



The Government Response to the
Health Select Committee Report
'Modernising Medical Careers'

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
July 2008



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The Government's Response to the Health Select Committee Report 'Modernising Medical Careers'

Introduction

The House of Commons Health Select Committee published its report into Modernising Medical Careers on Thursday 8th May 2008. This Command Paper sets out the Government's response to the conclusions and recommendations of that report.

The Modernising Medical Careers programme comprised integrated measures designed to improve the selection and recruitment process for entry to the various stages of postgraduate medical education and to enhance the arrangements and outcomes for that education and training. The need to make changes to the structure of training and recruitment for trainee doctors was supported by many in the medical profession.

However, in the course of implementation, serious problems were encountered. Not the least of them were serious difficulties in reconciling an increase in the number of domestic medical graduates, with what continued to be an 'open door' approach to medical graduates from outside Europe.

In addition, the selection and IT processes used for recruitment to specialty grades in 2007 was the subject of widespread and reasonable criticism, which led to a year which many trainee doctors found stressful and difficult.

The Department of Health has apologised for those difficulties and has no hesitation in doing so again. It is crucial that Government learns lessons from the problems of 2007, rebuilds its relationship with the medical profession at all levels and, in consultation with them and other key stakeholders, designs the best possible structure and systems for training and recruiting NHS doctors in future.

That is why we are grateful to those who have carefully investigated the background to what went wrong in 2007. As well as the Health Select Committee itself, Professor Sir John Tooke was commissioned by the Department to carry out an independent review of Modernising Medical Careers. His final report was published in January this year and makes many important and far-reaching recommendations.

The issues which led to the commissioning of Sir John's inquiry, and to that of the Health Select Committee emerged in practice from the beginning of 2007. Over the past year much progress has been made, not least through the crucial work of the MMC England Programme Board. Amongst other things, this has produced a recruitment and selection process for 2008 and a direction for 2009 which, while further improvements are needed, has shown itself to be more equitable and to have the broad support of the medical profession.

We are grateful to the Health Select Committee for welcoming changes already made in response to the problems of 2007, as well as simplified and improved governance arrangements for the MMC Programme.

Shortly before the publication of this response to the Health Select Committee, the Department of Health published the *NHS Next Stage Review High Quality Care for All and A High Quality Workforce*. These set out the broader context of issues affecting the medical workforce, as well as the specific recommendations made in this document.

* Please note that as far as possible, recommendations have been taken in the order in which they appear within the Health Select Committee Report. However, some recommendations have been grouped together where appropriate, and sections about the organisation of the 'Department of Health', 'Managing Reform' and 'NHS Medical Education England' have been re-ordered for purposes of clarity.

** Specific recommendations are referred to by their paragraph numbers within the 'Conclusions and recommendations' sections of the Health Select Committee report.

1. 'The Gathering Storm: 2003-2007'

- **We recommend that the Department heeds [warning signs that all is not well with a particular policy] in future. (Paragraph 1)**

In January 2008, the Department of Health published a specific Risk Policy and Risk Management Guidance for every member of staff within the Department and its Arms Length Bodies (ALBs) from Board level to junior members of staff in operational or delivery support roles. The Permanent Secretary, the NHS Chief Executive and the Chief Medical Officer have agreed the Policy and are committed to its application in all areas of the Department's business.

The Policy and associated guidance contains:

a high level policy statement which sets out what is expected of all staff and how risk is to be managed within the Department of Health. It demonstrates the Departmental Board's commitment to improving risk management and the seizing of opportunities that delivery of the Department's objectives can bring. The key components of the policy are:

- all staff are responsible for risk identification and management;
- there are agreed systems for escalation within projects and programmes, and into our corporate governance systems and ultimately to the Departmental Board which are supported by consistent systems and processes including the Enterprise Project Management (EPM) tool;
- staff development and communication of the risk policy;
- risk management is linked to the Department's wider business model, including business planning, Project and Programme Management and better policy making, and supported by internal control and assurance systems and performance improvement plans.

a practical risk management toolkit to help staff clarify their business objectives, identify risks and uncertainties to the delivery of their objectives, assess the impact and likelihood of risks, deal with the risks, record risks, monitor and review risks, and escalate and de-escalate risks. The basic mandatory principles of 'best practice' in risk management are also set out, as are some of the specific risk-related responsibilities at different levels of the Department of Health.

2. 'Fall-out: 2007-2008'

- **We recommend that the Department publishes an updated response to the Tooke Inquiry, setting out its final decisions on all 47 recommendations, immediately after the Next Stage Review of the NHS has been published. (Paragraph 4)**

A clear statement of decisions would be helpful for all involved but it is important to note that some of Sir John's recommendations require further work and evaluation, such as the proposal to split the existing two-year Foundation Programme for trainee doctors following their graduation from medical school.

A clear statement of the way forward for Modernising Medical Careers, including specific updates on all 47 of Professor Sir John Tooke's recommendations, will be published in Autumn 2008, alongside consideration of progress against the key principles of the Modernising Medical Careers programme.

