has failed to recognise that some complex multi-site acute trusts were unable to absorb changes on the scale imposed without prejudicing service. The effect on those multi-site acute trusts has been disproportionate.

10 E BASED APPLICATIONS/ SYSTEMS

1 It is appreciated that a national application system for junior doctors has many advantages particularly for the Foundation Year(s) and for the first few yeas of training. The application part of MTAS is probably suited for this role.

2 A national application system for training from ST3 and above may be more difficult to implement and should perhaps be considered at a later stage.

3 However, we believe that the recruitment and employment of all junior doctors should be the responsibility of the Trusts.

4 Modifications to the MTAS process should be piloted before wide-spread rolling out.

ANNEX A

Service Sub-group – Membership

Chair: Dr Allan Cole
Medical Director, University Hospitals of Leicester NHS Trust

Membership
Mr Steve Barnett, Director, NHS Employers
Dr Mike Browne, Medical Director, Walsall Hospitals NHS Trust
Mr Nigel Clifton, Chief Executive, Doncaster and Bassetlaw Hospitals NHS Foundation Trust
Dr Charles Gutteridge, Medical Director, Barts and the London Hospital NHS Trust
Dr Toby Hillman, Junior Doctor (SHO), East Midlands Deanery
Professor Aly Rashid, GP, Leicester
Mr Thangasamy Sankar, Associate Specialist, University Hospitals of Leicester NHS Trust

Dr Mark Simmonds, Junior Doctor (SpR), East Midlands Deanery
Mr Chris Welsh, Medical Director, Sheffield Teaching Hospitals NHS Foundation Trust

Secretariat: Mr Mike Elliott
Asst. Director of Human Resources (Retired)

ANNEX B

MMC Inquiry Service Issues Sub Group

Terms of Reference

1 To bring together a small group of individuals from a range of backgrounds, who have responsibility for providing a medical workforce to deliver health care.

2 To identify any shortcomings from a service perspective that have resulted from MMC paying particular attention to:

2.1 The role of junior doctors and their contribution to clinical service

2.2 The role of the non-specialist training grade workforce

2.3 The length of rotations

2.4 The impact of new training plans on consultant time

3 To consider the adequacy of current funding and workforce planning arrangements for junior doctors in the light of MMC

4 To prepare a report for the main Inquiry Panel by 31 July 2007 so that it can make recommendations on how changes could be made to improve medical service provision in the context of a new medical career structure.

APPENDIX 7

INTERNATIONAL COMPARISONS

1 International comparisons – UK, US, Canada, Australia, France, Germany, Sweden

a) Healthcare systems & the medical workforce

b) Education & training

c) Governance and regulation

d) Role of universities in postgraduate medical education

2 Postgraduate training and governance structures: UK, USA, Canada, Australia, France, Germany, Sweden

3 Selection processes into specialty training: US, Canada, Australia, Sweden & Germany

4 Assessment methods: US, Canada, Australia

5 Applications to postgraduate training in the USA

International healthcare system and medical workforce comparison

	U.S.	Canada	Australia	France	Germany	Sweden	U.K.
Healthcare system							
Healthcare expenditure							
• As % of GDP	15.3	9.9	9.6	10.5	10.6	9.1	8.1
• As $ per capita	6,102	3,043	3,122	3,566	3,502	3,531	2,880
By financing source							
• % public	45	70	68	78	77	85	87
• % private	55	30	32	22	23	15	13
• Public financing structure	Tax-financed for certain groups, or PIH through employer	Statutory health insurance through taxation	National health system funded through general taxation	Statutory health insurance funded through taxation	Statutory health insurance funded through income contributions	National health system funded through taxation	National health system funded through taxation
Organisational structure							
• Provider ownership	Primarily private	Public/private	Public/private	Public/private	Public/private	Primarily public	Primarily public
• HC payor structure	National and regional system	Decentralised dominated by provinces	Centralised	Increasingly decentralised to regional level	Decentralised (dominated by regionals)	Single HC payor, funds collected by counties	Centralised (single HC payor)
Medical workforce							
• Doctors/1,000	2.3	2.5	2.5	3.3	3.3	3.3	2.1
• OECD rank	24	20	19	10	11	13	26
• % GPs	29[1]	48	54	49	43	24	30
• % specialist	71[1]	52	46	51	57	76	70
• % medical workforce IMGs[2]	24.8	22			2.2		33.5[3]
Training statistics							
• Med. students/physicians	1:3.7	1:7	1:3.1	1:5.7	1:4	1:4	1:2.8
• Applicants/training posts	1.3:1	1:1.1					1.4:1[4]
• Applicants/med. student posts	2.3:1	4.2:1			4:1		2.3:1

1 American Medical Association data: 13% GPs, 87% specialists
2 Includes trainees engaged in service delivery
3 Includes 5.7% EEA graduates
4 2006 data

Source: OECD

Figure 7.1

International comparison of medical education and training

	U.S.	Canada	Australia	France	Germany	Sweden	U.K.
Medical school							
• Years of education – Pre-Med	4 years	4 years	3 years (optional)	None	None	None	None
– Med	4 years	4 years	4–6 years	6 years	>6 years	5.5 years	4–6 years
• Medical degree awarded	MD	MD	MBBS[3]	MD*	Staatsexamen	Läkare	'First MB'*
• Centralised final exam	Yes (USMLE)[1]	Yes (MCCQE)[2]	No	Yes (ECN[4])	Yes (Staatsexamen)	Yes (Läkarexamen)	No
Specialty training selection							
• When?	In final year of medical school	In final year of medical school	During basic training & after specialist entry exam	In final year of med school & after ECN* exam	In final year of medical school	During 18–21 months internship	In second post graduate year
• Centralised selection process	Yes ERAS[5]/NRMP[6]	Yes CaRMS[7]	Yes, centralised by specialty	Yes, based on ECN* scores	No	No	Both central & local
• Timing	Once per year	Once per year (two rounds)	Once per year	Once per year	Continuous	Continuous	Once per year
• Match/individual negotiation	Match	Match	individual negotiation	Match	individual negotiation	individual negotiation	Match
• Selection criteria	CV, PS[8], LoRs[9], MSPE[10], transcript, USMLE[1]	CV, PS, LoRs[9], PS, MSPR[11], transcript	Application form, CV, LoRs[9], transcript	ECN[4] scores	CV, transcripts, LoRs[9], Staatsexamen	CV, transcripts, LoRs[9]	CV, references, interview
Specialty training							
• Run-through process	Yes	Yes	No, except for selected specialties	Yes	No	No	Yes
• Modular?	Yes	Yes	Limited	Limited	Limited	Limited	Limited
• Training pre-requirements	1 year internship (in some cases)	None	1 year internship + 1–2 years RMO[12]	None	None	18–21 month internship	2 years Foundation training standard
• Years of specialty training	3–7 years	4–6 years	5–7 years	4–6 years	5+ years	5+ years	5+ years
• In-training assessment	Competency assessment specialty specific exams	Competency assessment	Competency assessment specialty specific exams	Competency assessment	No structured assessment	No structured assessment	Competency assessment

1 U.S. Medical Council Licensing Examination
2 Medical Council of Canada Qualifying Exam
3 Bachelor of medicine, Bachelor of Surgery
4 Epreuves Classantes Nationales
5 Electronic Residency Application service
6 National Residency Matching Programme
7 Canadian Residency Matching Service
8 Personal statement
9 Letter of recommendation
10 Medical Student Progress Evaluation
11 Medical Student Progress Report
12 Resident Medical Officer

*Received at the end of UG training; MBBS; MBBS/BSc; MBChB; MBBCh; BMBS depending on school

Source: OECD

Figure 7.2

International comparison of governance and regulation

	U.S.	Canada	Australia	France	Germany	Sweden	U.K.
Medical practice certification							
• Physician certification	• SMB[1] registration	• MCC[2] registration	• SMB[1] registration	• Registration with Order of Physicians	• Staatsexamen , Approval by Ministry of Health	• Registration with NBHW[5]	• GMC registration*
• Specialty certification	• ABMS[3] exam and SMB[1] accreditation	• Royal College exam	• Royal College exam	• Medical degree with certain speciality	• Chamber of physicians' exam	• Awarded by teaching hospital, voluntary exam	• CCT awarded by PMETB**
• CME[4]/recertification	• Re-certification, CME[4]	• CME[4]	• CME[4]	• CME[4]	• CME[4]	• CME	• CME
Management and governance							
• Accreditation for overall quality of training	• ABMS[3], ACGME[6]	• Royal College	• Royal College of Surgeons and Physicians	• Order of Physicians	• Chamber of Physicians	• Specialty societies	• PMETB
• Accountability for individual programme delivery	• Residency Programme Director	• Residency Programme Director	• Specialist Training Director	• Specialist Training Director	• Chief Physician	• Tutor	• Postgraduate Deanery
• Regulation of number of							
– Medical student posts?	• Yes, by medical school	• Yes, based on provincial needs	• Yes, based on national needs	• Yes, based on national needs	• Yes, by university	• Yes, based on county needs	• Yes, based on regional needs
– Specialty training posts?	• Yes, by medical school	• Yes, based on provincial needs	• Yes, based on national needs	• Yes, based on national needs	• Yes, by hospital	• Yes, based on county needs	• Yes, based on national needs
– Doctor practice posts?	• No	• No	• No	• No	• Yes, regional regulation	• No	• No
Medical workforce numbers in each speciality							
• Numbers regulated ? If yes	• No	• Yes	• Yes	• Yes	• Yes, for opening of private practice	• Yes	• No – although realistically determined by available numbers and cost
– Who decides?		• Province government	• AMWAC/Health Ministry	• Central government	• Regional medical profession	• County Councils	
– By what process?		• Comprehensive, open, consultative	• Comprehensive, open, consultative	• Mechanistic	• Mechanistic	• Mechanistic	
– Forecasted demand?	N/A	• Yes	• Yes	• Yes	• Yes	• Yes	
– Forecasted supply?		• Yes	• Yes	• Yes	• Yes	• Yes	
– Role of government and medical profession?		• High, consulting of stakeholders	• High, consulting of stakeholders	• Government driven	• Medical profession dominates	• Limited role	

1 State Medical Board
2 Medical Council of Canada
3 Amercian Board of Medical Specialities
4 Continuing Medical Education
5 National Board of Health and Welfare
6 Accreditation Council for Graduate Medical Education

*General Medical Council
** Certificate of Completion of Training, Post Graduate Medical Education Board

Source: OECD;

Figure 7.3

International comparison of the role of universities in postgraduate medical education

	U.S.	Canada	Australia	France	Germany
Involvement of university	• **High**	• **High**	• **Moderate**	• **Moderate**	• **Moderate**
Summary of university involvement	• Training delivered by a combination of the university and the hospital	• Training can only be delivered by programmes sponsored by universities	• Training run by colleges and hospitals with university links rather than by universities themselves	• Training run by hospitals with university involvement rather than by universities themselves	• Training run by chief physicians in hospitals, some with university links
Description of university involvement	• American Board of Medical Specialties accredits training programmes • These are run by universities who oversee teaching hospitals • Governance is by the medical school dean, graduate dean and residency programme chief	• College (RCPSC) oversees medical specialist education • RCPSC strictly stipulates all residency programmes must be sponsored by a medical school at a Canadian university in order to be accredited	• Colleges accredit teaching hospitals affiliated with universities to provide training • Large hospitals accredited for more programmes and hospitals without university link not usually accredited for training • Clinicians responsible for specialist training within teaching hospital often hold position attached to university medical school	• The decision to let students join the 3ème cycle of speciality training is made by a commission led by the university • Specialist training itself is administered by the hospital • Universities are involved in the thesis required by 3ème cycle	• In principle all hospitals, not just those linked to universities, can be involved in specialist training • However trainee oversight is the responsibility of an accredited chief physician rather than being the responsibility of an institution

Figure 7.4

Figure 7.5

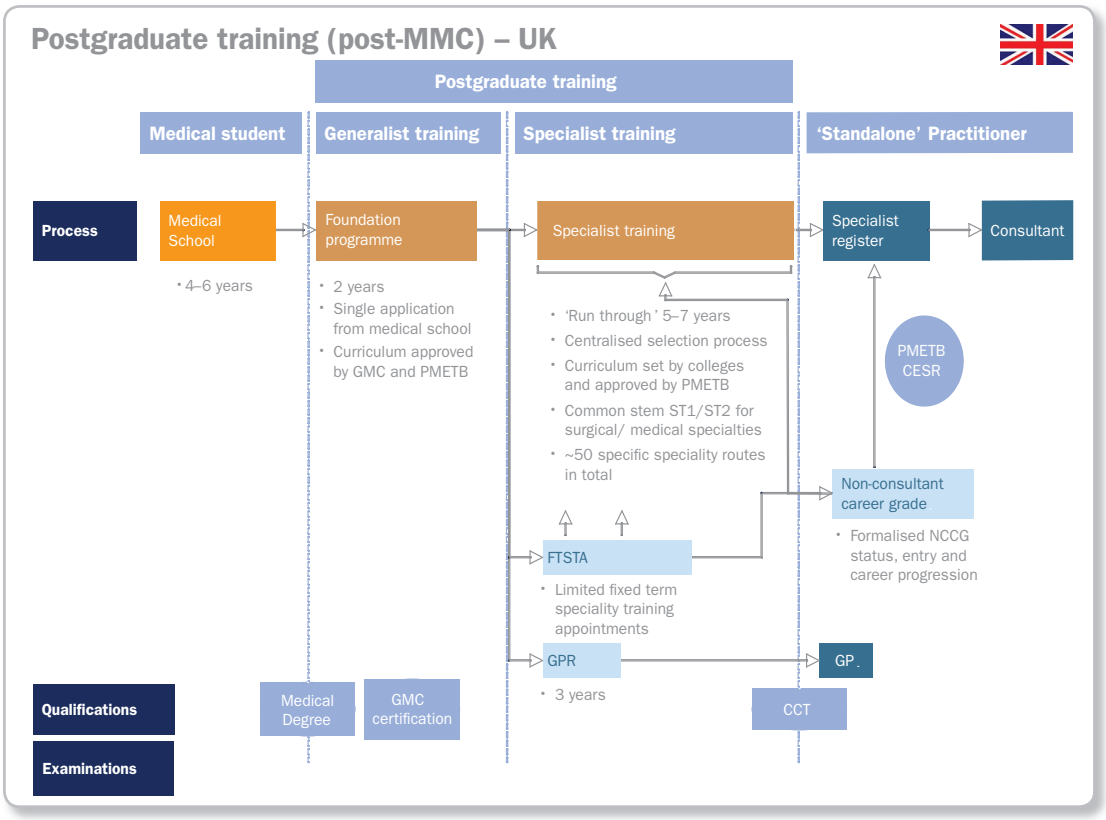
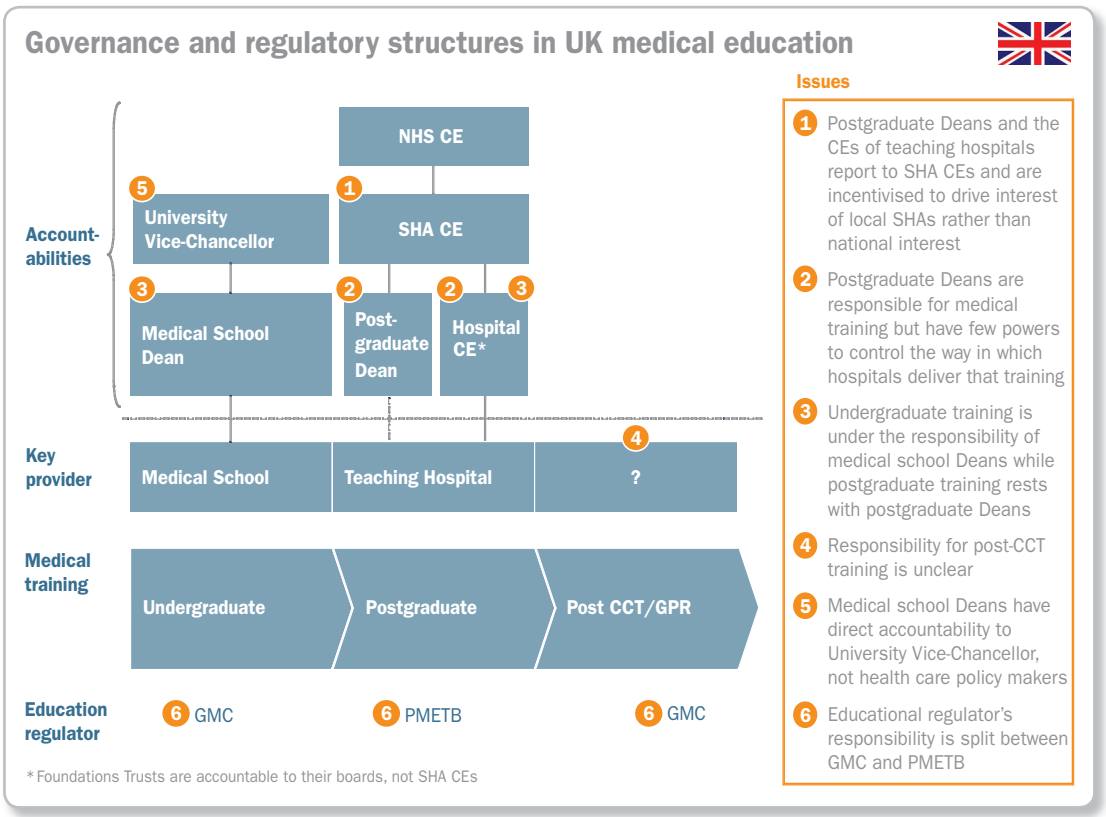