3. The Foundation Programme

- **We...recommend that the current two-year [Foundation Programme] scheme is retained while a full evaluation of its impact is carried out in due course. (Paragraph 5)**

The Department agrees that there needs to be a debate about the strengths and weaknesses of the Foundation Programme and a full evaluation is planned.

A preliminary evaluation of the Foundation Programme will review existing national and local research to identify lessons learned from the Foundation Programme and identify any information or data gaps.

This initial work, planned for completion by the end of the year, will be used as a basis for agreeing the terms of reference for a fuller evaluation examining the impact of the Foundation Programme under the auspices of the soon to be established Medical Education England (MEE), as announced in the *NHS Next Stage Review* and discussed later in this document. In the meantime, the two year Foundation Programme will continue.

- **We recommend that the Department addresses the Tooke Inquiry's concern that current arrangements for the Foundation Programme are not legally sound and considers the introduction of legislation to safeguard the legality of the current two-year programme. (Paragraph 6)**

The case made in the final Tooke Inquiry report to split the Foundation Programme was based on the understanding that there was a legal requirement to provide Foundation Year 1 jobs for graduates of UK medical schools to allow them to obtain full registration with the GMC following successful completion of Foundation Year 1.

The Department of Health sought the views of Counsel on this point. Counsel's advice was that the Tooke Inquiry interpretation of the legislation was flawed. Whilst it is correct that Foundation Year 1 should be undertaken under the supervision of a university there is no requirement on universities to ensure their students can undertake a Foundation Year 1 post and therefore no entitlement to such a post. All such posts must be sought in open competition.

However, the Department will seek to ensure that all successful UK medical graduates have access to Foundation Programme Year 1 placements to complete their GMC registration.

4. Specialty training

- **We...recommend that the 'mixed economy' of specialist training structures introduced in 2008 be retained and that any future changes be supported and led by the specialties concerned. That specialties be permitted to offer a mixture of run-through and uncoupled training posts where this best meets their needs. (Paragraph 8)**

To meet the aim of working with the profession on this important issue and building consensus on the way forward, an event for stakeholders drawn from the medical profession and its representatives, the NHS, Deaneries and medical educators was held on 3 June 2008. This provided the opportunity to consider the future specialty training structure in the light of both the Select Committee recommendation and the different recommendation from the Tooke Inquiry, as well as providing the opportunity for other ideas to be presented and discussed.

While acknowledging that more work and further engagement will be required, including a further stakeholder event later this year, before final decisions are taken, the conclusions to be drawn from the event were that there was support for this Select Committee recommendation. The event revealed broad consensus amongst the participants around the overall direction and a number of important conclusions from the day.

These included:

- there should be no rush to introduce any changes to postgraduate medical education and training structures in 2009, and that the mixed economy structure for 2008 should continue for 2009;
- there should be a common UK-wide structure for postgraduate medical education and training wherever possible;
- there was little support to take forward the model recommended by the Tooke Inquiry;
- the mixed economy model should continue – but there was scope to adapt, refine and improve it incrementally ("evolution, not revolution") in the light of the *NHS Next Stage Review*, the evaluation of the Foundation Programme, developments around access of international medical graduates to UK training, and other relevant issues;
- further work and debate was required around a number of key points:
 - development of the criteria to be applied in informing policy decisions;
 - the definition of core training;

- flexibility for trainees in training pathways – the concept of transferable skills and how they could be recognised and applied within the training structure;
- the balance of generalist training at lower levels of the speciality training process as against the point of entry to speciality training;
- the possible end points of training linked to modular credentialing (which formally record a doctor's capabilities at a particular point in their training);
- how sub-specialty training should be incorporated within the structure.

Recommendations to ministers based on these views and results will be made later this year.

5. Academic medicine

- **...we echo the Tooke Review's recommendations that integrated training schemes be developed and that doctors be allowed to transfer to and from the clinical training system in order to conduct research. That the number of centrally funded academic training posts be increased and that the academic training systems runs parallel to that for mainstream clinical training. (Paragraph 9)**

The National Institute for Health Research (NIHR) has developed an integrated academic training pathway to support doctors and dentists undertaking clinical training. Academic Clinical Fellowships (ACFs) and Clinical Lectureships (CLs) are available across England and run in parallel to standard specialty training. These innovative posts allow trainees to spend a proportion of time in research (25% for ACFs; 50% for CLs) with the remaining time spent completing clinical training.

The number of posts has increased steadily since 2006 and the NIHR is committed to expanding the scheme to fund 250 ACFs (750 ACFs in steady state) and 100 CLs (400 CLs in steady state) per year. The NIHR has already made good progress towards this goal.