Figure 7.6



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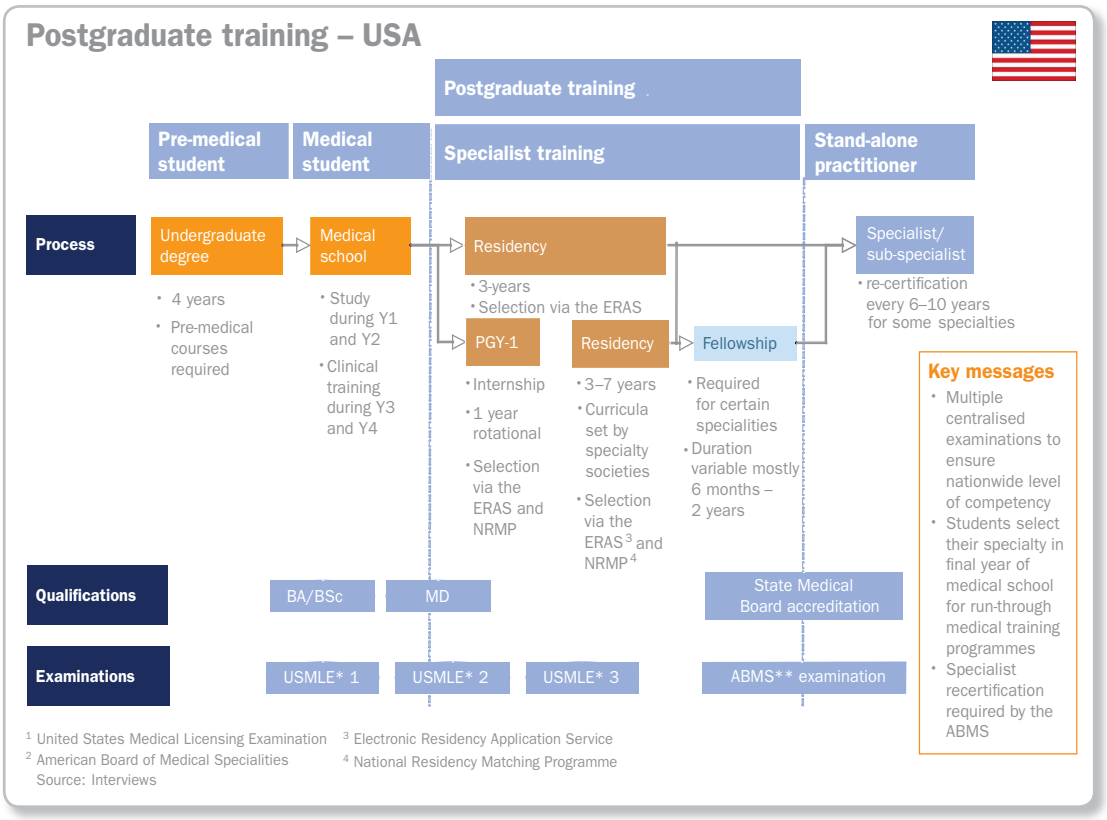

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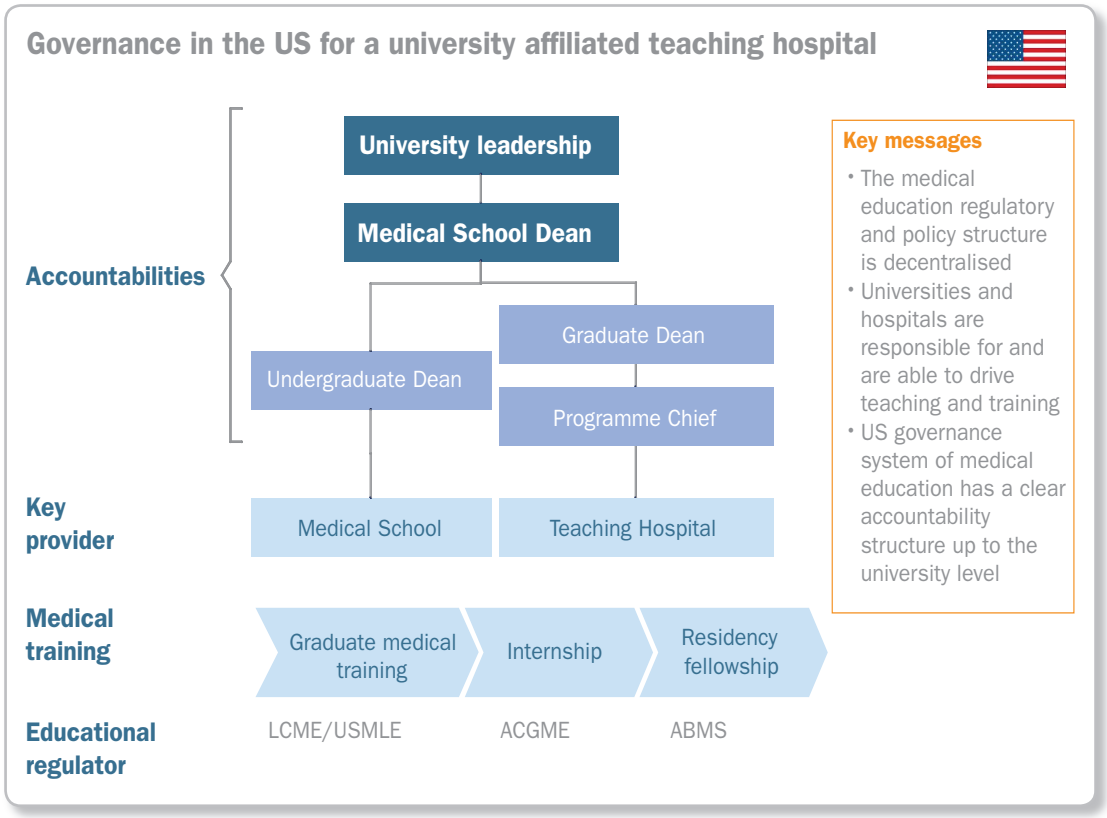
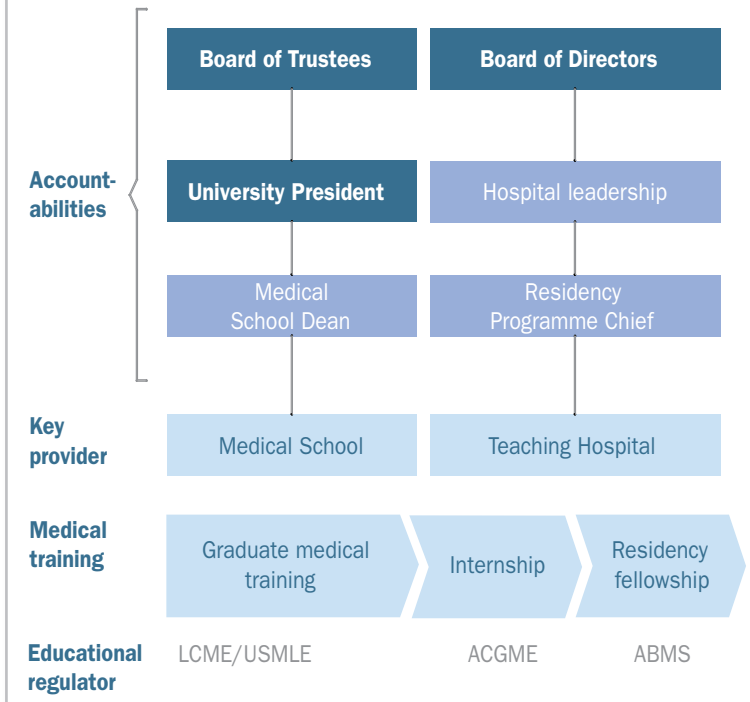


Figure 7.9

Governance in the US for a non-university affiliated hospital



Key messages

- The medical education regulatory and policy structure is decentralised
- Universities and hospitals are responsible for and are able to drive teaching and training
- US governance system of medical education has a clear accountability structure up to the university level

Figure 7.10

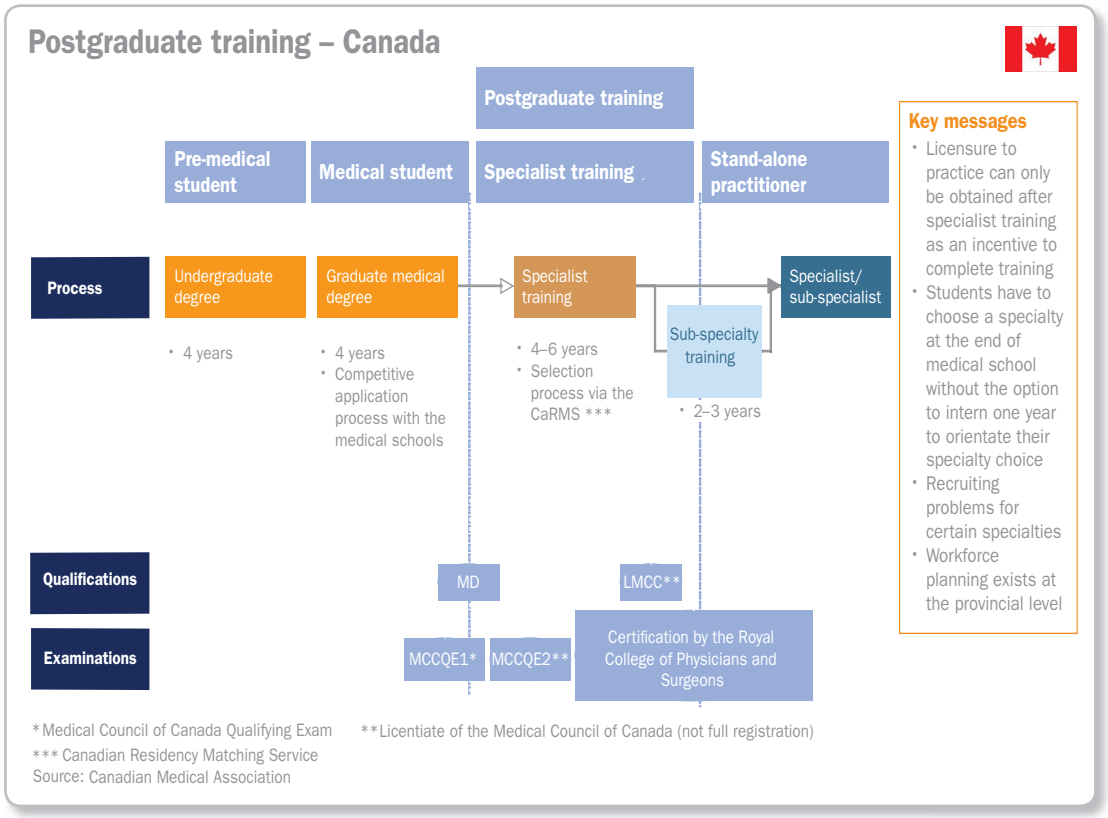
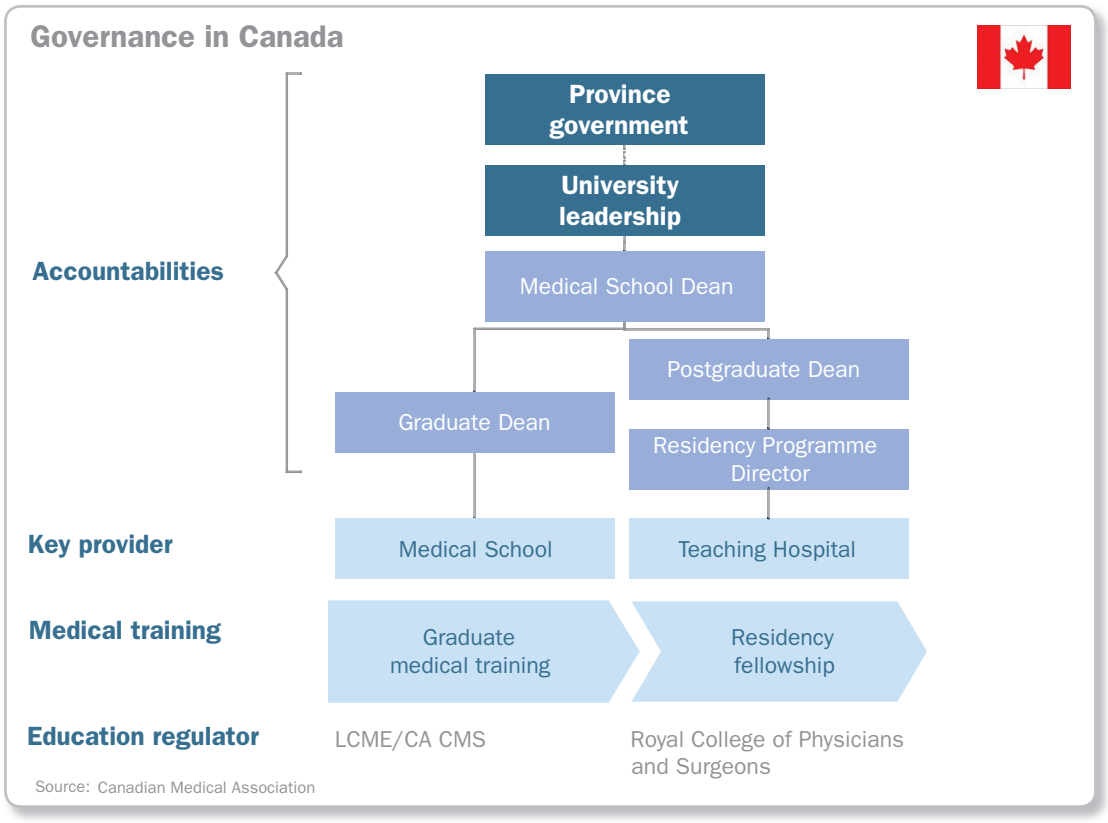


Figure 7.11



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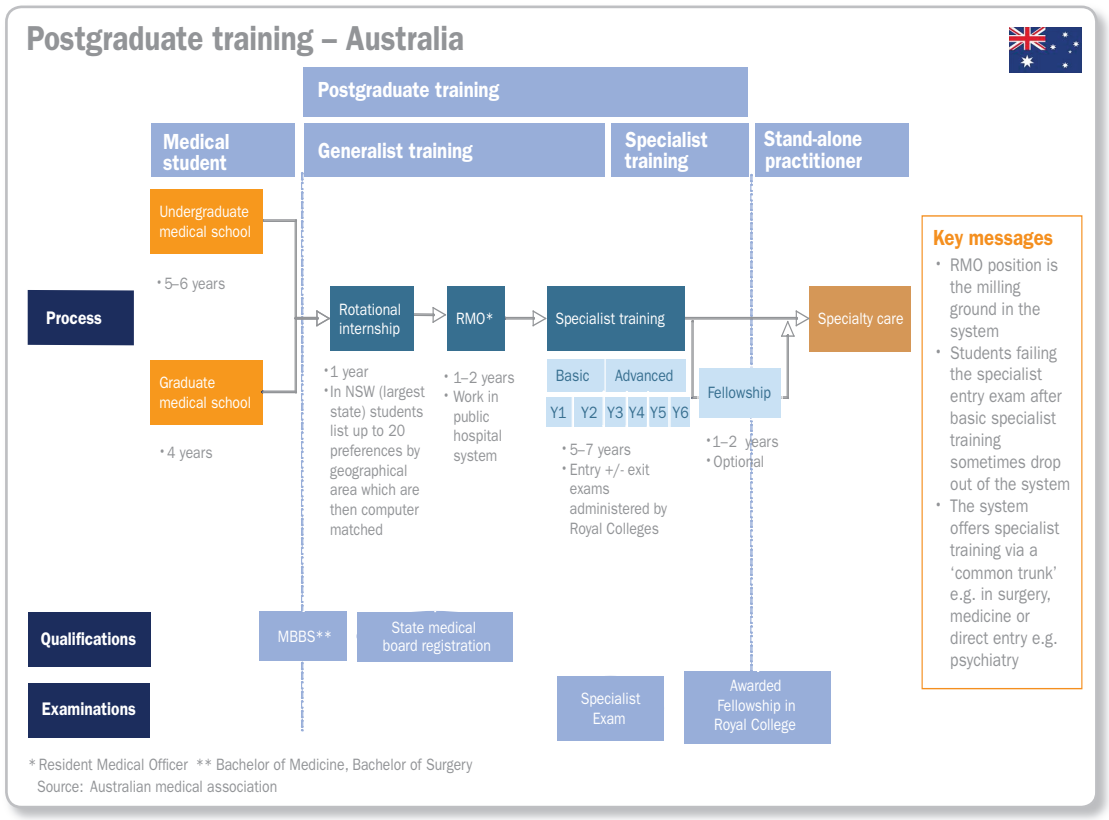

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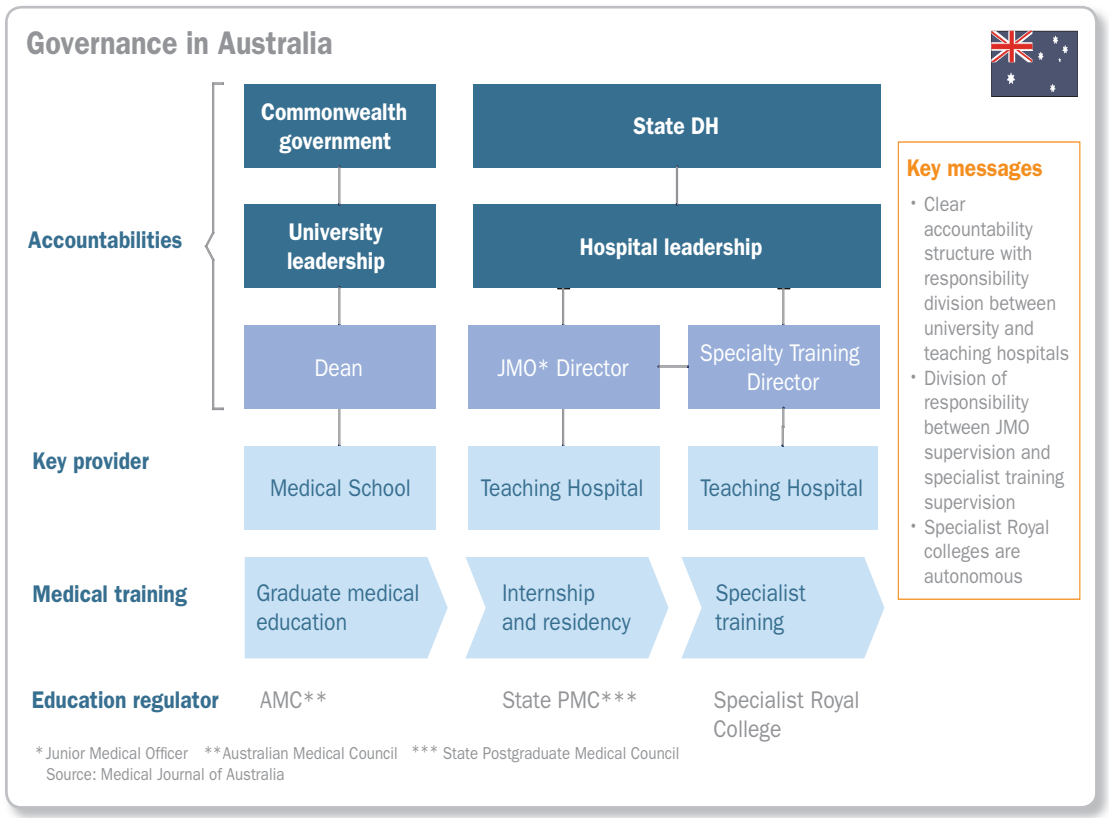

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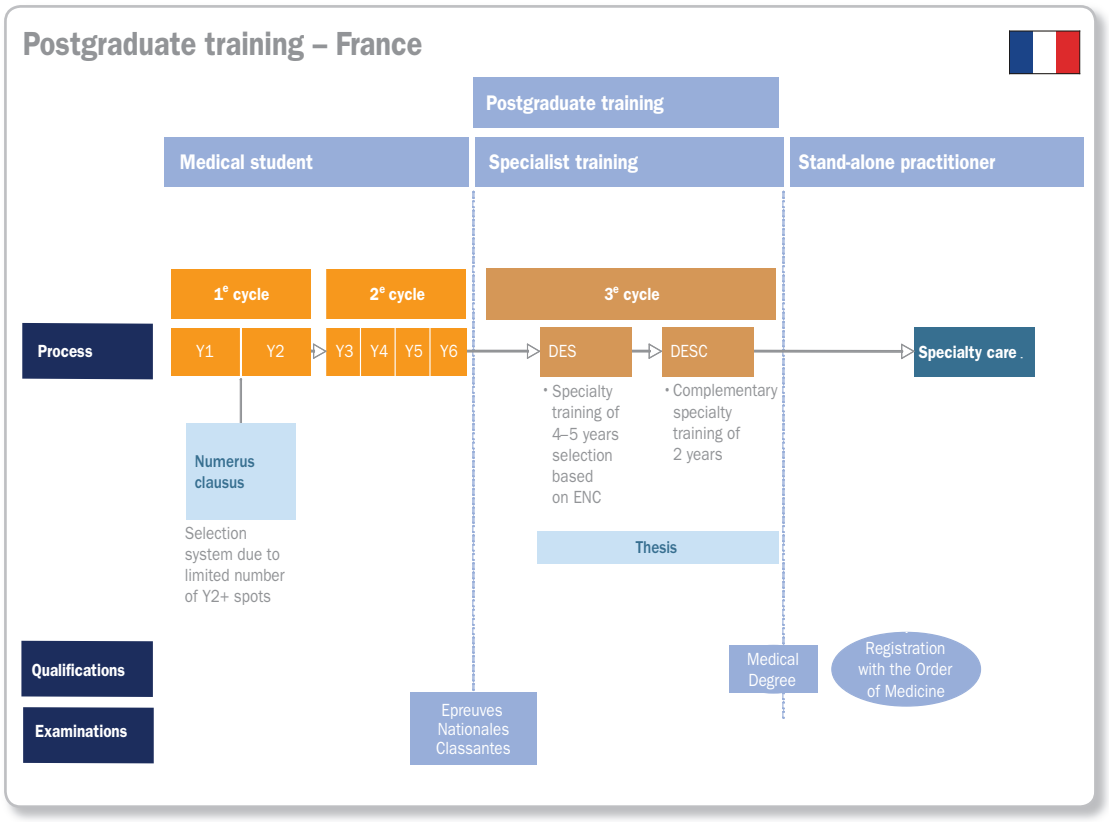

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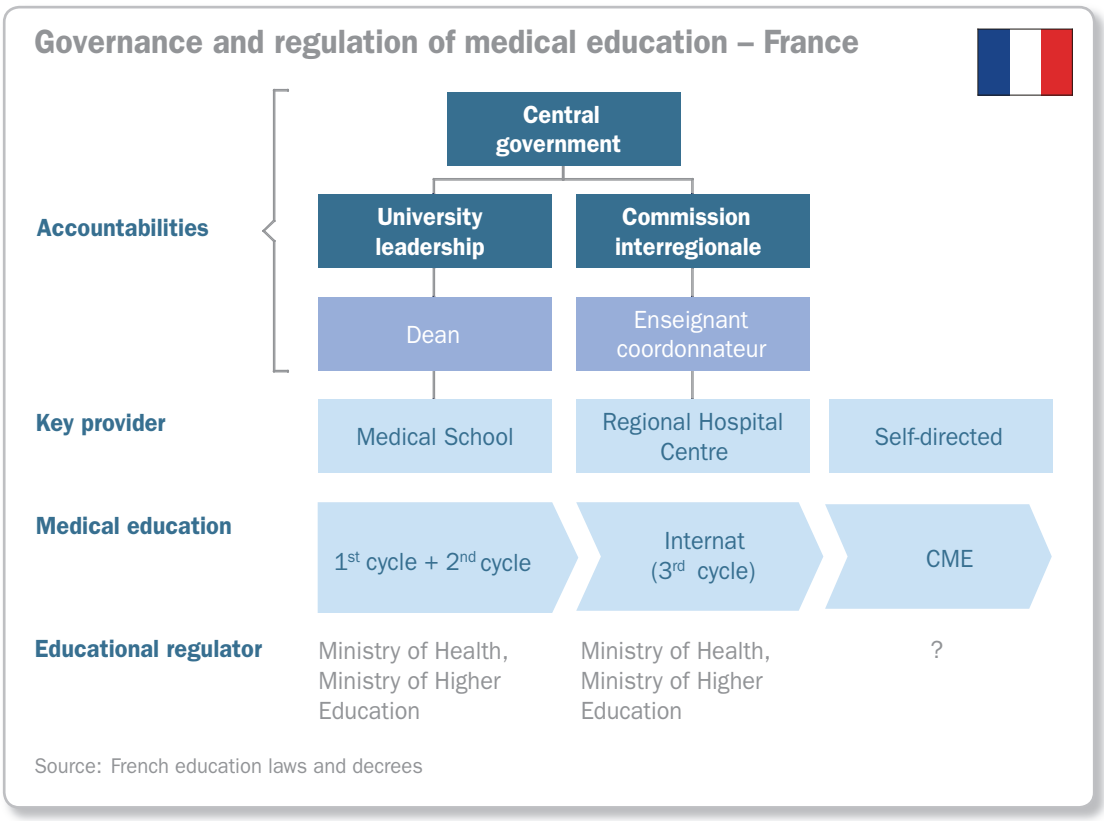

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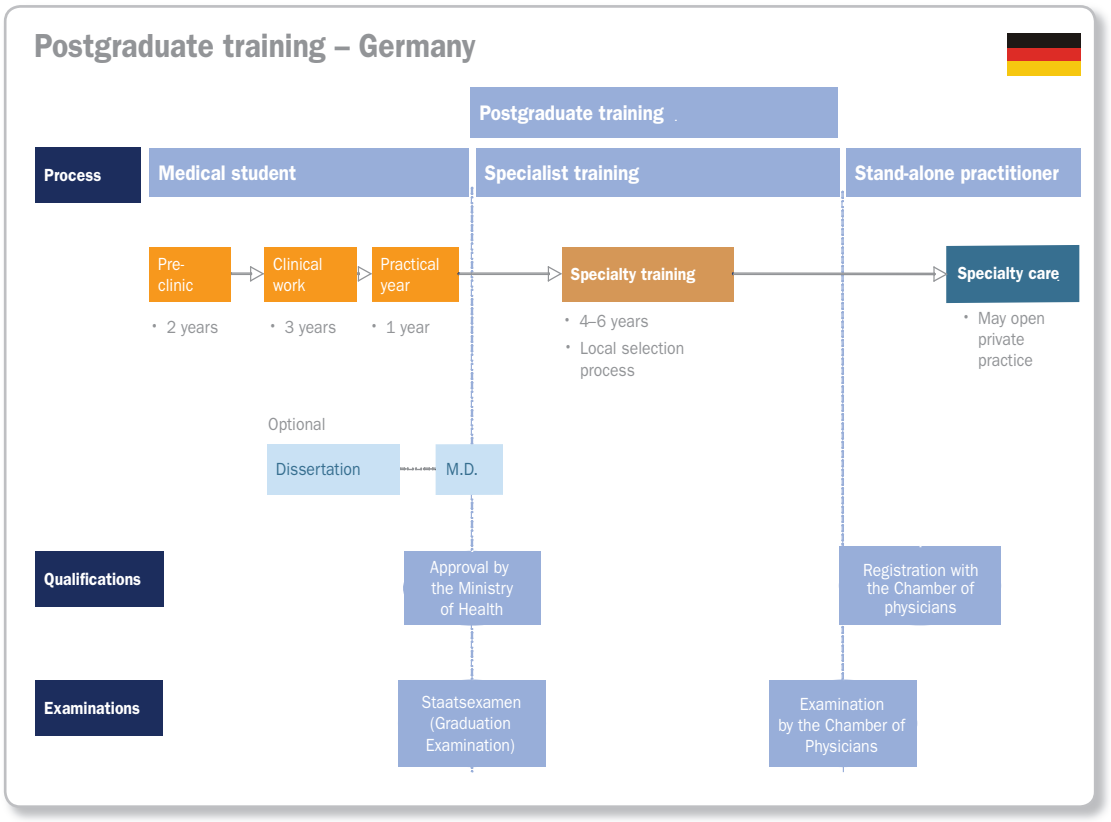