6. Recruitment and selection

- **We...recommend that the Department devolve all responsibility for recruitment to Deaneries as soon as possible, including allowing them to set their own timetables. (Paragraph 10)**

The Department of Health supports this recommendation, alongside an evolutionary approach to change in postgraduate medical education, training and recruitment. However, experience has shown that deaneries, Royal Colleges and trainee doctors' representatives welcome some elements of central coordination and guidance. While it need not necessarily be hosted within the Department of Health, and proposals for devolution to a Strategic Health Authority are made later in this response, the need for such a coordinating role may continue.

Similarly, there is experience from both the General Practice recruitment programme and the more recent specialty-specific recruitment process hosted by the Royal College of Obstetrics and Gynaecology, that specialties, in conjunction with a lead deanery, can operate successful, England-wide recruitment processes.

In order to gain feedback on processes to be used in 2009 and beyond, the Department has designed a process of engagement with stakeholders, including both trainee and consultant doctor. Such views will be crucial in determining the most appropriate future approaches.

- **We recommend that a staged recruitment process, with at least three substantial recruitment rounds per year, be established in the future. (Paragraph 12)**

This recommendation is supported, both in order to avoid unnecessary potential disruption within the NHS, and to offer trainee doctors themselves a wider range of opportunities and career options throughout the year.

However, it is important to note that those doctors leaving the Foundation Programme each year do so at the same time. The requirement to recruit to a large proportion of ST1 posts simultaneously across specialties in August is therefore likely to remain. In addition, as the MMC England Programme Board or its successor organisation (which is outlined below) devise more flexible recruitment rounds, logistical problems may need to be overcome so that the needs of the NHS can be met.

- **We recommend that the MMC Programme Board consider the case for introducing a national 'metric' [a national test or examination to increase the objectivity of shortlisting] as a matter of priority. (Paragraph 13)**

The MMC England Programme Board has agreed a programme of work to pilot and evaluate new selection methods. The pilots are intended to help establish the efficiency and effectiveness of various methods of selection and their suitability for selection to specialty training.

The pilots cover invigilated tests, used to rank applicants for shortlisting purposes, along with assessment centre approaches to selection. The evaluation of the pilots will establish whether such approaches are valid before decisions are taken to implement them specialty wide. The programme of pilots is expected to run until early in 2010.

The focus of the pilots programme is on selection methods that assess the competences and other aptitudes required for particular specialties or specialty groups, rather than generic assessments that cover all specialties. We will consider, with the MMC England Programme Board, whether the agreed programme should be extended to develop generic, rather than specialty specific, selection methodologies.

7. Staff grade and associate specialist posts

- **We recommend that the introduction of this new contract [for Staff and Associate Specialist Grades] be given a high priority by the Department. (Paragraph 14)**

The British Medical Association and the Department of Health agreed a new contract for Staff and Associate Grade (SAS) doctors in March 2008. Since 1st April 2008, SAS doctors have been able to express an interest in transferring to new contractual arrangements. When they have agreed a job plan with employers and accepted the offer of a new contract, doctors can move on to new terms.

Under the new contract, SAS doctors will receive fairer financial rewards that recognise their skills and experience, and will have greater opportunities to progress to the top of their grade.

- **We recommend that the remit of the MMC Programme Board be widened to include reform of the Staff and Associate Specialist (SAS) grades. (Paragraph 15)**

The Department will ask the MMC England Programme Board and then NHS Medical Education England (MEE) when established to take this forward as applied to education and training for the Staff and Associate Specialist grades.

- **[We recommend that] responsibility for regulating the training received by SAS doctors be given to the Postgraduate Medical Education and Training Board (PMETB), and subsequently the General Medical Council (GMC). (Paragraph 15)**

This recommendation will be considered as part of a wider review of clinical career structures, and the need to remove any remaining stigma associated with the SAS grade.

- **[We recommend that] the regulator work with the relevant Royal Colleges to develop a "credentialing" system to allow experience and competence gained in SAS posts to be recognised alongside formal training and to make it easier to achieve specialist registration via the CESR route. (Paragraph 15)**

The Department of Health agrees that access to specialist registration via the CESR route should be improved. Alongside modularised credentialing as outlined in the *NHS Next Stage Review* this will be of help to those in SAS posts.

- **[We recommend that] employers make use of the new SAS contract to ensure consistent access to funding for training and development and to develop extended roles for SAS doctors. (Paragraph 15)**

The Department has provided recurrent Multi Professional Education and Training (MPET) levy funding to support the development of staff grade and associate specialist doctors. £5 million was provided from 2007/08, while a further £7 million for specialty doctors and associate specialists was announced on 26th February for 2008/09 and beyond as part of the contract package.

In addition, The Department has worked in collaboration with NHS Employers to produce *An Employer's Best Practice Guide for Specialty Doctors*. This provides advice and information on how the additional funding can best be used.

Furthermore, the MPET budget service level agreement (SLA) and accountability framework has been issued to ensure that SHAs are held to account for the training they support. The SLA sets out that there should be a Learning and Development Agreement in place with NHS service providers to underpin the education and training funds passed to NHS trusts. These specify in some detail the outputs that should be delivered for the MPET investment being passed to them. One of the key performance indicators included in the SLA is that 'Funding for Non-consultant Career Grade (NCCG) Career Support, and training and continuing professional development (CPD) for SAS Grades funding should be used to support SAS doctors wishing to progress their careers'.

8. The consultant workforce

- **We recommend that the Department of Health and the relevant medical Royal Colleges examine the introduction of a hierarchy within the consultant grade similar to that used in clinical academia. (Paragraph 17)**

This is a controversial area of debate within the medical profession and will require detailed and extensive work in a context of engagement. We propose to ask the newly established and independent MEE to consider consultant career progression.

- **We recommend that the Department resolve [whether it is committed to the NHS Plan aspiration of moving from consultant-led to consultant-delivered care] conclusively as part of the *NHS Next Stage Review*. The Department must recognise that moving away from its commitment to consultant-delivered care would have significant implications. (Paragraph 18)**

The NHS Plan, published in 2000, recognised the need for a service delivered by trained doctors. This has been interpreted as supporting either a 'consultant-led' or a 'consultant delivered' service. The feasibility of achieving a fully implemented consultant delivered service has for some time been in question. Indeed, it could be interpreted as implying that all clinical services should be delivered by consultant staff, thus denying the substantial contribution and high quality care currently offered by other doctors and professionals in the clinical team.

The NHS Next Stage Review sets out a vision for NHS services that are delivered by a workforce planned around the evidenced needs of patients. Planning for the future medical workforce will be based upon the principles set out in the *NHS Next Stage Review* to achieve safe, high quality and affordable care, which should be based upon best clinical practice and a strong evidence base.

The new workforce planning, education and training system described, aims to ensure that decision making is as close to the frontline as possible. Working in partnership with staff, employers are responsible for developing the right workforce to provide safe, high quality and affordable patient services appropriate to the local circumstances. The professions will have a stronger voice to advise and shape strategic workforce planning, and the expression of skill mix in the delivery of care.

The BMA's recent document *Enhancing quality – promoting consultant expansion across the NHS* (April 2008) refers to a 'consultant-based' service, where the numbers of consultants in a particular service should be based on evidence that identifies the value of consultants in delivering higher quality and safer patient care with improved clinical outcomes. This is a helpful contribution to the present debate on improving the quality and safety of patient care across the NHS, and is one that the Department of Health wishes to explore further with the service and the medical profession.

- **We recommend that the Department of Health , other relevant Government departments and the medical profession work together to establish and publish and regularly update a clear rationale for deciding future training numbers. (Paragraph 19)**

This recommendation is supported. Scrutiny of workforce planning and its underpinning rationale will be the responsibility of a new organisation – MEE, as set out in the recently published *NHS Next Stage Review* and discussed later in this document. We will ask MEE to take this forward as part of its early work.

9. The supply of doctors

- **Belatedly implementing its employment guidance therefore remains the best option for managing non-EEA doctors available to the Department, and we recommend that this be done immediately if the guidance's legality is upheld. (Paragraph 23)**

On 30th April 2008, the House of Lords published its ruling on this issue. The ruling was complex. While it upheld the legality of the Department's ability to publish guidance, it also found that the specific guidance in question would have undermined the legitimate expectations of some international medical graduates. The Department is therefore unable to implement this specific guidance.

- **Primary legislation by the Department of Health to enforce its guidance might prove effective and we therefore recommend that the Department look further into this option if the House of Lords' verdict is unfavourable. (Paragraph 24)**

The Department of Health is undertaking detailed work with other Government departments to see how best to resolve this issue. It will clearly be important to develop a sustainable approach that supports training opportunities for UK trained doctors, without losing all of the benefits of international medical graduates for the NHS. The changes to the Immigration Rules will stand until a long-term course of action is agreed. One option, as a result of the House of Lords ruling, may be for the Department to issue further, revised guidance.

The Department has consulted widely on managing medical migration. The recent consultation process shows a clear consensus that Government intervention is necessary and justified to maximise the training opportunities for UK trained doctors. The changes to the Immigration Rules announced by the Home Office in February 2008 have been well-received. The full responses to the consultation will be made available on the MMC website.

- **We recommend that the Department of Health works with Royal Colleges and Postgraduate Deaneries to increase the number of dedicated opportunities for doctors from the developing world to train in the NHS for fixed periods, provided that the necessary capacity can be found within the training system. (Paragraph 25)**

One effect of the tremendous contribution which doctors from outside Europe have made to the NHS over its sixty year history is to establish a flow of expertise and experience between the UK and other parts of the world.

The Medical Training Initiative (MTI) enables doctors from developing health systems to come to the UK to gain experience and training on a temporary basis under Tier 5 of the Immigration Rules. The Home Office recently agreed to extend the period available under the MTI to two years, so that the scheme can be of greater benefit.

The Department of Health is also involved in discussions with certain countries on the possible development of exchange programmes supported by a formal bi-lateral memorandum of understanding.