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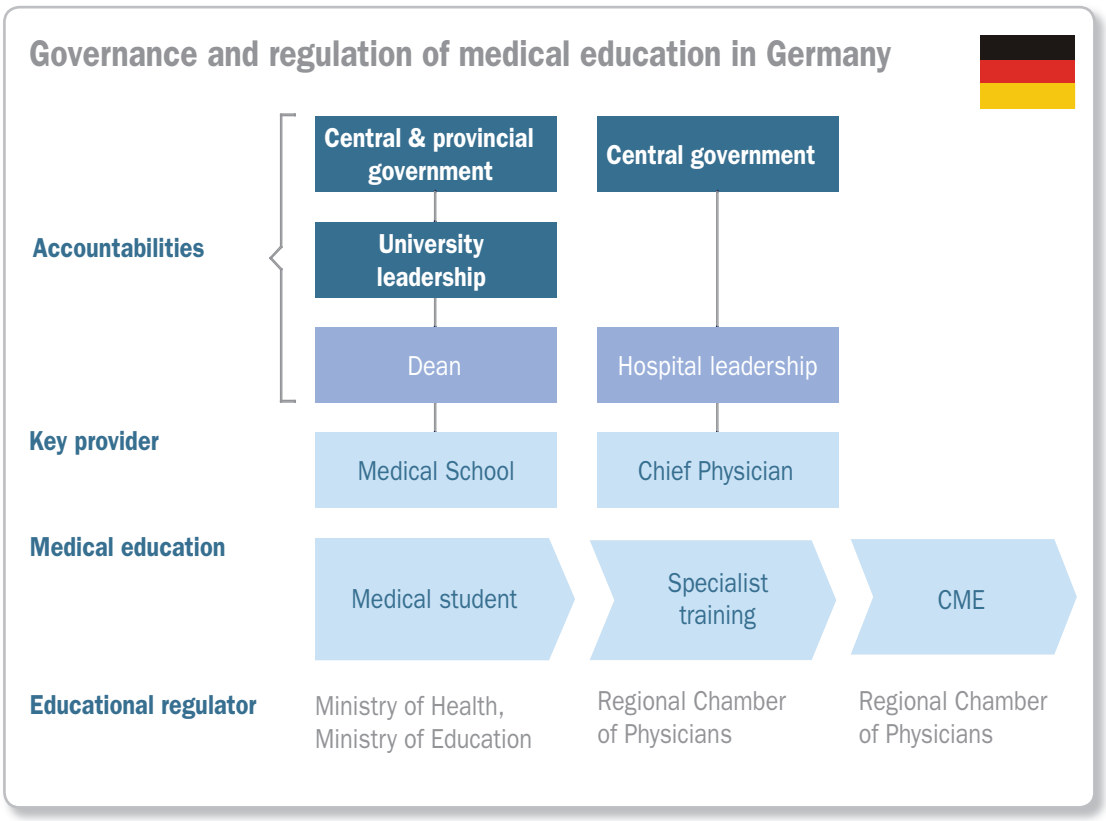

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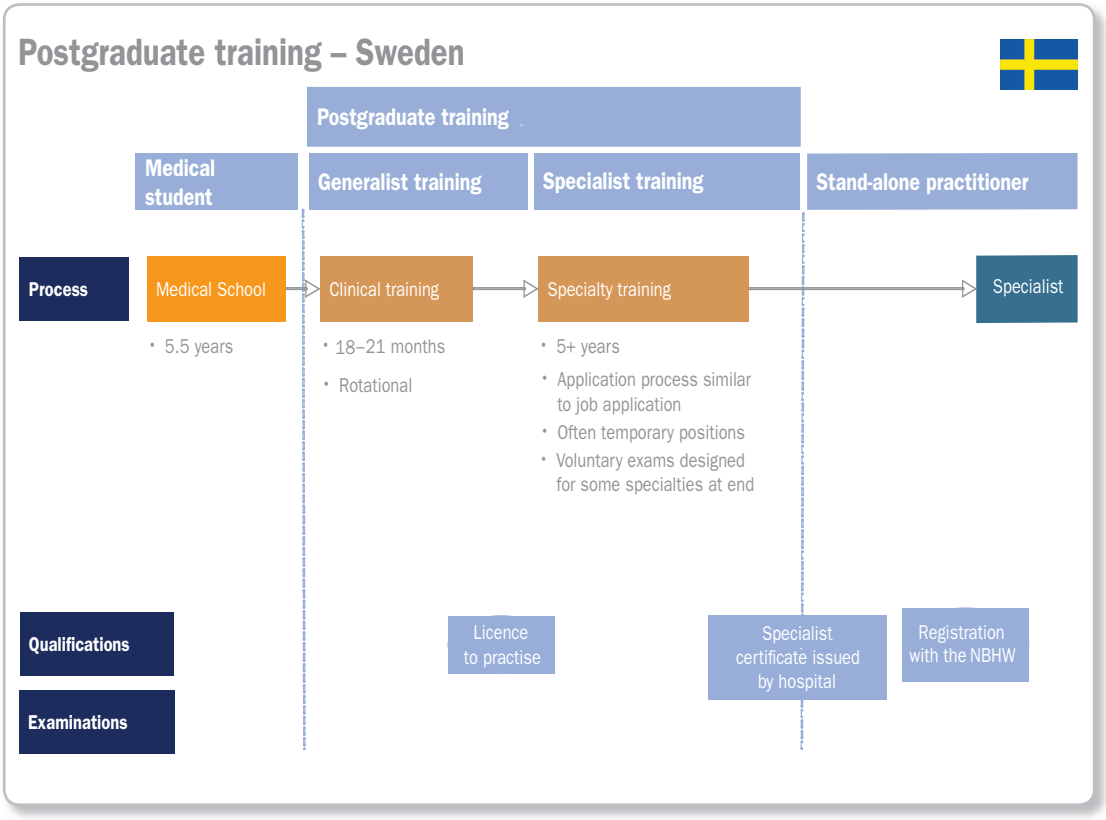

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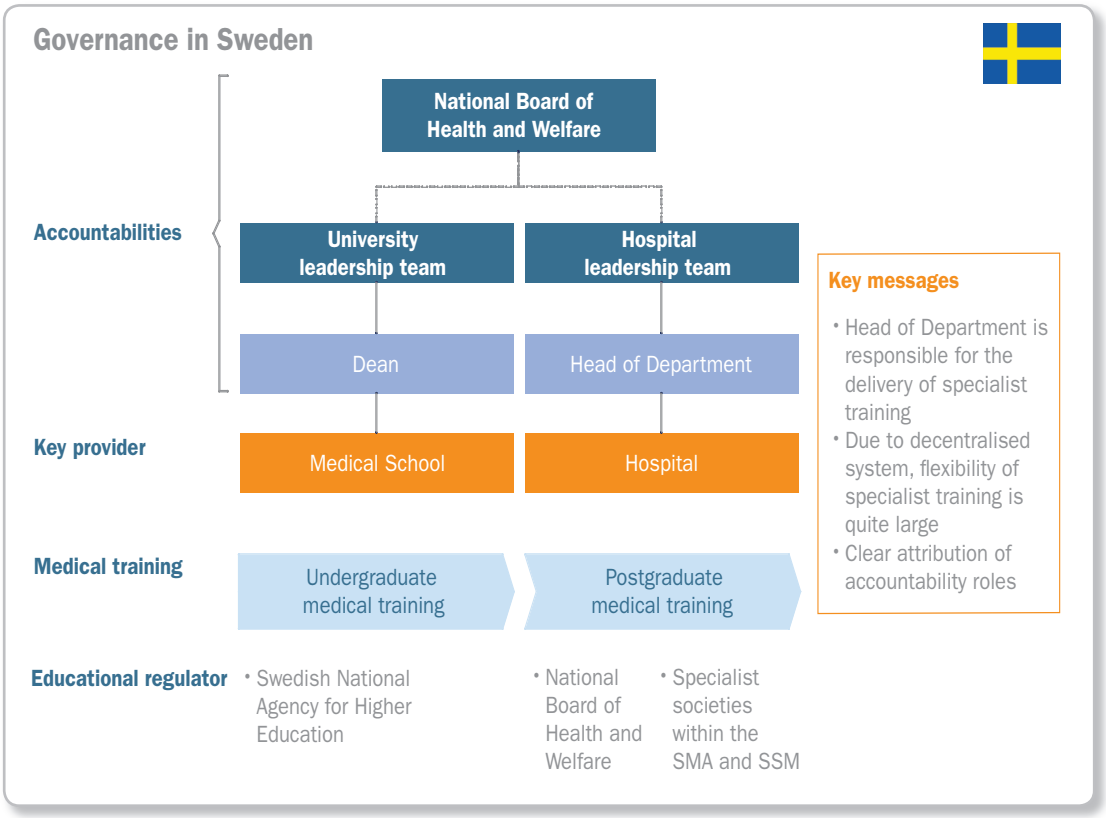

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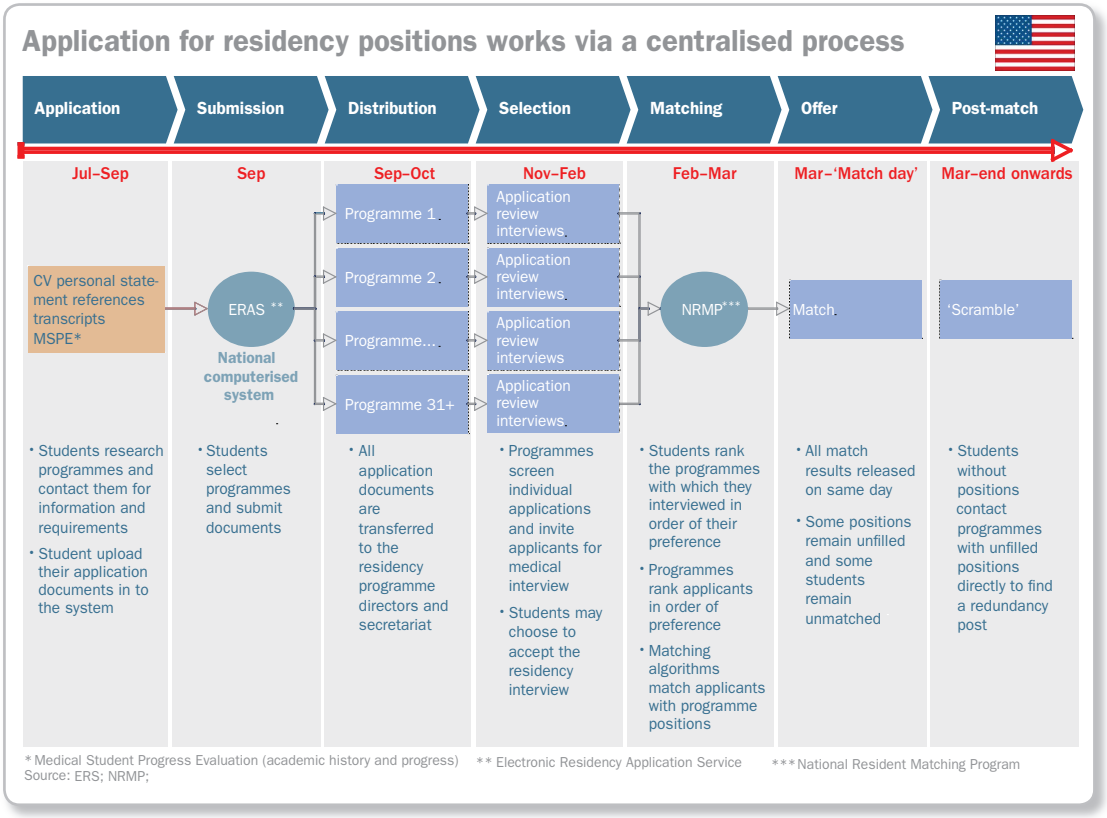
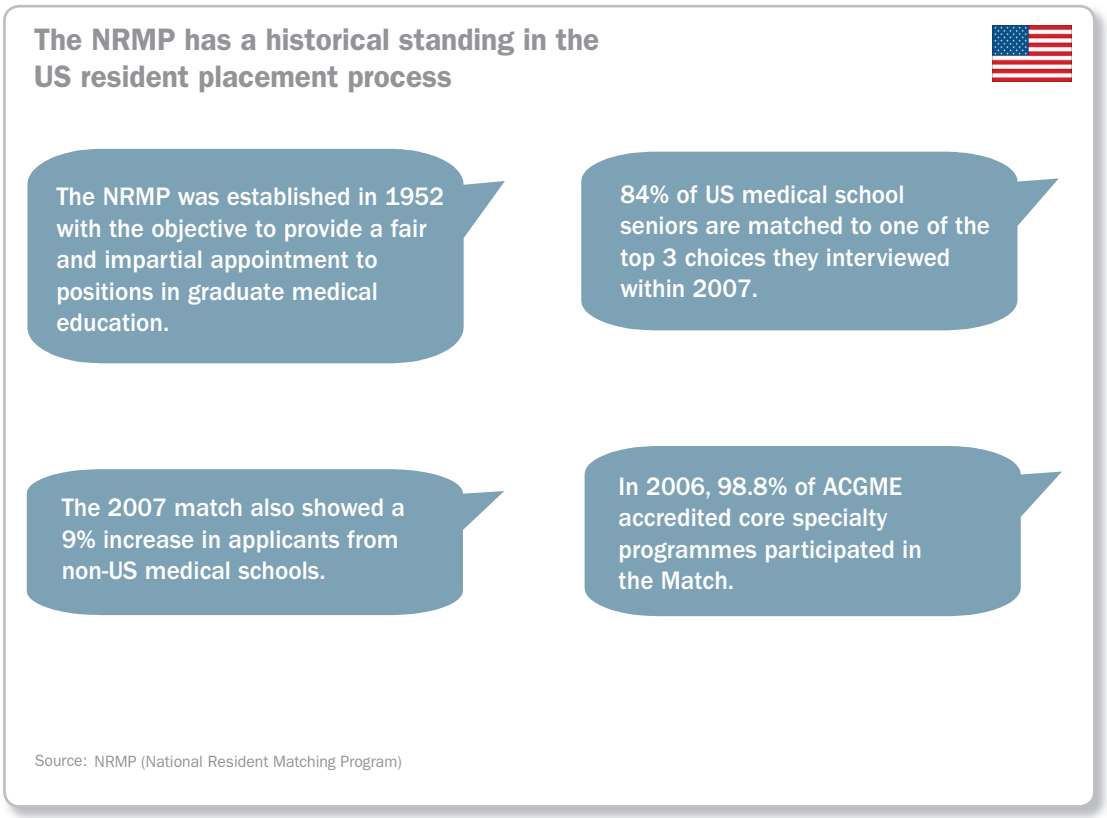


Figure 7.21



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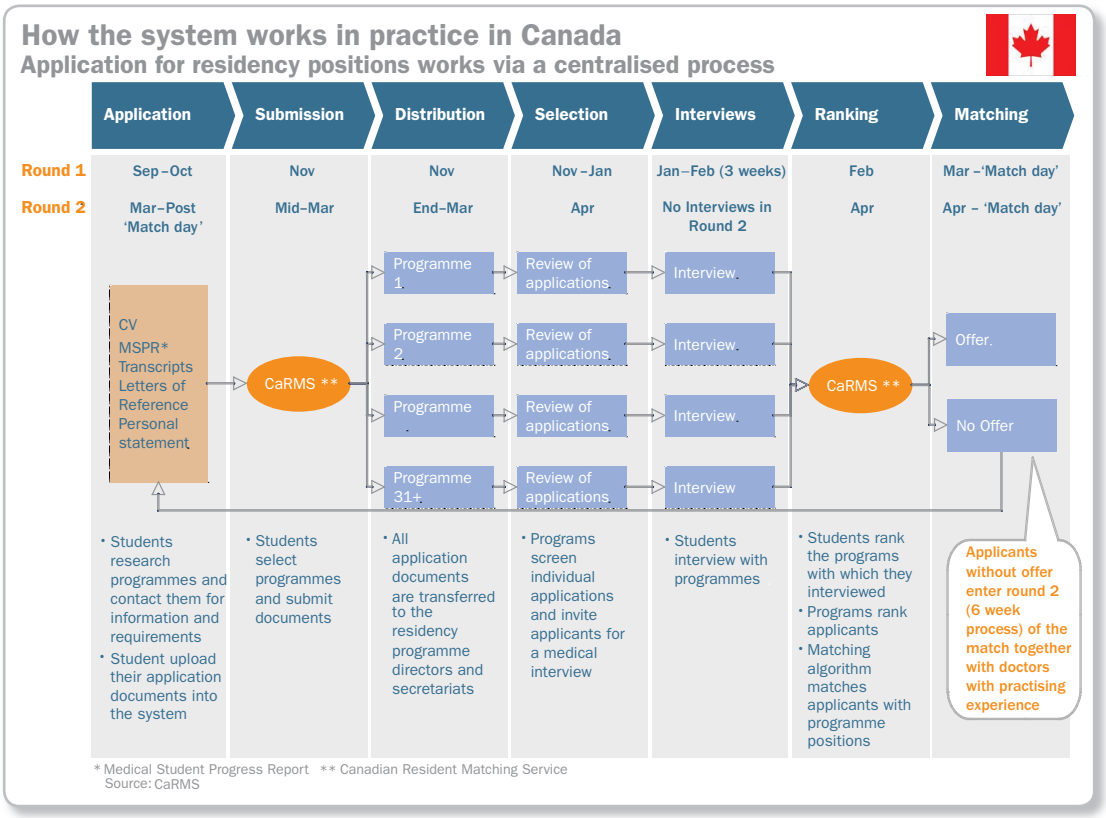