The Department of Health will be pleased to work with the Royal Colleges, Postgraduate Deaneries and others to see how best to make available opportunities for doctors from the developing world through the MTI, or via exchange programmes.

10. The role of the Chief Medical Officer

- **We recommend that the job description [of the Chief Medical Officer] be reviewed to define the role more accurately and then publicised to facilitate wider understanding of the CMO's duties and responsibilities. (Paragraph 28)**
- **Complete clarity is required regarding the roles of the CMO and the NHS Medical Director in the delivery of MMC. The Department should make clear how the CMO's role as professional lead for doctors in England can be carried out effectively give his distant relationship with MMC. (Paragraph 30)**

A description of the Chief Medical Officer's role and responsibilities is published on the Department of Health website (www.dh.gov.uk).

Broadly, they are as follows:

- to prepare policies and plans and implement programmes to protect the health of the public;
- to promote and take action to improve the health of the population and reduce health inequalities;
- to lead initiatives within the NHS to enhance the quality, safety and standards in clinical services;
- to prepare or review policy in particular areas of health or health care (as the senior doctor within Government).

Given this wide-ranging remit, it is unrealistic to expect that the Chief Medical Officer should take responsibility for the implementation of a particular policy.

For Modernising Medical Careers, it was not the case that the Chief Medical Officer 'chose' not to take a more active role in the detailed implementation of the policy. For the CMO to have become involved in the design of an application form, or an IT system, for example, would quite clearly have been out of keeping with a strategic leadership role, and a distraction from his other, important responsibilities.

However, one of the key lessons learned from the experiences of 2007 is the need to create a clinical post with specific responsibility for postgraduate medical education and training. Accordingly, the existing MMC Senior Responsible Owner post was re-created as a specific and freestanding role, freed of other responsibilities, in December 2007.

As a permanent solution, the Department has created the post of Director of Medical Education to be the Senior Responsible Owner for the MMC Programme. This post has a remit that covers the full continuum of medical training; from undergraduate, through pre-registration, Foundation Programme training and specialty and GP training, up to the award of the Certificate of Completion of Training (CCT) and certain aspects of continuing professional development. The postholder will work with the regulators, Royal Colleges, deaneries, employers, universities and others. This post will report directly to the NHS Medical Director who has operational responsibility for delivering quality and safety in the NHS – a key component of which is overseeing postgraduate medical education and training, and ensuring the workforce is fit for purpose.

The Chief Medical Officer, as the Government's chief medical adviser, has a strategic leadership role within the Department of Health which includes medical education and training. As a Permanent Secretary he sits on the NHS Management Board which oversees programmes of work in this area and has a UK-wide role on the UK Co-ordinating Group, ensuring the consistency of approach between the four countries, as well as attending the MMC England Programme Board. He will work closely with the NHS Medical Director, and with the Director of Medical Education, in this regard.

11. Commissioners and providers of training

A number of measures are required to strengthen individual organisations, realign responsibilities and improve co-ordination. To this end, we recommend:

- **In the future, the Department recognise that COPMeD is not an appropriate body to implement reforms. The Department of Health relied far too heavily on COPMeD, a body with limited authority and resources, during the development of the 2007 recruitment process. (Paragraph 35)**

The future of policy development and implementation is being considered alongside the effects of establishing MEE and the work of the MMC England Programme Board, which comprises a cross-section of the stakeholders involved.

- **Postgraduate Deaneries engage their local Strategic Health Authorities (SHAs) to ensure that these are closely engaged with the delivery of medical education. Improving the quality of education should be a specific objective for SHA Chief Executives. (Paragraph 35)**

It is the responsibility of SHAs through their postgraduate deaneries to oversee postgraduate medical education. The Chief Executive of the NHS, in his oversight role, will monitor that this is the case.

- **The Department of Health strengthen its performance management of SHAs, holding SHAs to account in particular for improving the quality of partnerships with the education sector and for effective commissioning of medical education and training. (Paragraph 35)**

A service level agreement (SLA) and accountability framework have been issued to Strategic Health Authorities (SHAs) in respect of the NHS central bundle budget allocations in both 2007–08 and 2008–09. A distinct MPET budget SLA was issued as part of this process.

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

The MPET levy budget for 2008/09 was increased by 6 per cent to help provide the resource for SHAs to develop the workforce required to deliver improving patient services and to offer routes into professional training, and other training opportunities for staff at all levels.

- **SHAs improve their wider links with the education sector, and in particular with universities and further education providers, whom they should regard as key strategic partners. Postgraduate Deans should be closely involved with this work, providing a link between the education sector and the NHS. This work should be replicated at a national level by the Department of Health. (Paragraph 35)**

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

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

At a strategic level, there is a Health Education Interface Group which has commissioned work to put in place a Health Education operating model. The model includes the arrangements for funding undergraduate and postgraduate education and the terms of reference and membership for a new national health/education forum.