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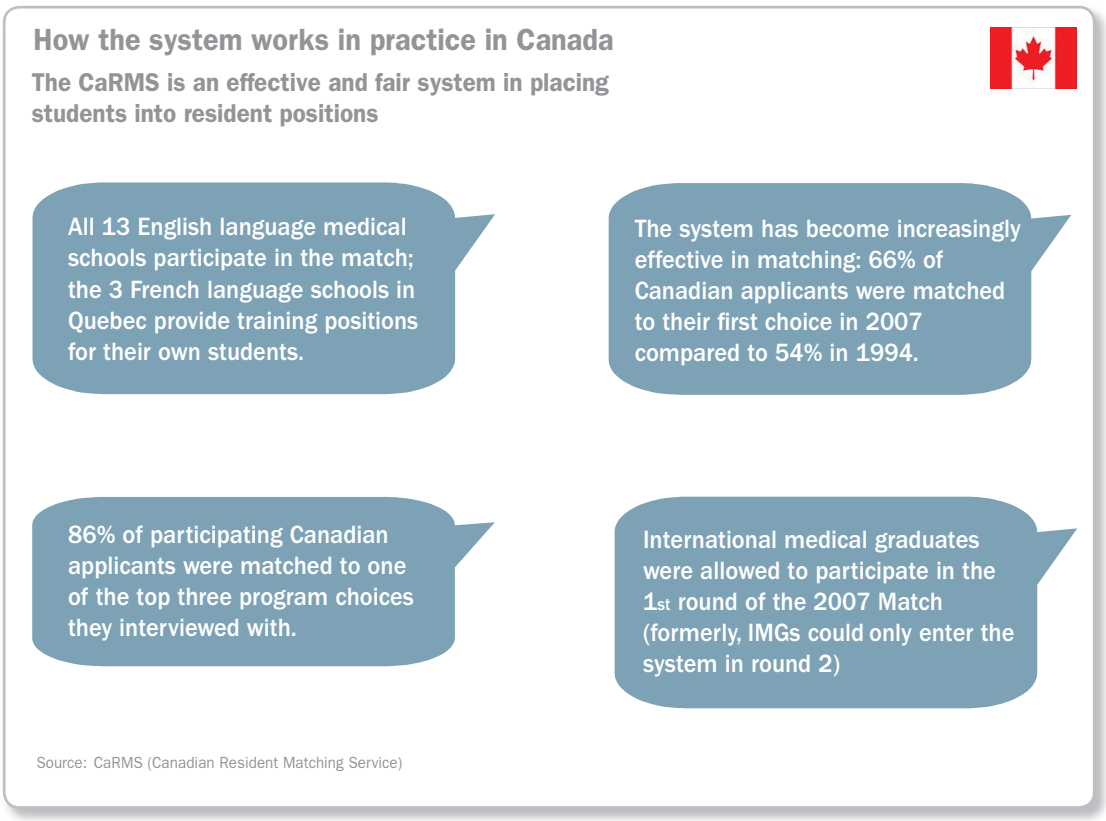

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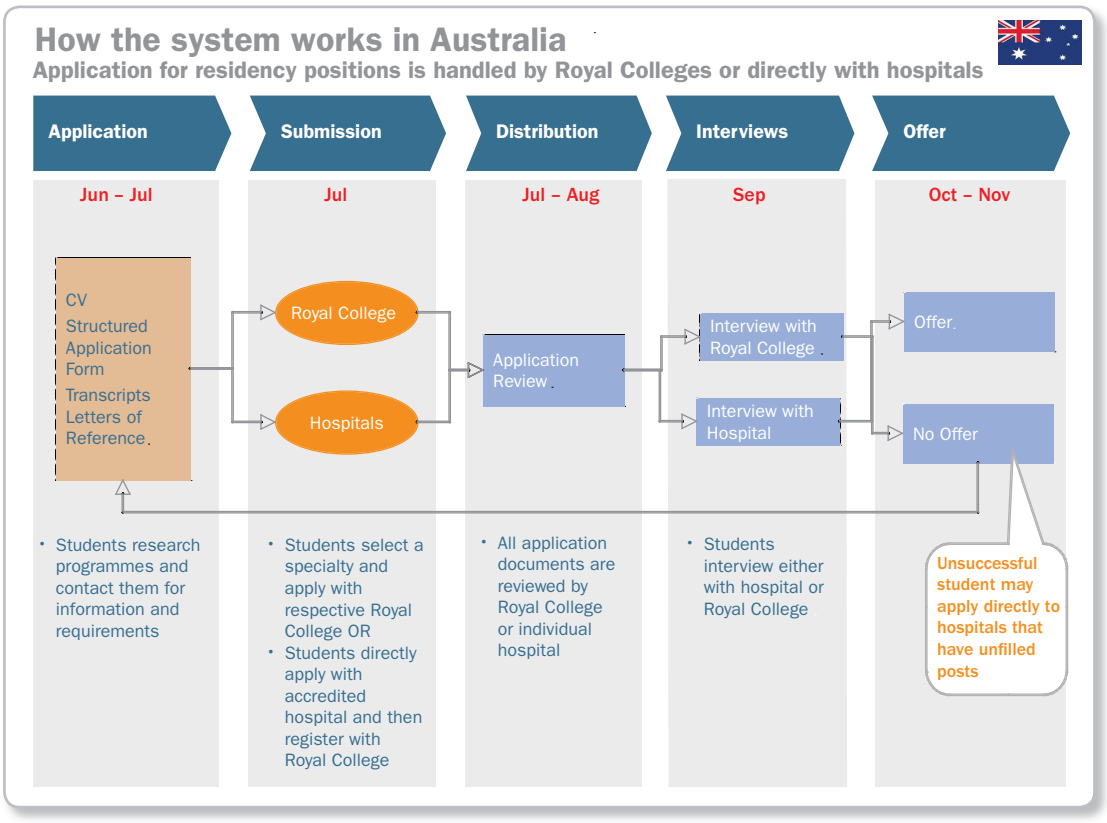


Figure 7.25

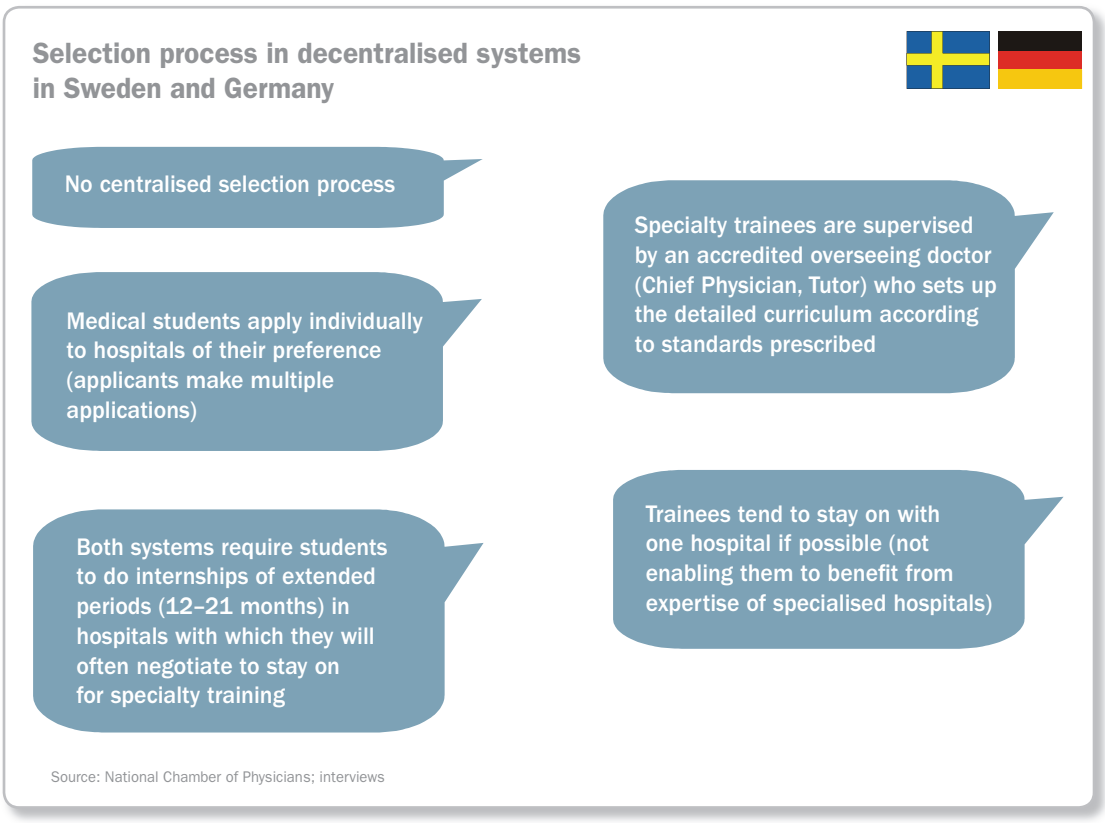


Figure 7.26

Comparing medical training assessment methods in USA, Canada and Australia

Type of assessment	USA	Canada	Australia
Continued in-training evaluation	• Clinical assessment • Semi-annual evaluation with resident programme directors	• Rotational in-training assessment • Semi-annual faculty evaluation report	• Rotational in-training assessment • Semi-annual trainee progress overview • 360-degree evaluation (colleague/patient evaluation)
In-training examination/ tests	• Frequent multiple choice tests • Annual mock oral examinations for advanced residents (R3+) as preparation for final certifying exam • Annual specialty board in-training examinations for advanced residents (R3+)	N/A	• In-training examinations may be required by the respective specialty Royal College e.g. orthopaedics, plastic surgery
Final evaluation/ opinion	• Final opinion stating ability of student to practise independently	• Final in-training evaluation	N/A
Final examination	• Certifying exams by the respective specialty board	• Certifying exam by the Royal College of Physicians and Surgeons	• Fellowship examination by the respective Royal College

Source: American Medical Association; Royal Australasian College of Surgeons

Figure 7.27

In the US almost 28,000 applicants applied for just over 21,000 first year postgraduate posts in 2007 suggests a 7,000 applicant oversupply

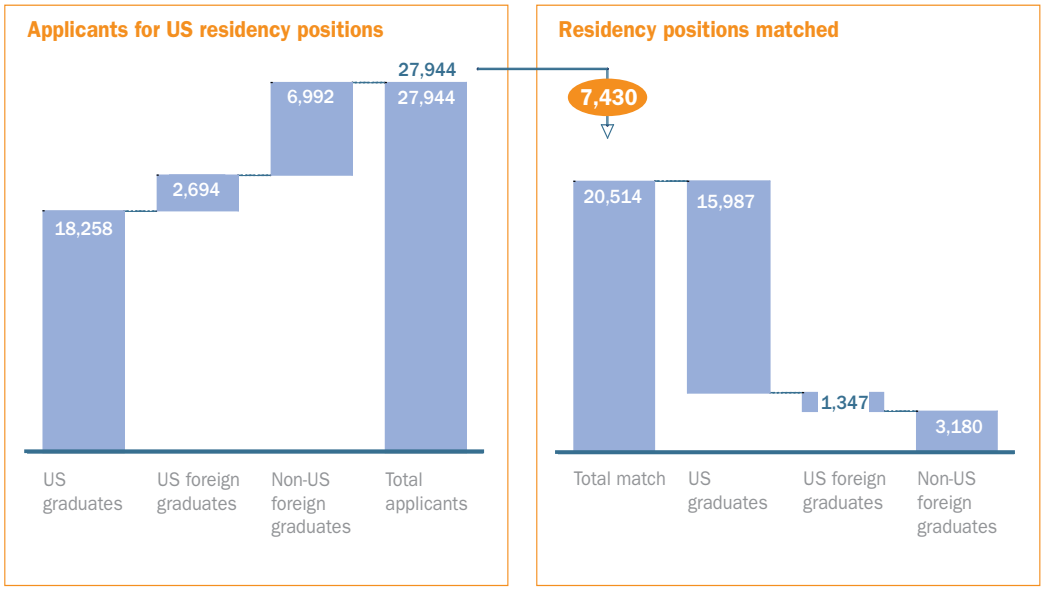
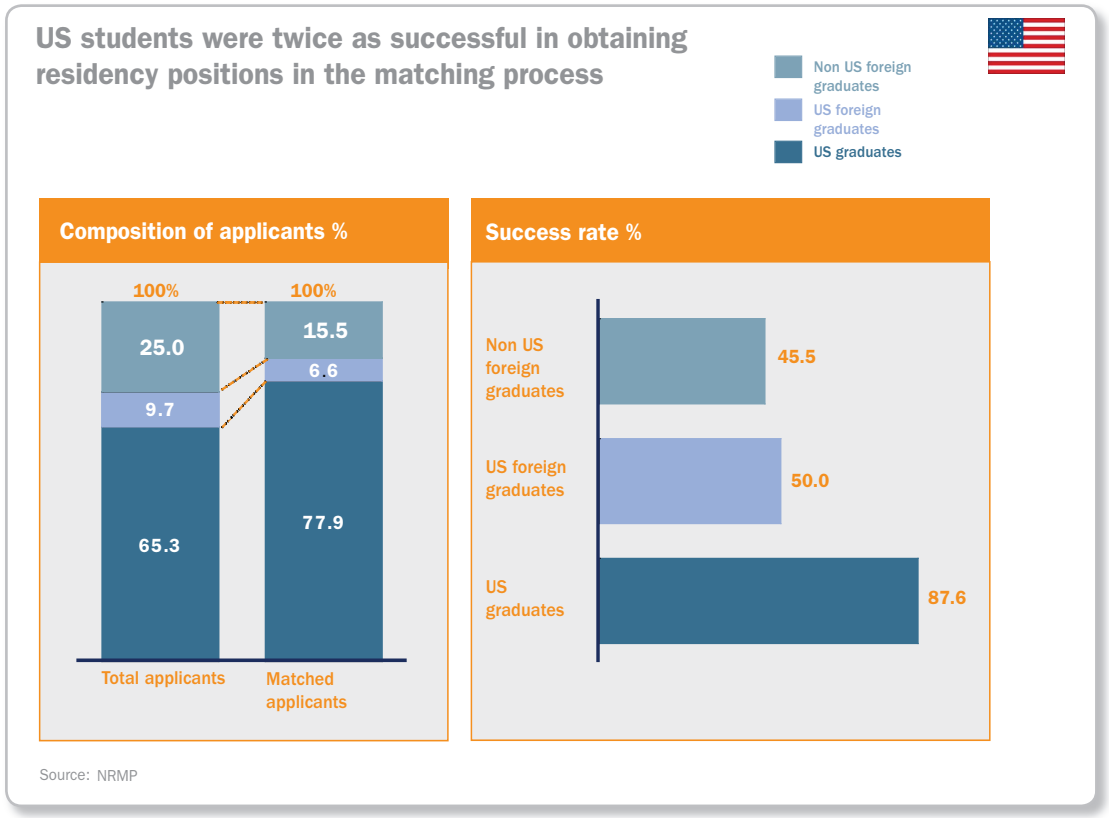
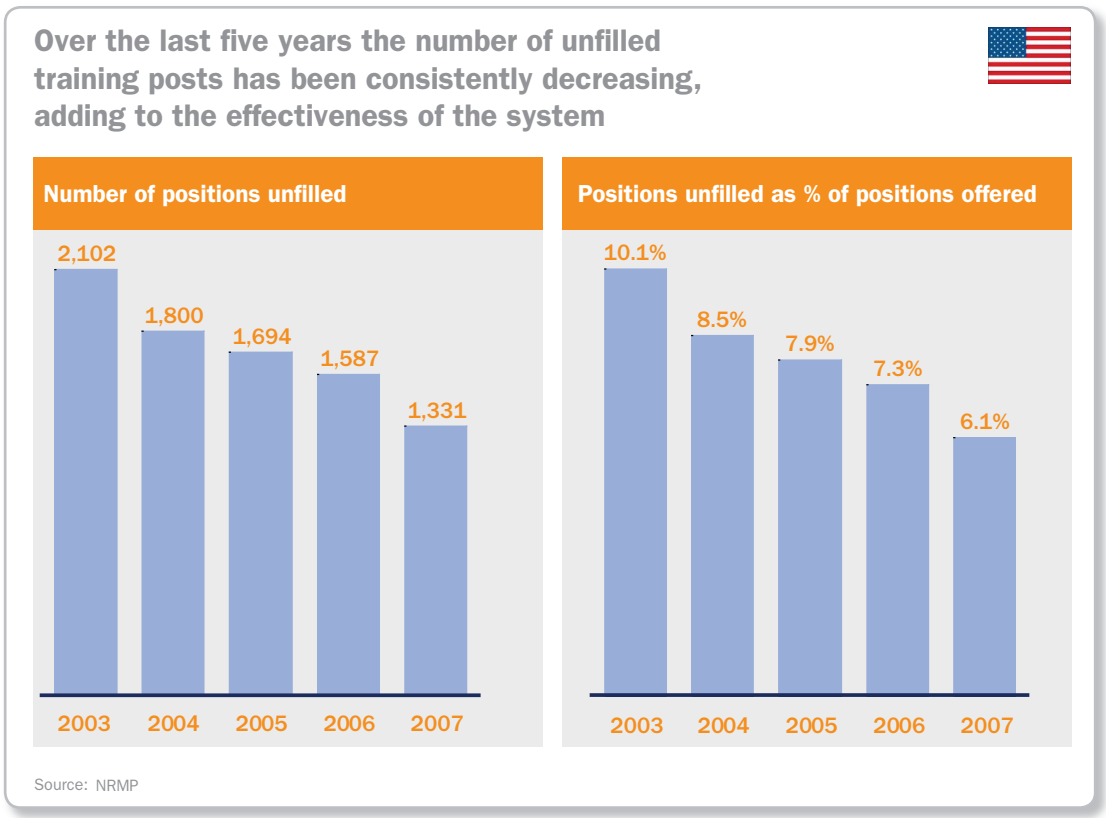


Figure 7.28



Source: NRMP

Figure 7.29



Source: NRMP

APPENDIX 8

THEMES FROM UNSOLICITED EVIDENCE

The Inquiry received 226 unsolicited communications which raised the following issues:

Contextual factors/miscellaneous

- Impact of EWTD: eroding efficiency, reducing supervised clinical experience
- Future role of the nurse
- Career choices
- Information from individual colleges and faculties on examinations
- Partnership possibilities with Association of Academic Health Centres in the UK
- Personal reflection of career development and impact of role models
- Concern about possibility of challenges to the review group's independence
- Positive comments about the openness of the Inquiry
- Concern about the Inquiry's online questionnaire
- Plea for the Inquiry to look at workforce implications alongside educational reforms
- A model for organising postgraduate medical education at the provider level

MMC – critical comments

- Training requirements conflict with service requirements
- Inflexibility
- Pilot schemes were too narrowly focused on feasibility
- Career choices made too early
- Clinical tasters provide insufficient exposure to specialities/particular problems for small specialties
- Truncation of learning time/4 month posts too short/ Rapid rotation of juniors through posts
- Does not promote discrimination between foundation doctors/ does not recognise and reward excellence
- May create recruitment problems in less popular specialties or geographies
- Pathway too defined/too narrow
- Many criticisms of run-through grade
- Place of research insufficiently acknowledged
- Diminishes choice
- Alternative career path needed for those not selected
- Too narrow in outlook
- Competency model criticised
- Too much paperwork
- Need more opportunity to value aspects that are less easy to measure e.g. team working, rapport
- Lack of evidence on its educational value
- Lack of provision for adequate mentoring
- Concerns about patient safety
- DOPS lacked robust criteria or were irrelevant or out of date
- CBD and miniCEX – not clear whether formative or summative
- MiniCEX form should facilitate interactive feedback
- Reservations about miniPAT
- Consultants are not IT literate
- Ministers did not listen to criticisms
- Foundation is not a coherent 2-year programme
- Cost impact on Trusts – may be leading to creation of insufficient posts
- Impact on workforce (varied arguments that too many and too few doctors may be trained)
- PMETB should be asked to clarify its vision of quality control
- Criticisms of PMETB, including inflexibility
- Concerns about perceived lack of independence from Department of Health / government
- Must consider MMC alongside workforce planning/training too many people
- Impact of immigration on UK doctors, who may be finding it hard to get posts
- Inadequately resourced e.g. consultants' time/ Need for more consultants if MMC is to be properly implemented
- Students did not think MMC would help them in their careers
- Trainees felt deprofessionalised and treated as commodities

MMC – less critical comments

- Technically well conceived (but problems in implementation)
- Support for concept of single national process for selection; don't throw the baby out with the bathwater

- Some job security once in run through training
- Suggest change to September for start of F1 and F2 jobs
- Criticisms of MMC have been made, but some of the problems are due to other factors (e.g. medical immigration)
- Clearer training framework benefits quality and uniformity of training and adequate workforce planning
- MMC gave a great opportunity to modernise training, and without it emergency medicine would not have been able to implement a proper programme, especially in anaesthesia and intensive care competencies (though major criticisms also made)

MTAS – critical comments/ suggestions for improvements

- Criticisms of national selection criteria
- Criticism of removal of specific identifiers
- Scoring system gives too little weight to important factors e.g. clinical experience, academic achievements; communication, probity etc given undue weight by comparison
- Rewards 'creative writing'
- Questions open to plagiarism
- Need more cohesion between person specification application form, short listing, interview and allocation
- Form should be easier to complete and assess
- Need for more training for assessors and shortlisters
- Selection tools should be piloted
- Insufficiently discriminatory between candidates
- Too complex
- Concerns about interview process
- Candidates in 1b did better than those in 1a; some had benefit of having learned what questions had been asked in 1a
- Structured interview should be retained prior to selection for ST1 or allocation into ST3
- Concern about short-listing
- Concern about interviews taking place only once a year
- Leads to lengthy period of uncertainty following interview
- Concern about poor chance of getting a job if called to interview
- Leads to poor morale
- Effect on family life (consequence of having little control on location)
- Poor audit trail for scoring
- Variability of scoring
- Should have more local input
- May lead to dead end careers
- May lead to medical unemployment/emigration
- Structured reference should carry more weight
- Royal colleges acquiesced with unsatisfactory arrangements
- Inadequately resourced
- Problems in the transition period, especially for those doing PhDs
- Concerns about the process being racially discriminatory

MTAS – not so critical comments

- Sympathy for centrally controlled selection process, though MTAS was not a success
- Positive experiences of interviewing for ST posts
- Successful use of similar process
- Problems are related mainly to not resourcing it properly

Evaluations and comments on educational methods and assessments

- Quality assurance
- Evaluation of Foundation Programme
- Technical review of MTAS
- Feedback and miniCEX
- Systems approach to evaluation
- Post-graduate selection – options review (with support for Computer Adaptive Testing)
- Feedback and formative assessment in the workplace
- Professional knowledge in medical practice
- Evaluation of intercollegiate surgical curriculum project

APPENDIX 9

REVIEW OF THE MEDICAL TRAINING APPLICATIONS SERVICE AND SELECTION PROCESS 2007

REPORT OF THE REVIEW GROUP

12 JULY 2007

CONTENTS

1 EXECUTIVE SUMMARY

The Review Group was established in March 2007 as a joint working party between the medical profession, Departments of Health and service to seek pragmatic solutions to the MTAS crisis in order to minimise the potential damage to trainees' careers and to patient care. The Group decided that:-

1 as shortlisting had not always identified the best candidates, all candidates would be interviewed for at least their first choice application and have the opportunity to re-rank their 4 applications in light of the competition ratios.

2 interviewers should be able to review curricula vitae and portfolios and use probing non-formulaic questioning.

3 the next round of applications should be based on local deanery processes using structured application forms incorporating curricula vitae.

4 additional training posts should be added in the next round in specialties at levels where there were both high competition ratios and projected workforce growth.

5 unsuccessful but appointable applicants should be actively supported.

Further recommendations

1 Additional new training posts need to be included in the 2008 and 2009 rounds in specialties with high competition ratios and growing workforce needs.

2 Flexibility for appointees should be maximised in order to minimise social disruption and support appointees' career development.

3 Urgent work needs to be done to understand and rectify the low number of UK graduates applying to some specialties, including psychiatry, paediatrics and obstetrics and gynaecology.

4 There must be co-ordinated planning of medical student numbers and training numbers with realistic estimates of the number of trained doctors required to provide high quality patient care in all branches of medicine.

2 INTRODUCTION

The introduction of the Medical Training Application Service (MTAS) triggered a major crisis in the medical profession. Those directly affected were the doctors who were applying for posts many of whom understandably felt their career prospects had been damaged through no fault of their own. All levels of the profession were profoundly affected and there were widespread calls for the process to be abandoned. This report deals with the actions of the Review Group trying to improve this situation. The main output of the Group has been the various decisions already announced over the past four months and these are appended.

This report seeks to

1 explain the rationale for those decisions and

2 document lessons learned during our discussions which might help those designing future processes for the selection of doctors in training.

3 BACKGROUND

Modernising Medical Careers (MMC) arose from concern expressed in the 1990s that junior doctors were largely providing service without having access to structured training. This 'lost tribe' of Senior House Officers was vital to the running of the NHS and provided invaluable patient care but SHOs were not receiving formal training to help them acquire the knowledge and skills needed to advance their careers. These concerns resulted in the Chief Medical Officer's report *Unfinished Business* from which the concept of MMC arose.

MMC developed two components. The first was the introduction of a 2 year Foundation Training programme for new medical graduates which was introduced in 2005. This was to be followed by a revised programme of Specialty Training to be introduced in August 2007. The main premises of this Specialty Training were to be that

- Specialty training would commence directly from Year 2 of Foundation.
- Specialty trainees would have a guarantee that they could complete training and achieve a Certificate of Completion of Training (CCT) in their chosen specialty provided they passed the PMETB approved assessments en route.
- Each specialty curriculum and associated assessments would be revised to PMETB standards and approved by PMETB prior to MMC Specialty Training commencing.

The initial view was that the early years of Specialty Training would consist of a number of broad streams or schools – for example medicine, surgery, primary care, laboratory medicine – progressively narrowing to specific specialties according to a combination of the trainee's aptitudes and workforce needs.

As 2007 approached, most specialties adopted specialty specific curricula which followed directly from Foundation, with the exceptions of Core Medical Training and Acute Care Common Stem (for Acute Medicine, Emergency Medicine, Intensive Care and Anaesthetics). It became apparent that transfers from one specialty training programme to another were going to be difficult to arrange and would usually require competing again to enter another specialty training programme from the beginning with little or no credit for competencies gained in the first specialty.

These 2 factors understandably increased the concerns of trainees that not only did they have to choose a specialty earlier than their

predecessors but also they needed to obtain entry to their preferred Specialty Training programme this year.

MMC Specialty Training was to be introduced in August 2007 for all levels of trainees who had not yet obtained a National Training Number for a Specialist Registrar (SpR) post. Appointments in Spring/Summer 2007 would thus be at four levels synchronously – ST1, ST2, ST3 and in a few specialties ST4.

Therefore the numbers of applicants would be very large with many graduating years applying at once – for example, physician trainees previously took on average 5.5 years after full registration to get an SpR post and thus more than 5 UK graduating years would be competing for ST1, ST2 and ST3 posts in 2007. The more senior experienced SHOs were already committed to a career and partly trained under the previous system. For them obtaining entry into ST posts in their already chosen specialty was a high stakes process, especially as many considered there were insufficient ST3 and ST4 level posts this year to provide them with a similar chance of career progression as the more junior trainees. The lack of certainty around opportunities to enter specialty training at levels above ST1 in future years created the feeling that this year's process represented the only chance for these doctors, and for Staff and Associate Specialist doctors, to progress their careers, and so increased the stress surrounding it.

All applications would be made through a centralised computerised system – the Medical Training Application Service (MTAS). Application forms were developed in conjunction with the Work Psychology Partnership using generic "white box" questions. Specialty specific questions were added to these generic questions. Identical application forms and scoring systems were used for each level of ST training.

Prior to applications being submitted numerous concerns were expressed about the application system and these had been accompanied by calls for the process to be halted or delayed to allow their rectification.

The identified concerns included whether:

- the MTAS computers could handle the large volume of information being input by a huge number of applicants;
- the computer system was secure;
- plagiarism would be detected;
- the person specifications were sufficiently discriminating;
- there were enough training posts to allow similar chances of accessing training in comparison to previous years. There were particular concerns whether there would be enough ST3 posts, and ST4 posts in some specialties, for experienced SHOs;

When applications were submitted there were problems with the system running slowly on occasions. There were also instances of candidates reporting that data they had entered were lost. However a major groundswell of concern arose once candidates judged excellent by colleagues found they had not been shortlisted for any of their 4 preferences. In addition it was reported that some outstanding candidates had not been shortlisted for Academic Clinical Fellowships. Both the Academy of Medical Royal Colleges and the BMA expressed serious concern and sought urgent action by the Departments of Health.

At the routine Academy meeting on March 5th business was dominated by anxieties expressed by every College and Faculty that urgent action needed to be taken to help the trainees who had been adversely affected. All believed that the system had worked satisfactorily in some geographies and specialties and that the interviews that had taken place had identified many excellent applicants who should not be disadvantaged by having the whole appointments process scrapped. The Academy sought and obtained an urgent meeting that evening with the Secretary of State to seek immediate action to modify the appointments process.

At that meeting it was agreed that a Review Group led by the Academy should be set up. The aim of the Review was 'to review the recruitment and selection process for application to specialty and GP training programmes in 2007 and make recommendations for improvement and restore confidence in the system'. This was not an independent review but a joint working party between the profession, the four UK Departments of Health and the service seeking pragmatic solutions which minimised potential damage to trainees' careers and to patient care. The initial membership is appended (Appendix 1).