The NHS Next Stage Review announced the intention to see enhanced partnerships between universities, industry and the NHS (primary and secondary care) established, building on international models of effective collaboration. These partnerships, referred to as Health Innovation and Education Clusters (HIECs), will focus on the effective and timely implementation of evidence-based improvements and innovations in patient care. Over time, and in keeping with local aspiration and ability, these HIECs will be able to be commissioned to provide healthcare professional education and training. Whilst these clusters are an opportunity and not obligatory, they represent a clear commitment to improving and supporting enhanced collaboration between the university sector and the NHS and with respect to Postgraduate medical education the clusters must involve the existing Postgraduate Deans and deaneries. In addition, it is proposed that SHAs should seek to define, explicitly, the separation between commissioning (and hence quality assurance) and provision of postgraduate medical education. This work will clearly involve the Postgraduate Deans and deaneries and clusters may form part of the provision solution to this requirement. SHAs will retain responsibility for commissioning and quality assurance of all healthcare professional education and training.

- **Employers continue to be given a much more prominent role in the design and implementation of changes to medical training, through NHS Employers at a national level and through NHS Trusts and Foundation Trusts at a local level. In particular, employers should be closely involved with future changes to recruitment and selection. (Paragraph 35)**

Both NHS Employers as a representative organisation, and a representative of NHS Trusts are members of the MMC England Programme Board, and it is the Department's intention that both continue to be represented.

- **NHS Trusts and Foundation Trusts ensure that responsibility for medical education is overseen by a board level director, typically the organisation's Medical Director. Wider education and training provision should also be overseen by at least one non-executive director. (Paragraph 35)**

It is important for NHS Trusts to take responsibility for delivering postgraduate medical education and training and the Department supports the concept of this being the responsibility of an individual director or directors at Trust Board level. However, taking this forward at local level, as well as the responsibilities of individual directors is a matter for individual Trust Boards and directors themselves.

12. Regulation and inspection

In order to improve the regulation and inspection of postgraduate training, we recommend that:

- **The amalgamation of the Postgraduate Medical Education and Training Board (PMETB) with the GMC be carried out in 2010 as planned. We advise the Department to proceed carefully with this reform and to recognise that merging the two regulators is a substantial and complex task which, if mishandled, could further destabilise the training system. (Paragraph 36)**

In his response to Professor Sir John Tooke's final report *Aspiring to Excellence*, the Secretary of State for Health accepted a recommendation to merge the PMETB with the GMC as soon as possible. Legislative processes mean that this cannot be before 2010. The Department of Health will publish a timetable for doing so once a plan has been developed.

- **The relevant Royal Colleges and Specialist Associations be more closely involved in the quality assurance of the training system, drawing on their knowledge and experience in this area. Royal Colleges should work with PMETB, and subsequently the GMC, at a national level, and with Postgraduate Deaneries at a local level. (Paragraph 36)**

The PMETB Quality Framework establishes that the prime role of quality assurance of postgraduate medical education and training rests with the regulator – PMETB itself. There is a requirement for Royal Colleges to provide quality management reports to PMETB on their areas of specialty, but the main responsibility for quality management rests with Deaneries, who will work with postgraduate specialty schools on a quality control system. Royal Colleges therefore have input at all three levels of quality assurance.

13. NHS Medical Education England

- **We...recommend that the Department does not create a new national body and focuses its attention instead on improving performance management and on supporting and reforming the Programme Board. (Paragraph 40)**

The creation of MEE was a key recommendation of Professor Sir John Tooke's final report *Aspiring to Excellence*. While supporting Sir John's reasons for this recommendation, the Select Committee sets out five specific reasons for not making a similar recommendation, namely that:

- a body dedicated to medical education alone would cause medical workforce planning to become further isolated from wider health service planning;
- there are already numerous organisations involved in medical training and it seems unlikely that creating another one would improve the coherence of the training programme;
- the creation of a national body would apparently run contrary to the Department's intention to devolve more responsibility to local organisations where possible;

- establishing a new organisation would be expensive and time-consuming and would potentially disrupt the implementation of future change;
- the theoretical independence of arms-length bodies has often proved illusory in practice.

The Department of Health has carefully considered Professor Sir John Tooke's original case for the establishment of MEE alongside the Select Committee's counter-arguments. Given the strengths of both, as set out in the *NHS Next Stage Review*, the Department proposes to establish MEE with the following changes to the remit as originally envisaged by Professor Sir John Tooke:

- in addition to MEE the Department will create professional advisory boards to provide an overview and assurance of workforce proposals for each of the professional groups. MEE will need to liaise with the other professional boards and national chief professional officers over the development of new roles and introduction of skill mix and new career pathway programmes;
- MEE would not take responsibility for the management of the Service Increment for Teaching (SIFT) and Medical and Dental Education Levy (MADEL) elements of the MPET levy, which would instead be the responsibility of SHAs, as it is now;
- taking account of different models for the creation of bodies such as MEE, ranging in their length, complexity and legal requirements, MEE will be established as an independent Advisory Non-Departmental Public Body;
- MEE will be chaired by an independent doctor appointed by the Appointments Commission and will be accountable to the NHS Medical Director. It will bring together representatives of professional bodies, employers and trades unions and senior representatives of the Department of Health and NHS leadership. The membership of MEE will have a non-departmental majority. Other professional advisory bodies that are set up will be accountable to the relevant national chief professional officers.