The terms of reference were to:

- Understand what has worked and not worked to date.
- Identify and promote good practice
- Recommend action to remedy any weaknesses, taking account of legal and operational constraints.
- Identify specifically what further action or guidance is required: - Immediately (or before completion of the first round)

Before commencement of the second round / Before any subsequent rounds:

- Develop improved arrangements for the support and care of applicants.

This report comprises the Review Group's responses to the specific objectives detailed above and also the resulting communications released by the Group documenting their decisions (Appendices 1-9).

4 REVIEW GROUP'S RESPONSES TO SPECIFIC OBJECTIVES

4.1 Understand what has worked

1. The ability to score applications on-line was appreciated by consultants when it worked.
2. The interview process, in main.
3. The General Practice application system.
4. The large number of non-UK doctors who applied, attracted by UK medical training.
5. The opportunity for candidates to see all available posts at one time...

4.2 Understand what has not worked

Application form

1. Transparency of application process including poor acceptance by the medical profession of the application form, the lack of use of CVs and the scoring system used.
2. The fact that most senior doctors did not see the full application form or scoring system in advance meant that they could not provide useful advice to candidates.
3. The application form, which was designed for ST1 without recognition that applicants, especially more senior applicants for ST3 and ST4, often had highly relevant postgraduate achievements.
4. The free-text boxes encouraged plagiarism and commercial websites sold responses. Plagiarism was common but the promised plagiarism software did not function initially. Even when it did, plagiarism detection was relatively unhelpful as it could identify similar responses but could not identify whether the applicant composed or copied the text and thus could not be used to exclude applicants. In addition, the word limit was felt to be too restrictive by many.
5. Academic achievement was felt to have received insufficient weighting.

MTAS computer and application system

1. While many applicants had no problems with their submissions, there were intermittent serious problems with submission of applications and some applicants reported losing submitted data. Not all posts were uploaded at the start of the application process.
2. The MTAS system had some reported problems with applicants' information not being available to shortlisters.
3. There were also reported problems with individuals being able to change other candidates' scores, but no evidence this happened.
4. There were two well documented serious security breaches.
5. Difficulty accessing advice from the help desk.
6. Difficulty submitting references. In addition some referees reported that only the answer 'No' could be entered to the question 'Would you employ this doctor again'.

Shortlisting processes

1. Longlisting omitted in some areas due to lack of time.
2. Person specifications reported to be too bland to exclude many candidates at longlisting.
3. Variable problems with shortlisting especially in some Deaneries. Some excellent candidates not shortlisted. Many very poor candidates were shortlisted.
4. Large time commitment required from consultant staff to shortlist. Consultants were often asked to participate at short notice adding to the clinical consequences.
5. High number of hours of Deanery staff involved in process.
6. Concern about non-medical personnel used in shortlisting process.

Interview process

1. Initial interviews felt by many to be too formulaic and politically correct rather than sufficiently probing to demonstrate differences in competencies and abilities. Some panels did not understand the need to use portfolios, application forms and CVs to augment the decision making process.
2. Some clashing of interview dates due to deaneries departing from pre-agreed interview schedules.
3. In many cases the time allocated to interviews was the minimum of 30 minutes which some interviewers felt was insufficient.
4. Concerns that those with high academic achievements were particularly disadvantaged by a non-CV based process.

Communications

1. Little understanding by the candidates or their mentors that many good candidates would not get posts or even interviews in Round 1.
2. No widespread understanding of the consequences, in terms of decreasing chances of obtaining an appointment in Round 1, of limiting applicants to 4 choices, whereas previously they could apply for multiple posts.

Appointments process

1. The high total number of applicants risked significant numbers of UK trained doctors being unsuccessful.
2. Very high competition ratios at ST3 for experienced SHOs in medicine and surgery whose

careers were seen to be adversely affected through no fault of their own by an imposed change in training pathways.

3 Appointments in General Practice based on candidates' expressed specialty preference order rather than in rank order of best candidates irrespective of their specialty preference. This does not appoint the best candidates, rather the best of those who say they are most committed to GP.

4.3 Identify and promote good practice

1 GP shortlisting and assessment centre process unaltered.

2 Use of CVs and probing non-formulaic questioning in interview process reiterated from first meeting with Secretary of State on March 5th.

3 Appointment committees urged to appoint only the excellent candidates in order to leave good training posts for Round 2 so that candidates could change their specialty or geography choices and enter another training programme. It was realised that the number of good candidates not appointed to posts in Round 1 might be increased by this decision.

4 Interviewing process reported to be mainly working well and better than shortlisting. This led to the decision to allow all applicants at least one interview in England and to the interview of all eligible applicants for all their choices in Scotland, Wales and Northern Ireland.

5 RECOMMEND ACTION TO REMEDY ANY WEAKNESSES, TAKING ACCOUNT OF LEGAL AND OPERATIONAL CONSTRAINTS

5.1 Identify specifically what further action or guidance is required: Immediately (or before completion of Round One)

At the March 7th meeting, the Group re-confirmed the recommendation made at the Academy's meeting with the Secretary of State on March 5th that

- CVs should be available at interview.
- questioning could be probing and not just formulaic.
- only clearly appointable candidates should be offered posts, to allow a significant numbers of opportunities for candidates in Round 2.

The Group was reassured that this advice had been issued and enacted.

The Review Group called from the outset for:

- An independent review into the causes of the MTAS crisis and the structure of MMC, and to advise on ways forward in future years. Our role was to reach pragmatic solutions which improved prospects for trainees and ensured continuing patient care. This required the co-operation of all parties and was not compatible with seeking to apportion blame.
- A system that allowed non-UK graduates to compete on merit.
- Better data gathering to allow rational decisions to be made both by the group and in subsequent years. Too many of the decisions of the Review Group had to be based on anecdote rather than firm evidence.

From the beginning the Review Group's work was hampered by this lack of objective evidence – an example being the absence of data on the frequency of the problems which had been widely reported. In addition the possible recommendations open to us were often severely restricted by limits on resources and time but practical solutions had to be found.

An early fundamental decision the Review Group needed to take was whether the flaws in the MTAS appointment system were so great that the process should be abandoned. This was debated very seriously and at length but on balance the decision was made to continue with, but modify, the process. This decision was based on reports

- from consultants and deans that there had been a huge investment of time into shortlisting and interviewing which they were not keen to waste
- from trainees that they had put considerable effort into their applications and in many cases to their interviews and been subject to significant anxiety which they did not wish to be wasted.
- from many units of application and many specialties that the process had worked satisfactorily.
- that the interview process in the main was working well and excellent candidates were being seen.
- that there was a reasonable correlation between shortlisting marks and interview results at least in some Deaneries.

However there were clear – albeit anecdotal – examples of individuals who were not shortlisted who would usually have been shortlisted under previous appointments processes.

There were also examples of part of the candidates' application not being visible to the shortlisters making it impossible to shortlist accurately.

Thus because

1. we could not guarantee that all candidates who were not shortlisted had been treated fairly and also
2. to try to restore the confidence of the profession in the process

we agreed that candidates who were not shortlisted deserved further scrutiny.

After exploring various options which proved unsatisfactory (appendices 1-3) we agreed to ensure that all applicants had a minimum of one interview (appendix 4).

Different solutions were applied in different nations with Scotland, Wales and Northern Ireland deciding to interview all applicants for all their choice levels.

This was not deemed realistic in England due to the large number of additional interviews that would be required. Thus it was agreed that all applicants in England should have at least one interview, the maximum number of interviews that we were informed could feasibly be done. It was agreed that this should be for their first choice application (following repreferencing, see below) and that this opportunity should be opened to all eligible candidates whether or not they had been shortlisted for some/all of their other choices. Eligibility was defined as having met the job specification – that is, longlistable.

By the time this decision had been made it was apparent that there had been considerable clustering of applications to some specialties and some geographies. In the interest of transparency it was decided that the specialty and geography specific competition ratios should be shared with the candidates and that they should be allowed to re-order their preference rankings between their 4 choices if they so wished. This would allow the candidates an opportunity to change to a less competitive option from their list if they so wished. This had the dual theoretical advantages of allowing the candidates an informed choice and allowing less popular specialties and geographies a greater opportunity to attract good candidates to rate them highly.

From this point of divergence in policy on April 5th, Northern Ireland, Wales and Scotland effectively became observers at the Review Group and most if not all communications thereafter were addressed to the English situation.

Psychiatry, Paediatrics and Obstetrics and Gynaecology requested permission to offer 2 interviews to applicants in England. This was rejected for logistic and legal reasons but it was agreed that deaneries could request permission to make special arrangements including additional interviews if they anticipated very low fill rates.

The Review Group enabled a separate process for academic posts in England. All applications were rescored using a revised scoring schedule which included academic achievements and the appropriate candidates interviewed.

The Review Group strongly recommended that all deaneries in all specialties and all jurisdictions should make and close their offers on the same date. The failure to comply with this in all geographies has added significantly to the displacement of doctors from their preferred or current home locality as anxiety levels were so high that the pressure to accept any offer was considerable.

5.2 Before commencement of Round Two

Adding extra interviews to Round One delayed the start of Round 2 by six weeks. The Review Group endeavoured to minimise this delay and set demanding targets for the dates of completion of Round 1, which the Postgraduate Deans met.

The Review Group accepted the widely held view that in order to restore the confidence of the profession in the process Round 2 should not

- use MTAS as an application portal

and should be based on

- local deanery based processes
- tried and tested application forms used in previous years
- interviews using structured CV-based portfolios

Analysis of the applications in Round 1 indicated that there were some specialties and ST levels where competition was particularly high. This especially applied to some specialties in medicine and surgery at ST3 level and to Clinical Radiology and Medical Microbiology at ST1. Following review of the workforce growth potential of these specialties 215 new run-through training slots were identified and added to the posts available in Round 2 (Appendix 9). The Review Group strongly advises that at least 100 additional ST3 posts are added in for medicine and surgery in each of 2008 and 2009.

The Round 2 process developed by the Review Group is described (Appendices 6,7,9)

5.3 Develop improved arrangements for the support and care of applicants

The Review Group was extremely concerned to increase the support and care of applicants. It was obvious early in the process that there were many fewer posts than applicants and that thousands of applicants would not get training posts at all and that in Round 1 thousands of UK graduates could not get posts whatever their abilities partly due to clustering of applications to the same geographies and specialties. The Review Group was concerned that the very understandable anxiety about appointment prospects would increase stress reactions among many candidates and precipitate mental health problems (including an increased risk of suicide) for some candidates. Deaneries, employers and Colleges were asked to ensure as much support as possible was available for junior doctors.

An important aspect of increasing support was improving communications with applicants. There was such intense concern throughout the profession at the start of the process that the Group felt that in order to achieve our aim of improving confidence in the system information had to be released as rapidly as possible. This included the need to explain that the whole appointment process was not being scrapped, and why, and what steps were being taken to strengthen the process. This pressure, unfortunately, contributed to information being released that was not fully tested and was subsequently revised. Concern about the damaging effects of these revisions contributed to a relative paucity of information being released in the latter part of the review process. However, this did ensure that clear and factually correct information was imparted to applicants. The Review Group's releases to candidates are appended.

Another aspect of improving support and care of applicants was to strengthen careers advice and develop support packages for candidates unsuccessful in Round 2. The development of these packages was severely hampered by the lack of data on which applicants were applying from approved UK training posts, or had previously held such posts. The most detailed support proposals were developed by the Department of Health in England (Appendix 9)

The Group was also concerned that the imperfect appointments process might result in an increased number of trainees accepting posts in specialties which they later discovered did not suit their aptitudes or aspirations. This will require sympathetic and careful management by Deaneries and greater flexibility in MMC than had recently been envisaged. Increasing the flexibility of the MMC training programme is an important long term objective identified by the Group.

The Group supported the facilitation of inter-deanery (and intra-deanery) transfer to help doctors whose linked applications could not be honoured due to the failure of MTAS or who had had to accept a job distant from their family base to ensure continued employment and training.

6 FUTURE APPOINTMENTS PROCESSES

While the Independent Review led by Sir John Tooke will be examining this area in detail, we have identified some issues which should be highlighted.

A key, if obvious, lesson is that major changes to medical training and appointments systems should be introduced only after careful piloting and where appropriate should be phased. The rapid synchronous introduction of a new computerised system across all specialties and geographies and at 4 levels of training without adequate piloting was overambitious.

A linked issue is that there needs to be greater transparency about the detail of any new application system in advance. Few had seen and discussed the application form in its entirety and the scoring template for shortlisting before they went live. The lack of understanding of, and belief in, the application form and scoring system among applicants and their mentors fuelled the feeling of anger and frustration when they realised relevant achievements were not being rewarded. The profession did not regard the consultation over the design of the form as sufficient or effective. The short time given to develop the application system may have contributed to the lack of wide consultation.

The Review Group took the stance that the only appointments system which would be acceptable to the profession for Round 2 was the familiar deanery based structured application system with CVs followed by interviews or selection centres. While this is not the longterm solution to medical training appointments, the next time there is a change from this position it is essential that the profession fully accepts the need for and benefits of change, the process suggested and the results of detailed pilots. The Group believe the profession would be pleased to accept a major role in the design and implementation of a revised process.

7 OTHER POINTS

7.1 Application form

1 This needs to be radically redesigned with wide consultation with the profession

2 White space boxes cannot be used to differentiate candidates when completed in a non-secure environment as plagiarism was so common.

Indeed even in a secure invigilated location it is likely plagiarism with memorisation would invalidate many of the obvious questions.

3 Forms and/or scoring systems should be modified for different training levels so differences in acquired competencies and experience can be identified. Relevant achievements, both academic achievements as well as clinical, should be scored appropriately.

4 One of the biggest problems the Review Group faced was the inability to identify which applicants were currently in training posts in the UK, which were in career posts in the UK and which were from outwith the NHS or UK University system. This hindered our ability to predict how many trainees would potentially be unemployed and thus to plan support packages. Future application systems should contain a unique identifier that allows such information to be tracked.

7.2 Short listing

Considerable consultant time was taken up in shortlisting, despite which many unappointable candidates were shortlisted (in Round 1a). There would be

considerable attractions in having a scheme which was both more accurate and less labour intensive. Successful models for shortlisting include the UK GP selection system and the US system both of which are based on scores in applied knowledge tests. These have advantages in being able to identify weak candidates allowing the rest to proceed to the main selection process. Such an approach deserves further evaluation. A generic clinical problem solving test might suffice. The rationale would however need to be fully accepted by all, especially the trainees, and successful pilots run before any such new tool could be introduced.

7.3 Appointments process

There is a need to pilot and assess the benefit of alternative ways to identify successful candidates other than traditional interview. Methods to assess aptitude and ability need further evaluation. These are high stakes assessments and high reliability is required. In the future adequate time must be made available for the selection process. There is a widespread view that a 30 minute interview is not sufficient, particularly in high competition specialties choosing between many excellent candidates.

Evaluation is also needed of systems which allow candidates to be 'interviewed' once for a given specialty and the resulting mark to be 'cascaded' to other geographical areas to which they have applied.

7.4 Frequency of appointment cycles

The Review Group believe that it is essential to have appointments made to training programmes more than once per year. Entry to ST1 needs to be predominantly annual (in August or whenever Foundation posts end), but at other levels a twice yearly, or more frequent, application processes would help to fill training vacancies as they occur and assimilate some FTSTAs into ST posts, assist smooth running of the service and restore some confidence in the system. The main date for starting posts should not coincide with the peak holiday period.