The recommendation of the Committee that the MMC Programme Board, in a strengthened and reconstituted form, should assume a coordinating role instead of MEE is another attractive argument. The Programme Board has proved itself a capable and effective organisation, sometimes in difficult circumstances.

However, the past two years' experience of managing postgraduate medical education, training and recruitment policy have shown that there is often a clear distinction between higher level direction setting and scrutiny, as opposed to more detailed implementation and operational management.

There is a clear medium term future for both types of organisation. MEE will provide high-level direction setting and scrutiny, while the MMC England Programme Board, reconstituted as MMC England Implementation Committee, will continue its successful focus on the operational implementation of policy. The Programme Board's role in providing policy advice to Ministers and the Department of Health will transfer to MEE, once that organisation is established. The remit of MEE and details of its role are set out in the recently published *NHS Next Stage Review*.

14. The Department of Health

We recommend that the Department:

- **Establish a clear distinction between its policy-making activities and its support for the detailed implementation of policy; (Paragraph 37)**

Assessing the feasibility of a policy's implementation is a core component of overall policy development and it is, in many cases, impossible to separate the two. To do so might in fact run counter to the development of feasible change and risk wasting resource as a result.

- **Ensure that the MMC Programme Board, with representation from across the medical profession, remains the main forum for policy development and for approving plans for future changes to medical training; (Paragraph 37)**

This recommendation is supported. However, it is important to note that the future NHS Medical Education for England (as outlined above) will provide high-level policy scrutiny and advice on medical education and training to the Department of Health, while the role of the MMC England Implementation Committee will change to focus on the implementation of MEE advice and policy.

- **Ensure that future consultation with the medical profession is more than a superficial exercise, that differences of opinion among consultees are reconciled where possible, and that the outcomes of consultation are clearly recorded; (Paragraph 37)**

The Department is currently undertaking a process of detailed consultation and engagement with the medical profession and its representative organisations on the future structure and processes of postgraduate medical education. Within this process is a clear focus on asking questions clearly, ensuring that their implications are understood, and that stakeholders understand their collective feedback as clearly as possible.

- **Reduce its direct involvement with policy implementation, ceding control to Postgraduate Deaneries, Royal Colleges and employers. (Paragraph 37)**

There is likely to remain a need for coordination between the relevant organisations involved – as currently fulfilled by the Department's MMC team.

However, responsibility for operational requirements and policy implementation, the latter overseen until now by the MMC England Programme Board, will therefore be devolved to the NHS and operational elements of the existing Department of Health MMC team devolved to the control of an SHA on behalf of the NHS in a way that carefully ensures business continuity of a function which is recognised as having made significant recent progress.

The current MMC England Programme Board will continue to carry out its current role until MEE is established and the Programme Board is reconstituted as the MMC England Implementation Committee.

15. Managing reform

The Department has already made a number of changes to programme management in light of the 2007 crisis and in response to the Tooke Inquiry. The governance systems for MMC have been simplified and improved and a single line of accountability established. The new MMC Programme Board appears to give the medical profession a more meaningful role in decision-making. And the Department has adopted a more conservative approach to implementing future reforms.

We welcome these changes. However, the constitution, independence and leadership of the MMC Programme Board remain too vague to provide assurance that it can develop and implement effective solutions to the challenges identified in this report. Members of the current Board themselves warned that the views of the profession are still not receiving adequate attention. We therefore recommend the following additional improvements to the programme management for MMC by the Department of Health:

- **Members of the Programme Board should be selected in equal numbers by the Department of Health and bodies representing the medical profession; a similar process should be used to select Chairs for the Programme Board; (Paragraph 30)**

The existing membership of the MMC England Programme Board is drawn from a broad range of stakeholders, including the medical profession, the NHS, Deaneries and others. Currently the ratio of medical to non-medical representatives on the Board is around two to one. If the Department were to select half the membership while the profession selected the other half, there could in fact be a reduction in the representation of the profession on the Board. Chairs of the Board are agreed collectively by Board members. It is envisaged that similar arrangements will apply to the MMC England Implementation Committee.

- **All future policy development decisions should be approved by the MMC Programme Board. (Paragraph 30)**

The MMC England Programme Board has considered a variety of decisions affecting postgraduate medical education, training and recruitment. These have included not only issues of direct relevance, but also of deeper or related implication – such as medical migration. Similarly, members of the Programme Board have been free to raise issues for discussion as they see fit. In future, the newly established MEE will provide advice and scrutiny on the quality of national workforce planning and on education and training commissioning plans developed at SHA level, while the MMC England Implementation Committee will oversee operational and implementation considerations.