7.5 Career planning

One of the major problems that resulted in understandable anxiety among candidates was the clumping of applications to the same specialties and same geographies. There was marked variation between specialties in their popularity with UK graduates. Obstetrics and Gynaecology, Paediatrics and Psychiatry all attracted around 0.5 UK graduates per training post while surgical and medical specialties often attracted over 1.5 UK graduates per post. (Appendix 10) There is a need to understand why this occurs and to make these undersubscribed specialties more attractive to UK graduates. Both improved career counselling and increased exposure in medical school and Foundation need to be considered.

7.6 Workforce planning

The Review Group expressed major concern about medical workforce planning. The potential for large numbers of UK based trainees being unable to access training including a large number of UK graduates is deeply concerning. This will be compounded by the significant growth in UK medical graduates over the next few years. There is an urgent need to join up planning of medical student numbers and training numbers with realistic estimates of the number of trained doctors required to provide high quality care.

There is also a need for clear policy on the recruitment of overseas doctors.

7.7 Output of training

The profession strongly believes that post-graduate medical training should produce doctors with CCTs at the current standard and who are competent to obtain consultant or GP principal posts.

8 CONCLUSION

MTAS sparked the biggest crisis within the medical profession in a generation and, despite our efforts, the anger continues to affect all levels of the profession. The Review Group has endeavoured to find solutions which are fair to all candidates but often we have had to choose the least worst option based on imperfect data; the introduction of ideal solutions was not possible or practical. Future appointment systems must have the full confidence of the profession before they are introduced.

12th July 2007

APPENDIX 10

MMC INQUIRY PANEL BIOGRAPHIES

MEMBERS

Professor Sir John Tooke

John Tooke trained at Oxford and at King's College Hospital Medical School and has held consultant posts at Charing Cross Hospital, where he was a Wellcome Trust Senior Lecturer, and in Exeter. He is Dean of the Peninsula College of Medicine and Dentistry and Professor of Vascular Medicine. He remains clinically active with interests in diabetes and vascular medicine as Honorary Consultant Physician at the Royal Devon and Exeter NHS Foundation Trust where he was Clinical Director from 1991-1995.

He chairs the Medical Schools Council (formerly CHMS) and the UK Health Education Advisory Committee. He is a UKCRC Board member and a member of the NIHR Advisory Board.

From 1997 – 1999 he was Director of the Postgraduate Medical School in Exeter, and was a non-executive Director of the S W Peninsula Strategic Health Authority from 2003-2006.

Sue Ashtiany

Born in Iran and educated in the UK, Ms Ashtiany took an undergraduate degree in Philosophy and Politics and a postgraduate degree in International Relations. She worked for the Joint Council for the Welfare of Immigrants and then the UN High Commission for Refugees after leaving University. During this period, she became increasingly interested in the legal, social and economic position of migrant workers in the UK and took some leave to research and write about this issue (her work being published as a Fabian Pamphlet entitled Britain's Migrant Workers).

She subsequently trained as a solicitor, specialising in employment and anti-discrimination law and is now a partner with the city firm Nabarro where she heads the Employment Group. She has always been keenly interested in health care having worked with the Anglia and Oxford Regional Health Authority on issues ranging from the implementation of the Calman Report on medical education and staffing, to the North Oxfordshire review of health care. She was a non-executive director of the Oxfordshire Ambulance Trust for 10 years and acting Chair for two years 2001-2003.

She is a Commissioner with the Equal Opportunities Commission, a non-executive member of the board of Channel 4 Television Corporation and a member of the Court of Oxford Brookes University.

Sir David Carter

Sir David Carter is a graduate of St Andrews University and holds an MD from the University of Dundee. He is currently Chairman of The Health Foundation and of the Board for Academic Medicine (Scotland). He is a Trustee and Vice Chairman of Cancer Research UK (CR-UK) and chairs the Council Research Strategy Group. He was Vice Principal of Edinburgh University from 2000 – 2002 following his time as Chief Medical Officer in

Scotland (1996-2000) and a surgical career during which he was Regius Professor of Clinical Surgery in Edinburgh (1988-1996) and St Mungo Professor of Surgery in Glasgow (1979-1988). He is a Fellow of the Royal Colleges of Surgeons of Edinburgh and England, Royal College of Physicians of Edinburgh, and Faculty of Public Health Medicine. His surgical interests centred on hepato-biliary and pancreatic disease. He was Surgeon to Her Majesty The Queen from 1993-1997. He has been President of the Association of Surgeons of Great Britain and Ireland (1996-97), Surgical Research Society (1996-97), and British Medical Association (2001-2). He was Chairman of the Scottish Council for Postgraduate Medical and Dental Education (1990-96) and a non-executive Director of Lothian Health Board (1994-96).

Dr Allan Cole

Dr Allan Cole has been Medical Director of the University Hospitals of Leicester NHS Trust since its inception in 2000 and was previously Medical Director of Glenfield Hospital since 1993. He is a consultant anaesthetist who still undertakes a limited clinical and teaching practice. He is a past Chairman of the British Association of Medical Managers (BAMM) and board member of the Association of Trust Medical Directors. He is a member of the Medical Leaders Professional Council which is advising on the structures to develop the medical managers of the future. He is currently also a member of the Interventional Procedures Advisory Committee (IPAC) of NICE. In the past, he was a member of the Specialty Workforce Advisory Committee (SWAG) and has been a member of the Expert Group on Safety for the Health Care Commission.

Sir Jonathan Michael

Sir Jonathan Michael qualified from St Thomas' Hospital Medical School in 1970. He underwent postgraduate medical training in London and the SE working at the Brompton, Guy's and St Thomas' Hospitals. In 1980 he was appointed Consultant General Physician and Nephrologist at the Queen Elizabeth Hospital in Birmingham. After spells as a Clinical Director he became Medical Director in 1993 and was appointed Chief Executive of the University Hospitals Birmingham NHS Trust in 1996. In 2000 he was appointed Chief Executive of Guy's and St Thomas' Hospital NHS Trust leading them to first wave Foundation Trust status in 2004. Knighted in 2005 for services to the NHS, Sir Jonathan was Chairman of the Association of UK University Hospitals and Chairman of the NHS Foundation Trust Network until 2007 when he left the NHS after 37 years.

Professor Aly Rashid

General Practitioner and Associate Director – National Clinical Assessment Service, Professor Rashid graduated from the University of Manchester in 1982 and gained his MD from the University in 1995. He worked as an inner city GP in Leicester from 1986 to 1992 whilst developing his academic career and was awarded the first Research Training Fellowship by the RCGP in 1987. Since 1992 Professor Rashid has worked as a part-time Principal in a semi-rural practice in Leicestershire, combining this with senior posts within the Postgraduate Deanery in Leicestershire and a Chair in Primary Health Care at de Montfort University from 1998. In 2006 Professor Rashid left his Associate Postgraduate Dean post to take up a national role as Associate Director at the National Clinical assessment Service. From 1993–6 Professor Rashid was National Chair of the Education Network at the RCGP and Director of the successful RCGP National Leadership Programme 2002-5.

Professor Rashid has published widely in peer reviewed journals in the fields of General Practice and Primary Health Care and has examined students at Masters and Doctorate levels. He has contributed to and helped organise national and international academic and professional conferences or meetings, speaking on a broad range of topics including doctors performance, innovations in medical education and diversity in health care. Professor Rashid has extensive experience of Committee work contributing to service, education, research and ethics development.

Professor Peter C. Smith

Peter C. Smith is Professor of Economics and Director of the Centre for Health Economics at the University of York. He is a mathematics graduate from the University of Oxford, and started his academic career in the public health department at the University of Cambridge. He has published widely on the financing and performance of health systems, and was founding editor of the journal Health Care Management Science. He has a special interest on the links between research evidence and policy. Professor Smith has served on numerous Department of Health advisory committees, and has advised several other UK ministries on finance and productivity issues. He is a board member of the Audit Commission, and chairs the advisory board of the ONS Centre for the Measurement of Government Activity. He has acted as consultant to many overseas ministries and international agencies, including the OECD, the World Health Organization, the International Monetary Fund, the European Commission and the World Bank.

Professor Stephen Tomlinson CBE

Professor Tomlinson graduated in medicine in 1968 from Sheffield. He did his specialist training at the Middlesex Hospital, London, then research at MIT and as a Wellcome Trust Senior Research Fellow in Clinical Science back in Sheffield. In 1985 he became Professor of Medicine at the Manchester Royal Infirmary, and was Dean of the Medical School and Faculty of Medicine, Dentistry and Nursing in the University of Manchester (1993-1999)

He became Vice-Chancellor of the University of Wales College of Medicine (UWCM) in August 2001. From 1 August 2004, following merger, he became Provost of the Wales College of Medicine, Biology, Life & Health Sciences and Deputy Vice-Chancellor, Cardiff University. In October 2006, he became Provost at Cardiff University. He has been a Consultant Physician in diabetes with the Cardiff and Vale NHS Trust since 2001 and a non-executive Director of the Velindre NHS Trust since 2002.In 2002-03 he was President of the Association of Physicians of Great Britain and Ireland, having been Secretary then Treasurer (1988-98). He is currently Chairman of the Tropical Health and Education Trust(THET)and ASH Wales.

CHIEF OPERATING OFFICER

Dr Katie Petty-Saphon

Katie Petty-Saphon was seconded to the Inquiry from her position as Executive Director of the Medical Schools Council (formerly CHMS) of the Council of Heads and Deans of Dental Schools and of the Association of UK University Hospitals. She read Natural Sciences at Cambridge and has a PhD in Biochemistry from the University of Birmingham. She is a former Governor of the University of Hertfordshire and a former Vice Chair of Princess Alexandra Hospital NHS Trust. She is a Trustee of the Royal Medical Benevolent Fund and an Associate of Newnham College Cambridge.

APPENDIX 11

GLOSSARY AND SEMINAL DOCUMENT WEB LINKS

Glossary

AoMRC	Academy of Medical Royal Colleges
AMS	Academy of Medical Sciences
AUKUH	Association of UK University Hospitals
CCSC	Central Consultants and Specialists Committee (BMA)
CCST	Certificate of Completion of Specialist Training
CCT	Certificate of Completion of Training
CGS	Certificate of Good Standing
CMO	Chief Medical Officer
COGPED	Committee of GP Education Directors
COPMeD	Conference of Postgraduate Medical Deans
DGH	District General Hospital
DH	Department of Health – this term is used interchangeably to mean both singular and plural Department(s) of Health, as appropriate in the context
EC	European Commission
EU	European Union
EWTD	European Working Time Directive
FY1	Foundation Year 1
FY2	Foundation Year 2
GPC	General Practice Committee (BMA)
GMC	General Medical Council
HESP	Health Education Strategic Partnership
HSMP	Highly Skilled Migrant Programme
JCPTGP	Joint Committee on Postgraduate Training for General Practice
JDC	Junior Doctors Committee (BMA)
LDA	Learning and Development Agreement
MADEL	Medical and Dental Education Levy
MMC	Modernising Medical Careers
MPET	Multi-Professional Education and Training.
MSC	Medical Schools Council
MTAS	Medical Training Application Service
MWSAC	Medical Workforce Standing Advisory Committee
NCCG	Non Consultant Career Grade
NHS	National Health Service
NHSE	National Health Service Employers
NHS:MEE	NHS Medical Education England
NICE	National Institute for Clinical Excellence
PMETB	Postgraduate Medical Education and Training Board

PRHO	Pre Registration House Officer
QOF	Quality and Outcomes Framework 2006
RCP	Royal College of Physicians
RCS	Royal College of Surgeons
SASC	Staff and Associate Specialist Committee (BMA)
SGUMDER	Steering Group for Undergraduate Medical and Dental Education and Research
SHA	Strategic Health Authority
SHO	Senior House Officer
SIFT	Service Increment for Teaching
SLA	Service level agreement
ST1	Specialist Training year 1
STA	Specialist Training Authority
StLaR	Strategic Learning and Research Advisory Group
WDC	Workforce Development Confederation
WRT	Workforce Review Team

Web links

Web links to documents referred to in the Report are listed below:

Unfinished Business
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4007842

Unfinished Business, Response to the Consultation
http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4071823

MMC The Next Steps
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010460

Best Research for Best health
http://www.dh.gov.uk/en/Policyandguidance/Researchanddevelopment/Researchanddevelopmentstrategy/DH_4127109

A Health Service of all the talents
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003182

NHS Plan 2000
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010198

The Future of Higher Education
http://www.dfes.gov.uk/hegateway/strategy/hestrategy/

Sir David Cooksey: A Review of UK Health Research Funding
http://www.hm-treasury.gov.uk/independent_reviews/cooksey_review/cookseyreview_index.cfm

Research for patient benefit
http://www.dh.gov.uk/en/Policyandguidance/Researchanddevelopment/A-Z/DH_4082668

Good Doctors Safer Patients
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4137232

Choice and opportunity: Modernising medical careers for non-consultant career grade doctors
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4050441

The 10 Key Principles for joint working between the universities and the NHS
http://www.medschools.ac.uk/publications.htm#2

BMA Junior Doctors Committee The Case for Delay
http://www.bma.org.uk/ap.nsf/Content/jdcmmcdelayshort

Clinical Academic Staffing levels in UK Medical and Dental Schools
http://www.medschools.ac.uk/survey.htm

Health is Global
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072697

Global Health partnerships
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065374

The Medical Act
http://www.gmc-uk.org/about/legislation/medical_act.asp

Health Select Committee Reports
http://www.publications.parliament.uk/pa/cm/cmhealth.htm

Crump Report: Future Role and Responsibilities of PDG Deaneries
http://64.233.183.104/search?q=cache:WQ9C6fY8P_AJ:www.selwdc.nhs.uk/document_view.php%3FPID%3D0000000228%26DID%3D00000000000000000387+Crump+Report&hl=en&ct=clnk&cd=2&gl=uk

Securing our Future, Derek Wanless
http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless_final.cfm

Securing good health for the whole population, Derek Wanless
http://www.hm-treasury.gov.uk/consultations_and_legislation/wanless/consult_wanless04_final.cfm

Our future health secured? Derek Wanless
http://www.kingsfund.org.uk/publications/kings_fund_publications/our_future.html

ACKNOWLEDGEMENTS

The Panel and Secretariat gratefully acknowledge the exceptional co-operation they have received from all those contributing to this Inquiry. It is a measure of the commitment to medicine and to the long term welfare of patients that such unstinting support and assistance has been provided.

The timescale for the Inquiry has of necessity been compressed. This added to the pressure to provide comprehensive, timely assessments of what went wrong – and to make constructive suggestions for the future.

To all who attended workshops, completed the e-consultation, contributed to the e-forum and created submissions for their representative organisations, we are extremely grateful.

In the background there were many members of staff in the Departments of Health, in the Modernising Medical Careers teams, in the Deaneries, in the Colleges and in PMETB, accessing archived material for us, without which the history could not have been revealed.

The professionalism of those organisations and individuals to whom work was sub-contracted – for the website, the workshops, the e-consultation and the production of this report – is acknowledged with thanks.

The normal routine of office of the Medical Schools Council was inevitably disrupted – but Helen Hayton, Ceri Margerison and Barbara Anderson rose to the challenge and were supportive, constructive and helpful.

Especial thanks though must go to Jan Smith, Sir John's Personal Assistant who worked tirelessly to decipher and type the emerging report in its multiple iterations and to ensure that systems were in place instantly to retrieve required information. She, and Carolyn Richardson scrupulously catalogued submissions and to both of them we are exceptionally grateful.

And finally we should like to acknowledge the contribution to medical education policy over many years of Paul Loveland of the Department of Health, who sadly died at the outset of this Inquiry.

MMC Inquiry
c/o 4th floor
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