- **A document reviewing the principles behind the MMC reforms should be agreed by the Programme Board and published by August 2008. (Paragraph 30)**

As set out in our response to the recommendation made in Paragraph 4 of the Health Select Committee's report, the Programme Board will consider the principles underpinning Modernising Medical Careers and will bring forward a paper for Board discussion over the coming months.

- **Meetings and decisions of the Programme Board must be properly minuted and attendance at the Programme Board should be consistent. (Paragraph 30)**

Meetings of the Programme Board are already carefully minuted and those minutes are published via the national MMC website (www.mmc.nhs.uk) after Board members have had a pre-publication opportunity for correction. Membership of the Programme Board has been as consistent as individual circumstances can allow and is now stable.

The exact arrangements for minutes of MEE and the MMC England Implementation Committee will be discussed and agreed.

- **All future changes should be piloted and evaluated. (Paragraph 30)**
- **A "big bang" approach to reform should be avoided wherever possible in future. (Paragraph 30)**

We agree, as has the Programme Board in its discussions, that all future changes should be carefully piloted and a 'big bang' approach avoided. This, for example, was why a deliberate decision was taken not to pursue or reintroduce a national IT-based recruitment system for 2008.

- **Communication with junior doctors should be improved and a single source of authoritative information established. (Paragraph 30)**

Communication with junior doctors needed improvement following the problems experienced in 2007. The national MMC website (www.mmc.nhs.uk) was completely revamped and redesigned for 2008, following consultation and discussion with junior doctors and their representative organisations. It now contains extensive background information, competition ratios for all deaneries, levels and specialties, and a wealth of other information, such as eligibility guidance for international medical graduates.

As part of a programme of continuing improvement, active consideration as to how the national website could be improved for 2008 is now underway, with a particular focus on improving convenience for applicants.

We also recommend the following improvements, which the Department should apply to all future change programmes:

- **The Department should produce, and publish where appropriate, formal business cases to support major change projects. The expected costs and benefits of reforms should be clearly stated and, if possible, quantified. (Paragraph 32)**

All new major projects are subject to the completion of a business case in the form of a Project Initiation Document (PID). The PID covers key objectives, performance criteria and benefits, timing, resources, business risks and interdependencies.

Key Departmental projects are reviewed as part of the quarterly Departmental business cycle. Wider system performance issues are regularly reviewed by the newly-formed Performance Committee and the Corporate Management Board undertakes a quarterly assessment using the Departmental performance scorecard.

- **Formal mechanisms for reviewing progress and risks across the whole of projects should be introduced. Regular reviews should inform decisions about whether timetables for the implementation of change are realistic. (Paragraph 32)**

Risk management has been integrated into the new Departmental business planning process. Operational risks are now systematically captured in the Enterprise Project Management (EPM) system and reviewed as part of the quarterly business management cycle. A new Directors Risk Forum has been created and the corporate risk register is regularly reviewed by the Audit Committee and at Board level.

- **The Permanent Secretary should monitor all substantial change programmes being conducted by the Department and should ensure that other senior officials are informed about the progress of key projects. (Paragraph 32)**

The Permanent Secretary's role within the Departmental Board ensures that he has a clear view of the direction of Departmental policy. In addition, he chairs a Corporate Management Board as a sub-committee of the Departmental Board. One of the specific roles of the Corporate Management Board, which also involves all other Directors-General, is to monitor all substantial change programmes.

- **The Department must ensure that project management is adequately resourced and proper training provided. Managing major change projects should not be regarded as a task that can be tacked on to existing job roles. (Paragraph 32)**

Project management training has been integrated into the Departmental training and development plan and new guidance on the application of programme and project management (PPM) methodologies has been published for all Department of Health staff. In the last twelve months over 300 Staff have been provided with formal PPM training and over 600 Staff have been provided with access to the new Departmental project management system (EPM)

- **Ministers and officials should set more realistic timescales for introducing major changes, and should be prepared to delay implementation if necessary. (Paragraph 32)**

A new prioritisation model has been developed to support the business planning process. The prioritisation model makes explicit reference to the timing and deliverability of Departmental policies and projects in the wider health and social care system. This approach was used to inform prioritisation decisions for the 2008/09 business planning priorities and will be used to assess the impacts of the NSR as part of the Department's change control process.

16. Conclusion

The Department of Health, the medical profession, and others involved in the problems of 2007 have learned a great deal about how, and how not to implement reform and much progress has been made.

In particular, the work of the MMC England Programme Board, sometimes carried out in difficult circumstances, has set a foundation for the development of a constructive and cooperative dialogue between the many stakeholders involved in postgraduate medical education and training.

Thanks to the work of many who have considered the best way forward following 2007, a clear consensus is now developing about what reforms are needed, and how those reforms should be carried out in future. The members of the Health Select Committee have made a vital contribution to that consensus, which we have reflected in this response and in the *NHS Next Stage Review A High Quality Workforce*.



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